FACTORS THAT ARE ASSOCIATED WITH LABOUR TURNOVER AMONG HEALTH PROFESSIONALS IN KENYA.

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DECLARATION

This project is my original work and has not been submitted for a degree in any other university.

Signed .....

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This project has been submitted for examination with my approval as the university supervisor.

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DEDICATION

To my parents Rose and Jotham who taught me the value of hard work

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ABSTRACT

While other studies have looked at labor turnover, this is the first to do so in relation to health professionals in Kenya to the best of my knowledge. This research aimed at determining the factors perceived to be most associated with labor turnover in both private and public health facilities in Nairobi.

The rationale of the study arose from the fact that labor turnover is central to effective planning for human resources. However, there are many difficulties arising from the management of labor turnover, where the organization is expected to put in place mechanisms to attract, motivate and retain health workforce for effective service delivery.

The study required collecting information from hospitals with both out-patient and in-patient facilities in Nairobi, fifteen hospitals responded positively. Data was collected using semi-structured questionnaire, which were dropped and picked up later at an agreed date. The data was analyzed using descriptive statistics.

Results following analysis indicated that: -

- All facilities (100%) experienced labor turnover.
- Most respondents (67%) cited poor remuneration as the factor that contributed to labor turnover to a great extend. This was followed by inadequate opportunities for advancement (27%) and training (20%).
- Family obligations was the factor least perceived to be associated with labor turnover.

Generally, the findings obtainable in this study are in agreement with those of other studies already done elsewhere though in rather different conditions.

Even then however, it is suggested that the further research may be undertaken to determine: -

- What organizations are doing to retain staff i.e. to reduce the rate of labor turnover?
- The consequences of the effects of labor turnover on service delivery.

CHAPTER 1

INTRODUCTION

1.1 The concept of Labor Turnover

A common index of labor performance used in organizations is labor turnover. This provides information about the ratio of leavers to the average numbers employed during the year as a percentage. A turnover rate of 25 per cent would be considered perfectly satisfactory by most firms. A turnover rate of 100 per cent would be considered a major problem. (Cole: 2002)

As part of the health care management, managers have to plan for the human resources. In the Health Sector, this is crucial since it touches on the life or death of the people. Assessing the demand and supply of human resources in health is complicated by labor turnover. No workforce is completely static – there are always some people leaving and entering the organization, even if the bulk of the workforce is stable.

Thus supply of labor is matched with the demand forecast for labor in various categories. The overall outcome is: -

(1) The supply available more or less matches the forecast of demand by staff category.

(2) The supply exceeds forecast requirements in one or more categories

(3) The supply falls short of requirements in one or more categories, (Cole: 2002).

The third outcome is likely to apply to most organizations most of the time, that is to say, they are always short of appropriately qualified personnel in one part or another of the business. The case of doctors in public hospitals in Kenya is an outright example. If people are constantly leaving, it is not possible for the

organization, or its units to achieve an acceptable level of stability to ensure the continuity of operations.

We use 'turnover' to mean "voluntary cessation of membership of an organization by an employee of that organization". When the employee controls the leaving process, then it is voluntary and this is of interest now. This definition refers to "cessation of membership" (Morrel et al: 2001) but it should be acknowledged that from more institutional or organizational perspective, turnover may also include accession or entry. Particularly where turnover is thought to be associated with a factor (such as organizational commitments) to be preceded by a psychological state (such as intent to quit), drawing the distinction between voluntary and involuntary turnover is important, otherwise assessment of relationship in terms of all organizational leavers' will be flowed.

Involuntary turnover may occur for reasons, which are independent of the affected employee(s), such as the (real or perceived) need to cut costs, restructure or downsize. Inclusion of these cases in a study of organizational leavers; will mean any relations between turnover and a personal characteristic will be significantly diluted. Where an instance of turnover is genuinely voluntary, this instance represents the exercise of choice and is the result of a decision process.

It is important to consider the extent to which an instance of voluntary turnover may be classified as 'avoidable'. In other words, it is a case of employee-instigated turnover, which could have been prevented. This classification is useful perhaps as it can indicate the global scope for future planned intervention. For example where an organization is able to identify that the bulk of voluntary turnover is beyond their control e.g. where voluntary turnover is a result of relocation by a spouse or partner, they might profit better from initiatives which seek to manage turnover post hoc, rather than theorized preventive measures (e.g. increasing salary levels) (Morrel et al: 2001).

Turnover is often not measured in a sophisticated enough manner to enable discrimination between cases where employees have chosen to leave, and cases why they have had to leave for reasons out of their control. Often organizations use a relatively crude measure of turnover such as below:

$$\frac{\text{Leavers in Year}}{\text{Average number of staff in post during the year.}} \times 100$$

This does not distinguish the cases where people left because they were dissatisfied or cases where people left because of ill health or where they retired, or where they were made redundant. Yet measurement of turnover needs to be sophisticated enough to enable those responsible for resource planning to identify various categories of leavers. This is because any single figure measure of turnover will be inadequate in so far as it treats all those who leave a homogeneous group.

Although a relatively clear cut behavior and one which apparently readily leads itself to simple cumulative measurements, attempts to meaningfully record the incidents of turnover can result in ambiguity. Yet the need for organizations to measure employee turnover is substantive. Turnover is an index of organizational effectiveness, and as such warrants attention and some understanding per se. Additionally, however information on turnover can help the planning, prediction, and control of resourcing. Furthermore, if we can consider the notion that the goal for organizations is to manage turnover effectively, we clearly understand the phenomena (ILO: 1999).

In an Article by Sandrine Cazes and Alena Nesporava (International Labour Review) the authors note the disappearance of the life long employment system

following the economic reforms carried out in the late 1980's and early 1990's in nine transition countries (Bulgaria, Czech Republic, Estonia, Hungary, Lithuania, Poland, Russian Federation, Slovenia and Ukraine). Analyzing both cross country and time series data for the 1990's the authors conclude that labour turnover tends and follow a counter cyclical pattern in transition countries, which is the opposite of the pattern observed in advanced industrialized countries. At the same time, job stability as measured by job tenure i.e. the length of time that currently employed individuals have spent with their present employer follows a pro-cyclical pattern in transitional countries, which is again the opposite of what happens in the advanced industrialized countries (World Bank: 2001).

In advanced industrialized countries, labour turnover accelerates in periods of economic growth primarily because new job opportunities encourage people to change jobs voluntarily. In contrast, labour turnover declines during economic downturns as enterprises cut costs by reducing new hires and resorting to redundancies, which deters workers from changing jobs voluntarily.

During boom periods in the business cycle in industrialized countries, employment growth revives, more jobs are created and more people are hired, which reduces average job tenure (new recruits start with zero tenure). In addition, voluntary departures increase, because of better opportunities else where thereby reducing average tenure. In contrast, workers in transition countries behave differently and even in an improved economic situation, seem hesitant to quit their jobs voluntarily and move to other jobs. The main reason for this is heightened perception of job insecurity. There is a reluctance to quit voluntarily because of weak demand for labour and risk aversion from job mobility e.g. sliding into poverty during functional unemployment.

1.2 Health Care Sector

In many countries, the health sector workforce is dissatisfied, underpaid, poorly motivated, and skeptical of decision markers' ability to solve problems facing the health sector. Yet, it is people – the managers and staff working in health – who are responsible for implementing the changes resulting from health-sector reforms.

Countries throughout the world have long suffered from a severe lack of skilled health workers and managers. The delivery of health services is labour intensive, and the workforce is the primary determinant of health system effectiveness. Strategies and systems for human capacity development in most ministries of health are inadequate to meet the needs of the population (Miller et al 2004: 1-20). For instance, the lack of health staff has compromised healthcare in rural areas in many countries. However, the situation has become a crisis because of HIV/AIDS and accelerated globalization. The demands of new technology and time – consuming care have overburdened already weak systems for human resource development and management, and drained health staff from other health services.

If the acute shortage of trained staff in countries with a high prevalence of HIV/AIDS are not addressed in the short term, these countries will be unable to deliver effective services for other priority health problems. In these countries, staff attrition rates are rising due to HIV infection, illness, and death, as well as migration of staff. Vacancy rates in all public sector organizations are also rising while the post off skills candidates to fill positions is shrinking. Consider that at Lilongwe central, an 830 – bed hospital in Malawi, there are supposed to be 532 nurses. Now there are only 182 (Dugger 2004). Shortages of staff increase the burden on the staff that are on duty.

Absenteeism and low morale are widespread in most health facilities. In Malawi, for instance, illness results in laboratory technicians working on average only 24

hours per week, not the expected 44 hours (Aiken at al 2003). Work related stress reduces health workers' productivity. Factors that foster burnout among health workers include caring for an overwhelming number of dying patients and lack of skills to assume new responsibilities. For example, in 2003 about 80% of hospital beds in Uganda were occupied by people with HIV/AIDS (Nakaweesi 2003).

Governments and donors recognize this crisis. They understand that health workers are the lifeline connecting resources and medicines to the millions of men, women, and children who need services.

In many developing countries, health systems are facing increasing challenges to meet basic health care needs. These challenges include: -

- Inadequate numbers of qualified health workers
- Mismatch between needed health worker skills and available skills
- Worker deployment and retention problems
- Lack of supportive policies and strong planning and management systems
- Poor use of available financial and material resources, and weak collaboration between the public and private sector

Since the demand for health care increases but treatments are costly, the challenge is to guarantee access to well functioning health care services at a reasonable cost, while not eliminating the provision of additional health care services for those prepared to pay.

Health care delivery is highly labor intensive, the quality, efficiency and equity of services are all dependent on the availability of skilled and competent health professionals where and when they are needed, who are appropriately trained to deliver the required services at a high standard. Health sector restructuring is underway in Kenya and decentralization and privatization are influencing

traditional patterns of work and health sector financing. In addition, globalization is changing expectation about location and regulation of work (ICN, 2001).

The working environment is one of the fundamental means of achieving the objectives defined in an organization (Herman 1974). It is a prerequisite to the organizational survival and affects performance and productivity. Under unfavorable working conditions, there may be high employee turnover and low production and therefore a loss to the organization (Bates 1998). In Kenya the health sector is affected by poor work conditions that has adversely affected health care service delivery. Since 1960's Africa, which is a large continent, has experienced persistent and severe economic downturn due to poor staff attitude towards work and lack of motivation are among problems affecting health professionals (UNEP, 1977). The existing health infrastructure and medical systems need to be considered because hospitals have health professionals who are eager to work but do not have the means to perform their jobs effectively (NIEHs 2001).

At the millennium summit in 2000, representatives from 189 countries committed themselves towards a world in which sustaining development and eliminating poverty would have the highest priority (UN General Assembly Resolution A/Res/55/2, September 2000). The millennium development goals (MDGs) with their targets and indicators summarize these commitments and have been commonly accepted as a framework for measuring development progress. Of the total 48 indicators, 18 are directly related to health. This is an indication that health care is an important aspect of the economy.

Any business needs a source of labor to function. This axiom applies equally whether we rely solely on a basic economical model of the firm, with labor as one of the four factors of production or a Marxist account, which emphasizes labor power, or subscribe to more complex models of organizations, which place importance of knowledge management. Even if organizations of the future have

'virtual' employees, they will need to manage them as a resource (Morrel et al: 2001).

When an employee leaves, this can have a variety of effects that not only impact on the organization, but also the individual's employee and wider society. This can be positive or negative and a greater understanding of the process of labor turnover can increase the degree to which organizations and employees within organizations can influence these effects.

Despite an enormous literature on turnover in organizations, there is as yet no universally accepted account or framework for why people choose to leave. This prohibits understanding the phenomenon after the events yet neither is there an accepted means of assessing the likelihood of an individual's deciding to leave in the future, which prohibits prediction of turnover. The issue of labour turnover then becomes critical in addressing health sector problems. The fact that health professionals leave the organization for whatever reason can accelerate the already existing problems and shortages. Health care increases but treatments are costly, the challenge is to guarantee access to well functioning health care services at a reasonable cost, while not eliminating the provision of additional health care services for those prepared to pay (WHO, 2000).

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According to the HSSP (1999-2004), Kenya's health care delivery system needs professionally trained and strongly motivated personnel to perform effectively. The delivery of quality health services is dependent on the availability of sufficient resources, which include finances, human and material resources. Personnel costs account for more than 66 per cent of the total recurrent budget of the ministry. The ministry of Health has staff strength of 36,375 who are deployed countrywide. The Ministry also has a surplus of staff in the lower cadres and a deficit in the numbers of professional staffs. The HSSP's strategic objective is to provide a well-motivated and committed health workforce. The professionals should have relevant competencies in the right numbers at all levels at the right time for efficient delivery of health care services. (HSSP 1999-2004).

1.3 STATEMENT OF THE PROBLEM

In the International Labor Review (2001), an article by Sandrine Cazes and Alena Nesporova notes the disappearance of life long employment systems following the economic reforms carried out in the late 1980s an early 1990s in nine transition countries (Bulgaria, Czech Republic, Estonia, Hungary, Lithuania, Poland, Russian Federation, Slovania and Ukraine). They note that in advanced industrialized countries labor turnover accelerates in periods of economic growth primarily because new job opportunities encourage people to change jobs voluntarily. In contrast, labor turnover declines during economic downturns as enterprise cut costs by reducing new hires and resorting to redundancies, which deters workers from changing jobs voluntarily.

During boom periods in the business cycle in industrialized countries employment grows, more jobs are created and more people hired, which reduces average job tenure (new recruits start with zero tenure). In addition, departures increase, because of better opportunities elsewhere, thereby reducing average tenure. In contrast, workers in transition countries behave differently in that even in an improved economic situation, seem hesitant to quit their jobs voluntarily and move to other jobs. The main reason for this is heightened perception of job insecurity. There is a reluctance to quit voluntarily because of weak demand for labor and risk aversion from job mobility. The health sector is somewhat unique in that it does not follow the business cycle trend in employment. Instead there is a perennial shortage of skilled heath workers in some categories such as doctors and nurses partly due to voluntary attrition.

A study by the Center on Wisconsin strategy (COWS)(2001) focused on strategies to reduce turnover of frontline health care workers in South Central Wisconsin Nursing homes. They used wages, work environment and quality of care as explanatory variables and labor turnover as a dependent variable. However, wages, work environment and quality of care are not the only factors that relate to labour turnover. Therefore there is need to identify in more detail

the factors that contribute to labor turnover to be able to appreciate the enormity of the problem.

In their study of turnover, (Morrel et al: 2001) focused on how turnover is manifested and its consequences measured. They studied the impact of turnover behavior on organizational effectiveness, and critiqued various models of turnover. However this study did not address factors that may be associated with labour turnover. The study was also based on only one organization, thus making it impossible to generalize the findings to other organizations.

HIV/AIDS affects the performance of health systems by increasing demand for services in both quantity and complexity and by reducing the supply of services by its impact on the numbers and performance of the health workforce (World Bank 1999). Shortages of staff, supplies, and medicines and limited maintenance of health infrastructure have been attributed to the fact that governments in sub-Saharan African place low priority on health and welfare as reflected in the national budget allocations for the health sector (WHO: 1994). Since HIV/AIDS is a major concern in health, it is important to find out the proportion of labour turnover attributed to HIV/AIDS and to other factors such as uncompetitive wages or poor working conditions.

Planning for Human Resources in the health sector is critical since it touches on the life or death of the people. The sector is labour-intensive and the effectiveness of the organization will depend on how well it plans for its human resources. Labour turnover takes a critical dimension because it affects on the success of Human Resource plans.

This is why it is important to pay attention to labour turnover in the sector in view of developing plans to attract, motivate and retrain the workforce. An understanding of the factors that are attributed to labour turnover if taken into account in planning will reduce labour turnover in the health sector.

1.4 OBJECTIVES OF THE STUDY

- To determine factors that are associated with labor turnover in the health sector in Kenya.
- To determine factors that are perceived to be most prevalent in contributing to labor turnover in Kenya's health sector.

1.5 SIGNIFICANCE OF THE STUDY

It is hoped that the findings will be of benefit to policy makers and human resource practitioners. It will provide information on labour turnover trends and causes, which can be used to solve the human resource crisis in health institutions in Kenya.

It is also expected that the study would establish ground for further researches by academics and thereby make prediction and interventions in the control of labour turnover helpful.

CHAPTER 2

LITERATURE REVIEW

2.1 Overview of Labor Turnover

The number of trained health workers in Africa has historically been inadequate but in recent years, many countries have suffered from serious scarcities of almost all cadres due to economic and fiscal difficulties and incomplete civil service reforms. Managing human resources effectively and efficiently plays a critical role in ensuring that a satisfied, motivated workforce achieves quality health services. It also plays an important role in increasing staff performance and productivity, enhancing an organizations competitive advantage, and contributing directly to organizational goals. (The Manager, Spring 1999 Vol. III, Number 1).

The human resource (HR) problem in the health sector in sub-Saharan Africa (SSA) has reached crisis proportions in many countries. Although the gravity of the problem varies across the region, the situation in some countries is so grave that urgent action is needed. A complex set of factors has contributed to this problem, some exogenous such as the austere fiscal measures introduced by structural adjustment, which often result in cut backs in the number of health workers. But endogenous factors are also to blame, including misdirected human resource and training policies, weak institutions, and inappropriate structures.

The grave HR situation in sub – Saharan Africa can be characterized by the following: -

- The number of trained health workers has historically been inadequate, but in recent years, many countries have suffered from scarcities of almost all cadres of workers.
- Production of health workers has not kept pace with need, especially with the ever-increasing burden of decrease brought about by HIV/AIDS and resurgent epidemics.

- Some countries have focused on producing more expensive (i.e. less cost-effective) cadres of health workers relative to their disease burden and relative to what they can afford to sustain. In addition, the scope of professional practice by each cadre has been too rigid and inflexible, considering the African health settings in which they work.
- Attrition of civil servants has reached critical rates due to the combined effects of the accelerated retrenchment and voluntary retirement and departure, the search for greener pastures locally and abroad, and the sickness and eventual death primarily due to AIDS.
- Many government health workers are ill motivated because they are poorly paid, poorly equipped, infrequently supervised and informed, and have limited career opportunities within the civil service.
- Many medical, technical and managerial positions are now vacant, and scarce medical personnel are often misused for management tasks.
- Donor resources devoted to training and human resource development, though large in some countries have been poorly coordinated and have not addressed the underlying cause of poor staff motivation.
- Urban / rural imbalance in the distribution of health workers, a problem in the past is worsening.
- Personnel management systems are highly centralized and weak, and human resource planning and management has not been given the importance it deserves.
- New structures, practices and technologies are imposing a heavy strain on an already weak human resource base in the health sector.
- Finally, poor morale may be engendering adoptive and counter-productive behaviour among health workers (WHO: 2002).

2.2 The Challenge of Turnover

Most health care facilities do not truck the costs of turnover, because turnover itself, as well as its associated costs, can be difficult to measure. Turnover rates can be deceiving and deserve some clarification. Even a single rate of "100 per cent" turnover can mean quite different things.

Whereas abstract models of "turnover rates" influencing 'staffing levels' or 'head counts' may provide organizations with sufficient numbers (an efficiency measure), the potential of a more comprehensive understanding of turnover within organizations lies in the ability to manage turnover effectively. However, there are problems implicit in gaining such an understanding. Even setting a side the notion of voluntariness, confusion can surround the determinants of decisions to quit or 'reasons' (Campion 1991) and other relationally defined aspects such as avoidability (Abelson 1987). Inspite of this, turnover rates remain an important and meaningful measure, and provide an important lens on job quality and workforce instability among health workers.

Enforced early retirement, voluntary departure, and retrenchment are key features of civil services reforms in Africa. Though rightly premised on the need to reduce the large civil service to make it make effective, they had a deleterious effects on the supply of critical and experienced workers in the health sector. These reforms were affected in such countries as Cameroon, Central African Republic, Congo, the Gambia, Ghana, Guinea, Guinea – Bissau, Kenya, Mali Senegal Tanzania and Uganda. The conditionality driven approach to civil service reform in Africa has focused more on the absolute number of workers to be retrenched (because of over staffing), rather than the needed skill mix. Poor sequencing of civil service reform also resulted in down sizing even before ministerial rationalization, as in Kenya in mid 1990s (Wescott n.d.). Although no detailed data are available most observers noted that in most cases, the skilled and most experienced health workers had left (since they had more employment options), rather than the unskilled and least experienced ones.

Moonlighting and eventual voluntary departure from the civil service for more lucrative local employment has also marked the African health sector labor market in recent years. A major factor has been the rather quick liberalization of medical practice in such countries as Malawi, Mozambique, and Tanzania resulting in the movement of trained MOH civil servants to private practice, either individually or with non-profit or for profit health providers. As medical practice becomes privatized, doctors may eventually opt only to practice privately. Pharmacists and, to a lesser extent, laboratory technicians are more likely to move completely into the private sector, as has been shown in Ghana (Ghana MOH 2000).

The proliferation of NGOs in the 1990s certainly caused a discernible exodus of health workers from the government service, either as direct health providers, program managers or consultants NGO health projects attract a wide range of government health professionals since the pay is much better and the work is similar to that of the civil servants, hence very little retraining costs are needed.

Resigned or retired health civil servants still practicing their profession locally and privately are not viewed as "wasted" relative to those who have gone on to other endeavors. In fact, those who moved to the NGO and for profit sectors probably became more productive. But those who have opted out of health services completely represent large wasted investments in preservice and in-service training, which no longer yield outputs in terms of service delivery, and for which the government and donors have to incur more costs to replace them. Replacement costs alone would be significant given the magnitude of loses. Data from Ghana, Zambia and Zimbabwe show that losses from the public health sector continue at a rate of 15 to 40 percent per year.

Out-migration has also adversely affected the labour supply in many African health sectors. Health workers from poorer African countries such as Ghana, Kenya, Malawi, and Zimbabwe have moved to more affluent countries on the

continent, notably South Africa and Botswana. A recent study found that only one quarter of rural doctors in South Africa are natives of that country the remainder mainly coming from other African states. Others have emigrated to the United Kingdom, Canada, and the United states. A global carousel phenomenon has been observed among skilled health professionals where workers from poorer African countries migrate to richer southern African neighbors, Southern African doctors migrate to Canada or the UK; and UK and Canadian doctors themselves migrate to the US (USAID, Feb 2003).

The African medical and nursing brain drain, as reported in local papers is staggering. In Zambia, out of more than 600 doctors trained in the country since independence, only 50 remain (Couper 2002). The government of Kenya advertised 100 doctors' vacancies in 2001, but only eight applied. Ghana, which has built a reputation for producing international – quality professional's health workers, recorded a loss of 328 nurses from its council of nurses and midwives register in 1999, which is equivalent to the country's annual output of registered nurses. Losses of nurses for 2000 have been estimated to be 600 and t he outflow of other professional groups is likely to be similar or greater (Ghana MOH 2000). Active foreign recruitment of health professionals, including x-ray technicians and radiographers, is ongoing in Ghana, Kenya, South Africa, Uganda and Zambia, through local papers, professionals' journals and job fairs.

African health workers' migration to industrial countries presents a serious problem of reverse subsidy, since African governments heavily financed many of these workers' training. The African brain drain is intimately linked with the shortage of health workers in industrial countries, which is fueling the demand. In the US, it is estimated that 126,000 nursing posts are currently unfilled and that the shortage will hit 500,000 full time equivalent staff in 2015 (US DHHS 2002).

Sickness and death primarily from HIV/AIDS also represents a significant loss of health workers in Africa. It has been estimated that HIV/AIDS accounts for anywhere from 19 percent to 53 percent of all deaths among government staff in a

typical African country (Tawfik and Kinoti 2001). Disease also reduces the number of hours or days that staffs are available to render services. The number of deaths is even more disturbing compared with the capacity to train replacement staff. In Malawi, the number of deaths among nurses represents 40 percent of the average annual output of nurses from training. It is unknown how much of this factor accounts for attrition or for students' reluctance to enter the medical and nursing professions. But the absence of extra incentives (hazard pay) for those providing direct care to HIV/AIDS patients has not improved the situation.

2.3 Cost Of Turnover

High turnover is costly to all health care facilities. The most obvious costs associated with turnover are dollars spent on recruiting and training replacements and dollars paid to hire expensive "subs" from temporary help agencies (or locums) to fill in when facilities are short-staffed. Less easy to calculate but no less important, are productivity losses that result from the decline in the quality of care due to less continuity of care. The cost of recruiting and training a frontline caregiver in a nursing home has been estimated at four time the employee's monthly salary or $4 (Hoffman 2001, Pillemer, 1996 and Zarht 1992). This cost moreover does not include the costs associated with lost productivity (Atchley 1996), or the cost of the attrition that occurs between interviewing, hiring, training, and long term retention (White 1994). There are more hidden costs associated with turnover as well. If an organization did not have to spend considerable time and money funding replacement workers, for example, it could devote resources and energy in new directions. This hidden cost of turnover is one that often gets overlooked when considering strategies to reduce turnover. If less were spent dealing with turnover, organizations could actually focus on increasing productivity and improving customer satisfaction. It results in higher long-term profitability and improved quality of care (COWS). Other costs include, additional record keeping for personnel and fiscal items, possible service breakdowns reduced job satisfaction of existing employees among others.

Turnover is an important measure. However given its correlation with a wide variety of job experience and quality of care issues. It is still an important one for looking at stability of jobs and care in the health care industry. It is a common and useful benchmark in assessing the quality of employment in health facilities.

2.4 Shortages of Health Professionals

In general, the health personnel to population ratios in Africa have been high and have always lagged behind the rest of the world. In the 1980's, one doctor catered for 10,800 persons in sub-Saharan Africa (SSA), compared to 1,400 in all developing countries and 300 in industrialized countries. In the same period, one nurse catered to 2,100 persons in Africa compared to 1,700 persons in all developing countries and 170 in industrial countries (World Bank 1994). The provider-to-population ratios persistently remained high in the 1990s with most countries having 1 doctor per 10,000 populations or more. In fact, ten countries have 1 doctor per 30,000 populations. Comparable countries like Bolivia, Hunduras, and India have 1:2,000 or 1:3,000 ratios. Thirty-one countries do not meet WHO's "Health for All" standards of 1 doctor per 5000 population. Even those that do have enough doctors, geographic maldistribution is so severe that there may be a 1:500 ratio in the city (Nairobi) while remote Turkana district suffers from 1:60,000 ratios. Even in South Africa, a better-endowed country, poor districts may only have 1 doctor for the population of 30,000 (WHO 2002).

2.5 Causes Turnover of Health Professionals

There has been noted to be a discrepancy between rural and urban rates of turnover. Some African countries have shown degree in equalizing the regional distribution of trained health workers. Political imperatives provided the impetus to deploy health workers more equitably across regions in Malawi and Tanzania. Malawi for instance, now has a better balance of health workers across its three regions than a decade ago (Picazo 2002). The discrepancy between rural and urban countries in South Central Wiscousin has been attributed to the rural workers having fewer external job opportunities in the more rural counties (thus

low labour turnover) (Cows). This is a contrast to the situation in Sub-Saharan Africa.

The gender dimension of geographic maldistribution of health workers has not been adequately analysed, although there are indications that gender is an important factor in the human resource problem. In the Gambia, it has been shown that women are more likely to resign within the first five years of service than men. Insensitive posting policies may force women who are just starting a family to resign rather than take up a post that would be too far away (Martineau and King 1997). The preponderance of women in the health workforce may be an important factor in geographic maldistribution because women often have to follow their husbands where they work, which is invariably in cities.

National research shows that low wages are correlated with high turnover among frontline caregiver (DCA 2002a; Massachusets Health Forum 2000; and Dawson and Surpin 2001a) and that in some cases benefits are even more important than wages in affecting turnover (Brown 2002). While we know that wages do not entirely determine turnover, it is an important correlate.

Except in relatively wealthier countries such as South Africa and Botswana most African governments have salary levels that are generally low and structures that are perceived by civil servants to be inadequate. Many countries offer only subsistence – level salaries (or even lower) and are not in a position, given the need for fairness across the civil service and constraints on public sector expenditure to increase it. As a result, staffs are poorly motivated (USAID, 2003).

Within comparable tasks and positions, civil service salaries are generally lower than their private sector counterparts. For example, in Zimbabwe in 1998, a nurse could expect a 40 percent increase in salary if she/he left governments service to join the private health sector. For experienced health service managers, joining

international organizations (bilateral donors, NGOs, private Voluntary organizations, and UN agencies) can bring salaries and benefits packages that are double their government income. The continuing budgetary constraints on government expenditures over the past decade means that the salary differentials between the public and private sectors in Africa may have widened.

In addition to problems caused by absolute levels of pay, problems of salary relativity among skilled health workers also exist both within the public sector and between the public and private sectors. In Southern African countries, salary levels for the different professions still reflect relativity established during colonial times, and little has been done to adjust these to respond to changing circumstances in the labour market. For example, most governments experience difficulties in retaining pharmacists and pharmacy technicians, as they are in demand in the private health and industrial sectors as sales representatives for drug companies.

High turnover has been found to compromise the quality of care that patients receive. Research suggests that quality of care is compromised by high turnover in at least three ways (Dawson and Surpin 2001a; Wunderlich et al 1996; Harrington 1996; Burger et al 2000): -

(i) High turnover means that relatively inexperienced staff members, and fewer of them are required to take care of more patients. In a rushed or unsafe manner – unsafe to both client and worker (Dawson & Surpin 2001a).

(ii) High turnover precludes the development of relationships that are critical to both the client and caregiver, creating "needless opportunities for mistakes and (removing) from the client a sense of dignity and control over herself and her environment" (Dawson & Surpin 2001a).

(iii) High turnover sometimes means that potential clients are simply turned away, or that those clients who are admitted do not receive essential care from overworked staff (Dawson and Surpin 2001a). In short high turnover rates "produce the antithesis to consume poor quality" (Turnham and Dawson 2003).

Low quality care is a chronic problem in this industry. The high turnover numbers accounts of short fall of staff, and subsequent poor care raise important questions. Just how do those outcomes cost the health care industry? If residents suffered additional injuries or illness because of low quality care, would not medical attention cost more than wage increases or improvements in benefits for health workers?

In the study of the State of Winconsin, the researchers tried to investigate the connection between turnover and quality of care, as measured by numbers of complaints, violations, and deficiencies. In South Central Wisconsin, turnover is strongly correlated with the quality of care that clients receive. For the region as a whole, high turnover homes receive more complains and are cited for many more violations and deficiencies than are low-turnover homes.

While the correlation between turnover and quality of care is clear, it is important to note that there may be other factors that also have an impact on the observed differences in the number of complaints, violations, and deficiencies. For example, insufficient staffing – which is not necessarily the result of high turnover, but often is related to it – may be an important factor in some cases.

Before remedies can be prescribed for reducing turnover, you must have a clear idea of the causes. Studies show that the highest rates of turnover usually occur in the first month after hiring. After employees are settled in their jobs, make friends, and actually feel at home, they are less likely to leave.

It has also been generally established that an inverse relationship exists between turnover and age. That is, turnover rates tend to be high among younger employees and show a proportional decline with employees' advancing age, (Petrillose J.M. 2002).

Here are some factors or conditions that cause employees to leave their jobs: -

Inadequate selection and deployment methods may cause unrest and dissatisfaction among new employees. Employees may be placed in jobs that are too difficult, or their skills may be underused. In either case, new employees may become discouraged and may quit in the hope of obtaining more suitable employment elsewhere. Infrequent or irregular supervision of rural health facilities has also reduced staff morale and probably the quality of services provided as well. Cuts in supervision budgets (personnel travel allowances, expenditures for gasoline, and vehicle repairs) have severely hampered program monitoring in many African countries. Visiting donor missions report many districts not being visited by central MOH supervision teams. Generally, poor communication services (lack of radios, telephones, or fax machines or allowances to maintain these) and weak electronic connectivity have not helped to ease this supervision gap.

Inadequate information about jobs or the requirements of the employees needed to fill jobs satisfactorily may result in hiring under-qualified or over-qualified employees. Then, employees may become discouraged and quit). Lack of regular information from the central headquarters to peripheral facilities also contributes to low morale. As many African countries have embarked on health sector reforms and other programs, information to key stakeholders the - health providers themselves – has usually been ignored, making workers confused and stressed about the uncertainties that reforms bring (USAID 2003).

Unsatisfactory working conditions or surroundings may discourage new employees, unless adequate compensation is made to offset the conditions and a full explanation is given to new employees when they are hired.

Poor working conditions and lack of corresponding inputs (drugs, medical supplies, stationery, etc) also contribute to the disillusionment of African health workers. In 1998, a staff survey conducted in Zimbabwe found that the inability to offer effective care for patients due to the lack of equipment, appropriate drugs, and supplies was the reason cited most frequently by respondents for resigning from the government (Zimbabwe MHCW 1999).

Lack of opportunity for advancement through seniority or otherwise may result in dissatisfaction that simmers in an employee's mind until he/she finally quit. In the case of jobs having no real future, applicants should receive a full explanation before they are hired.

Inadequate or poor supervision is a frequent cause of turnover. Employees need guidance, especially when they are new on the job. Lack of good supervision at this critical time often results in termination.

An inadequate or unsound wage classification structure may cause dissatisfaction and may result in termination. New employees often wonder why they receive less money than an associate who is apparently performing the same job functions.

Lack of a well-organized training program may result in loss of employees. If employees are not properly trained in their new job, they may think they are not progressing rapidly enough and that advancement is slow.

Ineffective grievance procedures or delays in acting on grievances often result in termination of employment.

Lack of proper facilities and appropriate services, such as adequate employee changing rooms, dining areas, breaks, child/parental care, selective health benefits, and other health and safety provisions, are major causes of turnover and absenteeism. Many employees—both men and women—have dual responsibilities of job and home. These matters should be considered by management.

Inadequate community facilities such as housing, transportation, childcare, shopping, laundry, banking, and recreation, are causes of turnover. This is especially true of immigrants who may quit soon after they are hired if they are unable to cope with housing situations in the community. They may return to their former homes and be lost to the community as well as to your business (Pettrilose J. M. 2002).

2.6 Strategies for Improving Retention or Reducing Turnover

2.6.1 Increase Wages

Higher paid workers are less likely to leave than their lower paid counterparts linking compensation to knowledge and experience also encourage health workers to obtain education and training that will improve their skills. Higher paid workers are likely to put effort more in their jobs – in terms of time, dedication, and initiative – providing a better quality of care as a result.

2.6.2. Improve Benefits

The lack of affordable health insurance and other benefits makes it difficult for health professionals to stay in their jobs. Making these benefits available will increase the chances that dedicated staff will be able to continue working in the field.

2.6.3. Increase Training

When health care facilities don't invest money and time and train their employees, they send the message that the workers are not valued and are dispensable. Agencies should provide adequate orientation for new staff

and support ongoing training for long-term staff. Better training will also enhance the quality of care.

2.6.4. Ensure Safety and reliable Schedules

Health workers will benefit from balanced and safe workloads that offer full time employment without resulting in overwork.

2.6.5. Create Career Ladders

When organizations do not create career ladders when committed and experienced workers, employees believe that their hard work and experience is worthless. Health workers and their employees will gain from opportunities for career growth and advancement within the organization as well as across the continuum of long term care services.

2.6.6. Enhance Support networks

When facilities don't allow workers to have input into how work is organized, they send the message that employees' opinions simply don't matter. To ensure that health workers have a greater voice, in the workplace, facilities can improve supervision and encourage two –way communication at staff meeting.

- Give greater respect and recognition when health workers talk about feeling unsupported on the job, they often cite the lack of respect and recognition for the difficult work they do on a daily basis. Health care facilities should establish formal company-wide recognition, programs that reward workers for recognition and high quality of care.
- Institute labour-management controls there should be a joint effort on your part and that of labour unions to prevent waste of labour and consequent loss of productivity because of excessive turnover. If your collective bargaining agreement has a grievance system by all means use it. In this case, a union is often more than happy to do the bulk of the work (COWS: 2003).

2.7 Summary

Various studies have been done on labor turnover. These studies have concentrated on the measurement of labor turnover and its manifestation and consequences on Human resources. Thus, what has been largely documented are numbers of staff leaving organizations and not the factors that are associated with their exit. This study seeks to identify these factors in order to establish the extent to which specific factors are important.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Research Design

This was a descriptive research, which seeks to identify the factors that are attributed to labor turnover among health professionals in hospitals in Nairobi.

3.1 The Population

The population of interest for this study will consist of all the 33 public and private hospitals in Nairobi as listed by the Ministry of Health. These are hospitals that have both in-patient and out- patient facilities. This eliminates clinics, health centers and the numerous out- patient facilities some of which have only one or two members of staff. This list is on Appendix 2. This will be a census study since the population is small.

3.2 Data Collection

The data will be collected using a semi-structured questionnaire. It will be divided into thee parts. The first part will gather data on the demographic aspects of the population. These include years of operation, patient capacity, services offered and number of staff. This is in order to compare the institutions in terms of these variables.

The second part aims to establish the factors that are attributed to lobar turnover using a likert scale. The questionnaires will be administered on "drop and pick later" basis.

3.3 Data Analysis

Descriptive statistics will be used to analyze the data. Descriptive statistics, mainly measures of central tendency, frequencies and percentages will be used to analyze the data. A comparative analysis will be done to compare the differences or similarities between public and private hospitals. Data will be presented using cross tabulation e.g. pie chart, bar chart and line graphs.

CHAPTER FOUR

RESEARCH FINDINGS AND DISCUSSION

4.1. Introduction

A population of 33 hospitals was surveyed but only 15 (45.5%) of them responded to the questionnaire. Their responses were then analysed to give meaning to the research. The results are presented discussed in the following sections.

4.2. Descriptive Statistics

Table 4.1: Hospital Ownership

	Frequency	Percent	Cumulative Percent
Public	4	26.7	26.7
Private	11	73.3	100.0
Total	15	100.0	

As shown in Table 4.1 above, it was found that 73.3% of the health facilities in Nairobi are privately owned while 26.7% are public. This is explainable by the fact that the health care facilities in Nairobi are largely controlled by the private sector.

Table 4.2 Present Numbers of Employees

Range	Frequency	Percent	Cumulative percent
Less than 50	6	40.0	40.0
From 50 – 100	2	13.3	53.3
From 101 – 200	2	13.3	66.7
2001 and above	5	33.3	100.0
Total	15	100.0	

The majority of respondents (40%) had less than 50 employees as shown in Table 4.2. Those with from 50-100 and from 101-200 employees were 13.3% each while those with 201 and above employees represented 33.3% of the hospitals. This meant that most of the hospitals are small with less than 50 employees.

Table 4.3 Distribution of Health Professionals by Percentage

Category	<5	5 - 10	10 - 15	15 - 20	>20	None
Doctors	47	27	0	0	27	0
Pharmacists	60	20	0	7	13	0
Nurses	0	27	20	7	47	0
Dentists	33	7	7	7	0	47
Physiotherapists	60	7	0	7	7	20
Orthopaedics	47	0	0	0	20	33
Public Health Officers	27	7	7	7	7	47
Radiographers	53	0	7	0	13	60
Medical Engineers	13	7	7	0	13	60
Medical Laboratory Technologists	40	13	13	7	20	7
Clinical Officers	40	27	7	0	27	0
Health Records & Information Officers	60	13	0	0	20	7

The following categories of health professionals were not available in some of the hospitals: Dentists (47%), Physiotherapists (20%), and Orthopaedics (33%) Public Health Officers (47%), Radiographers (27%), Health Records and Information Officers (7%), Medical Engineering (60%), Medical laboratory Technologists (6.7%). This indicated that the services were either outsourced or were performed by people who are not professionally qualified. This could also explain the incidence of quacks posing as professionals that has been the case in health facilities.

The Table 4.4 above also shows that 60% of hospitals had less than 5 pharmacists, 20% had between 5-10, adding to a cumulative frequency of 80%. This shows that the number of pharmacists that facilities employ is not high. It also explains the fact that this is one of the professions that is often abused with people with no relevant qualifications practicing without being detected.

From the Table above 47% of the facilities had above twenty nurses. This is explainable by the fact that nurses are the most critical cadre in most institutions and often account for the biggest number of professionals. However the hospitals studied were small with less than 50 staffs, which explain the cumulative percentages of 53% with less than 20 nurses.

The data above also shows that 47% of the hospitals have less than 5 with 47% with above 20. Doctors are very expensive to compensate and the results could explain the fact that most facilities cannot afford many doctors. There is also a general shortage of doctors in the country. Most hospitals hire doctors on locum or temporary assignment.

It is noted that some (47%) of the hospitals had no dentists. Those with less than 5 accounted for 33%. This is explainable by the fact that dental services are often considered separately and most hospitals refer patient to the numerous outpatient facilities that offer this service. Also dental diseases are not usually life threatening or emergency. The same trend applies for physiotherapists with 60% with less than 5; Orthopaedics with 47%; Public Health Officers with 47%; Medical Laboratory Officers with 40%; and Medical Engineers with 60%. These services are often outsourced or offered on outpatient basis.

Table 4.4 Labour Turnover 2000 to 2004

	Frequency	Percent	Cumulative Percent
Yes	15	100.0	100.0

100% respondents indicated that there were employees who left during the period 2000 to 2004 as shown in Table 4.4 above. This confirms that labour turnover among health professionals is indeed a reality.

Table 4.5 Employees Giving Notice of Leaving

	Frequency	Percent	Cumulative Percent
Yes	14	93.3	93.3
No	1	6.7	100.0
Total	15	100.0	

Question 8 asked the respondents to indicate by yes or no whether or not employees gave notice of intention to leave the organisation; 93.3% of the respondents answered yes indicating that such a notice was given while 6.7% said no.

4.6 Presence of Human Resource Planning and Labour Forecast

	Frequency	Percent	Cumulative Percent
Yes	8	53.3	53.3
No	7	46.7	100.0
Total	15	100.0	

From the data in Table 4.6 above, 53.3% of the respondents practiced Human Resource Planning, while 46.7% did not. This showed that most organisations recognize the importance of human resource planning. It also confirms that health workers are critical and thus most organisations appreciate the need to have plans for these professionals.

Table 4.7 Perceived extent of shortage of staff in hospitals

Category	Not at all	Little extent	Moderate extent	Great extent	Very great extent	Not applicable
Doctors	27	27	27		20	0
Pharmacists	47	20	13	20		0
Nurses	13	20	40	7	20	0
Physiotherapists	47	33	13			7
Orthopaedics	53	27	13			7
Radiographers	53	33	13			0
Medical Eng.	47	27	13			13
Public Health Officers	47	20	13	7		13
Medical laboratory Technologists	40	20	27	13		0
Clinical Officers	40	20	20	7	7	7
Health Records and Information Officers	53	40				7

From the data in Table 4.7 above, it is evident that 20% of the respondents perceived the extent of shortage of Doctors and Nurses as being to a very great extent, while 53% of the respondents felt that Orthopaedics, Radiographers and Health Records and Information Officer were not in short supply.

Table 4.8 Mean Score of the perceived shortage of Health Professionals

	Not at all	Little extent	Moderate extent	Great extent	Very great extent
Mean	42	26	19	11	16

On average, 42% of the respondents perceived that, there were no shortages of health professionals. This is explainable by the fact the most hospitals have only certain cadres while other cadres are not there at all.

Table 4.9 Factors that are associated with Labour Turnover

Factors	Not at all	Little extent	Moderate extent	Great extent	Very great extent
Death	7	73	20		
Ineffective selection of staff	27	60	13		
Unmet expectations	13	27	47	13	
Limited opportunities for advancement	20	27	20	27	7
Poor relations with supervisor	20	67	14		
Inequity in compensation	7	53	27	13	
Poor remuneration	7	13	7	67	7
Inadequate training opportunities	13	33	33	20	
Ineffective grievance procedures	20	67	13		
Inadequate facilities	7	40	47	7	
Inadequate concern with employees welfare	27	40	33		
Reform e.g. retrenchment, downsizing, restructuring	53	27	20		
Retirement	33	53	13		
Ill health	27	60	7	7	
Family obligations	60	40			

From the data in Table 4.9 above, ***Poor Remuneration*** of staff is the most important factor associated with labour turnover with 67% of the respondents indicating that it contributes to turnover to a great extent. This is followed with ***inadequate opportunities for advancement and inadequate training opportunities***. This is explainable by the fact that the need for employees to advance is important leading to the high number of health workers seeking to advance outside the country, leading to outmigration. The limited opportunities in institutions that offer advanced health courses in the country makes the employees look outside for such opportunities.

Question 12 asked the respondents to indicate what they thought was the consequence of labour turnover. Tables 4.10 to 4.14 summarise the responses as indicated below. To some extent each of the listed factors i.e. ***heavy workload, poor quality of service, cost of***

recruitment/training, loss of experience/qualifications and workforce shortages were perceived to be a consequence of labour turnover.

Table 4.10. Extent to which Labour Turnover results in heavy workload

	Frequency	Percent	Cumulative Percent
Not al all	3	20.0	20.0
Little extent	1	6.7	26.7
Moderate extent	5	33.3	60.0
Great extent	5	33.3	93.3
Very great extent	1	6.7	100.0
Total	15	100.0	

From the Table 4.10 above 33.3% of the respondents see increased workloads as a consequence of labour turnover to a great extent. Those left are expect to handle the workload before the organisation replaces them. This may take time given that there is shortage of these employees in the labour market.

Table 4.11 – Extent to which labour Turnover affects Poor quality of care

	Frequency	Percent	Cumulative Percent
Not al all	1	6.7	6.7
Little extent	10	66.7	73.3
Moderate extent	2	13.3	86.7
Great extent	1	6.7	93.3
Very great extent	1	6.7	100.0
Total	15	100.0	

From the data in Table 4.11 above shows that a cumulative 86.7% is a consequence of labour turnover as far as poor quality of care is concerned. However it is expected that if an institution does not have an adequate number of staff the quality of care is

compromised. This is explainable by the fact that most of the respondents are private organisations that will not so readily accept that their institution offer poor quality of care.

Table 4.12 Extent to which Labour Turnover affects Cost of recruitment/training

	Frequency	Percent	Cumulative Percent
Little extent	6	40.0	40.0
Moderate extent	5	33.3	73.3
Great extent	4	26.7	100.0
Total	15	100.0	

Most of the respondents (73.3%) indicated that the cost of recruitment is not a serious consequence of labour turnover. This is due to the fact that most small organisations are recruiting their staff through referrals and walk-in candidates, which is not expensive recruitment method. This negates the findings in the literature review that showed that turnover is very costly to organisations.

Table 4.13 – Extent to which Labour Turnover results in Loss of Experience / Qualification

	Frequency	Percent	Cumulative Percent
Little extent	3	20.0	20.0
Moderate extent	5	33.3	53.3
Great extent	3	20.0	73.3
Very great extent	4	26.7	100.0
Total	15	100.0	

Experienced employees leave the organisation since they are the ones most sort after in the labour market. The data in the Table 4.13 above shows that 20% of the respondent's perceived that to great extent it is consequence while 26.7% indicated it is a very

important consequence. This in turn affects quality of care as well as increased workloads.

Table 4.14 Extent to which Labour Turnover causes workforce shortage

	Frequency	Percent	Cumulative Percent
Not at all	1	6.7	6.7
Little extent	3	20.0	26.0
Moderate extent	4	26.7	53.3
Great extent	5	33.3	86.7
Very great extent	2	13.3	100.0
Total	15	100.0	

From the Table 4.14 above 60% of the respondents perceived that labour turnover causes workforce shortages to a great extent. This is an obvious indicator of staff leaving the organisation in a labour market that has limited supply.

CHAPTER FIVE

SUMMARY AND CONCLUSIONS

5.1 Summary

The objectives of the study were to determine factors that are associated with labor turnover in the health sector in Kenya with a view to finding out what factors(s) are perceived to be most prevalent in contributing to the incident of labor turnover. In order to achieve these objectives, a survey was carried out and data collected using questionnaire.

Of the 33 hospitals, surveyed, 15 or 45.5% responded, while 18 or 64.4% either returned the questionnaires uncompleted or did not respond at all. The data was thereafter analyzed and presented using tables for frequency distribution and percentages as well as diagrams.

The study revealed that majority of hospitals were private (73.3%), while 26.7% represented public hospitals. Many of the hospitals had less that 50 employees thus qualifying as small institutions for the purpose of this study. 33.3% had staff above 201. Poor remuneration was the factor cited as associated to labor turnover with most respondents (67.6%), indicating that it contributed to the incident of labor turnover to a great extent. The other factors were inadequate training opportunities (33.5%); limited opportunities for advancement (27.6%); inequity in compensation 13.1%; unmet expectations, 13.3% and inadequate facilities (7.1%); and ill health (7.7%). This further supports the literature review that poor working conditions including the terms of service are issues that institutions need to look at in trying to deal with labor turnover. Family obligations was the factor least perceived to be associated with labor turnover.

5.2 Conclusions

Factors that are associated with labor turnover are many and most organization indicated that a combination of them contributed to employees leaving the organization to some extent. It can also be concluded that labor turnover has its consequences such as loss of experiences and qualifications 27.1%, increased workloads 79%; poor quality of care 7.3%, workforce shortages 13.3% and the cost of recruitment / training.

Generally, the findings in this study tend to be in agreement with those already done outside Kenya, although the relative importance of the various factors may be quite different. For example whereas this study indicated that family obligations contributed least to the incident of labor turnover, relocation of spouses was seen to be important in studies carried out in the US. This shows that such studies may be replicated in Kenya in other geographic regions, or in other countries.

Finally, the health sector is critical and institutions need to be aware of the bad effects of labor turnover with a view to trying to improve the working conditions to enable them motivate, attract and retain a high caliber workforce. Many of these institutions need to address the issue of remuneration and follow the global trend that indicates that health workers are some of the best paid people.

5.3. Limitation of the Study

- The non-response rate was high. Most of the respondents did not have permission to fill questionnaires, as it is the policy of most hospitals not to give information. Some respondents said that the questionnaires had to be discussed in the research and ethics committee and this meant I had to wait for the committee to convene. Some declined to fill the questionnaires for various reasons such as busy schedules, while other returned them unfilled.

- Further, budgetary and time constraints led the sample to be determined from Nairobi, which is an urban center, and the findings may not be replicated in rural setting or in other geographic regions outside Nairobi.

5.4. Recommendations for further Research

- A study to investigate what organizations are doing to retain staff, i.e. to reduce the rate of labor turnover.
- Recommendations to the government and other stakeholders on the human resource strategies and policies that may be adapted to reduce labor turnover.

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Appendix 1 questionnaire

This questionnaire is divided into three parts. Section A B and C. Kindly answer questions in each section.

Your answers will remain anonymous and strictly confidential and in no instance will your name be mentioned in the report.

Section A: General Hospital data

1. Name of Hospital (optional) ----------

2. Year of establishment in Kenya ----------

3. Ownership of the Hospital (Tick (√) where applicable)
   i. Public (includes parastatals) ( )
   ii. Private (includes church bared, NGO's ETC) ( )

4. How many employees do you have in the Hospital at present (Tick (√) as Applicable)
   i. Less than 50 ( )
   ii. 50 – 100 ( )
   iii. 101-200 ( )
   iv. Above 201 ( )
   v. Any other please specify

   .....

   .....

5. How many of the following categories of the health professionals do you have?

   Please tick (√) as applicable.

Category	Less than 5	Between 5 – 10	Between 10 – 15	Between 15 – 20	Above 20
Doctors					
Pharmacists					
Nurses					
Dentists					
Physiotherapists					
Orthopedics					
Public Health Officers					
Radiographers					
Medical Engineers					
Medical Laboratory Technologists					
Clinical Officers					
Health Records & Information Officers					
Others					

If others please specify

.....

.....

Section B: Factors attributed to labor Turnover

6. Have you had staff leaving the organization in the past 5-year from 2000 to 2004?

(Tick (√) as applicable)

i. Yes ( )

ii. No ( )

If yes please indicate how many left in the following years.

Year	Number
2004	
2003	
2002	
2001	
2000	

8. Do employees give notice of intention to leave? (Tick (√) as applicable)

i. Yes ( )

ii. No ( )

9. Do you have human resource planning and labor forecast in place in the organization?

(Tick (√) as applicable)

i. Yes ( )

ii. No ( )

10. Do you consider the institution as having staff shortage?

If yes what category of staff and to what extent.

1. Not at all
2. Little extent
3. Moderate extent
4. Great Extent
5. Very Great extent

Category	**1**	**2**	**3**	**4**	**5**
Doctors					
Pharmacists					
Nurses					
Physiotherapists					
Orthopedics					
Radiographers					
Medical Engineers					
Public Health Officers					
Medical Laboratory Technologists					
Clinical Officers					
Health Records & Information Officers					

SECTION C

11. The following factors are attributed to labor turnover, which ones do you and to what extent (Tick (√) as applicable choices)

1. Not at all
2. Little extent
3. Moderate extent
4. Great extent
5. Very great extent

Factors	**1**	**2**	**3**	**4**	**5**
Death					
Ineffective selection of staff					
Unmet expectations					
Limited opportunities for advancement					
Poor relations with supervisor					
Inequity in compensation					
Poor remuneration					
Inadequate training opportunities					
Ineffective grievance procedures					
Inadequate facilities					
Inadequate concern with employees welfare					
Reform e.g. retrenchment, downsizing, restructuring					
Retirement					
Ill health					
Family obligations					

12. What in your opinion is the most important consequence of labour turnover in your organization and to what extent (Tick (√) as applicable

1. Not at all
2. Little extent
3. Moderate extent
4. Great extent
5. Very great extent

Factor	**1**	**2**	**3**	**4**	**5**
Increased work loads					
Poor Quality of care					
Cost of recruitment / training					
Loss of experience / qualification					
Workforce shortages					
Other(s)					

If other please specify. ----------

APPENDIX 2

HOSPITALS IN NAIROBI	**STATUS**
1. The Aga Khan Hospital, 3rd Parklands are	Private
2. Avenue Hospital 1st Parklands Avenue	Private
3. City Park Hospital, Park Road	Private
4. Coptic Hospital, Ngong Road	Private
5. Getrude's Garden children Hospital, Muthaiga Rd.	Private
6. Gomongo Huruma Maternity Home, Huruma Rd.	Private
7. Guru Nanak Ramgatha Sikh Hospital, Muranga Rd.	Private
8. Hurlingham hospital Management Ltd, Arwings Kodhek Rd.	Private
9. Inder Nursing Home (Hospital), Juja Rd.	Private
10. Jamaa Home and Maternity Hospital, Buru Buru crescent	Private
11. Kenyatta National Hospital, Mbagathi Rd.	Public
12. Lily Women Hospital, 2nd Ave Parklands	Private
13. Lions Sightfirst Eye Hospital, Loresho Kaptagat Rd.	Private
14. MP Shah Hospital Social Service League Shivach Rd Parkland	Private
15. Masaba Hospital, Kirichwa Rd of Ngong Rd.	Private
16. Mater Hospital, Dunga Rd. Industrial Area	Private
17. Mbagathi District Hospital, Mbagathi way	Public
18. Metropolitan Hospital Nairobi, Buruburu Rabai Rd.	Private
19. Metropolitan Hospital Nairobi, Buruburu Rabai Rd.	Private
20. Mother's and child Hospital Ltd, 1st Ave Eastleigh	Private
21. Nairobi Equator Hospital, Bukani Rd. Nairobi West	Private
22. The Nairobi Hospital, Arwings Kodhek Rd.	Private
23. Nairobi West Hospital, Gandhi Avenue	Private
24. Nazareth Hospital, Riara Ridge Karuri	Private
25. Nyina wa Mumbi Maternity, Kikuyu/Dagoreti Juuction	Private
26. Prime Care Hospital Outering Rd.	Private
27. Pumwani Maternity Hospital – General Mathenge Rd.	Public
28. St James Hospital, Mombasa Rd.	Private
29. St. Mary's Mission Hospital Nairobi, off Langata Rd.	Private

30. South ' B' Hospital, Kapiti cresent South B	Private
31. Tropical Medical Services, Mombasa Rd.	Private
32. Umoja Hospital, off Moi Drive	Private
33. Westland Cottage Hospital, East Church Rd.	Private

MINISTRY OF EDUCATION, SCIENCE & TECHNOLOGY

Telegrams: EDUCATION", Nairobi

Fax No.
Telephone: 318581
When replying please quote

REPUBLIC OF KENYA

JOGOO HOUSE
HARAMBEE AVENUE
P. O. Box 30040
NAIROBI
KENYA

MOEST 13/090 Vol X 128

22nd September, 2005

Joan A. Machayo
University of Nairobi
P.O. BOX 30197
NAIROBI

Dear Madam

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on "Factors associated with Labour Turn over among health professionals", I am pleased to inform you that you have been authorized to carry out research in all Hospitals in Kenya for a period ending 30th March, 2006.

You are advised to report to the District Commissioners, the District Education Officers, the Medical Officers of Health and the Medical Officers in Charge of the Hospitals you will visit before embarking on your research project.

It is noted that the research is a requirement in part fulfillment for the award of MBA Degree of the University of Nairobi.

Yours faithfully

M. O. ONDIEKI
FOR: PERMANENT SECRETARY

Cc
All the District Commissioners

All the Medical Officers of Health

All the District Education Officers

INTRODUCTION LETTER

Joan A. Machayo,
Faculty of Commerce,
University of Nairobi,
P. O. Box 30197,
NAIROBI.

19th September 2005

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

RE: REQUEST FOR RESEARCH DATA

I am a postgraduate student at the University of Nairobi conducting research on **Factors that are associated with labour turnover among Health Professionals in Kenya.**

Your hospital has been selected for the study, which will be concentrated in Nairobi province. I would therefore highly appreciate your providing me with the information requested in the attached questionnaire.

I wish to assure you that the information you provide will be treated confidentially and used only for research purposes.

Thank you very much for your anticipated assistance.

Yours faithfully,

JOAN A. MACHAYO
POST GRADUATE STUDENT
UNIVERSITY OF NAIROBI.

Countersigned .....

Prof. P. Kobonyo PHD
(University Supervisor).