th worker retention in Kenya: An assessment of current practice

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Abstract:

The importance of health workers to the effective functioning of healthcare systems is widely recognized (Ndetei et al, 2007). Shortages of health workers constitute a significant barrier to achieving health-related Millennium Development Goals (MDGs) and expanding health interventions in developing countries. In Kenya, internal migration of workers, from rural/poor areas to urban/rich areas, is just as serious a problem as international migration. Shortages in the health workforce are aggravated by the unequal distribution of health workers as a result of economical, social, professional and security factors that all sustain a steady internal migration of health personnel from rural to urban areas, from the public to the private sector, and out of the health profession itself. The crisis calls for investment in incentives to recruit and retain personnel in poorer, rural areas to service communities that need them most. This study was undertaken within the Regional Network for Equity in Health in east and southern Africa (EQUINET), in co-operation with the Regional Health Secretariat for East, Central and Southern Africa (ECSA). It was co-ordinated by the University of Namibia, with support from the Training and Research Support Centre, University of Limpopo and the ECSA Regional Health Secretariat. The study aimed to conduct a literature review and field research to obtain data on strategies for the retention of health workers in various institutions in Kenya. Specifically, we aimed to: Åestablish the context for, and trends in, the recruitment and retention of health workers; Åidentify existing policies, strategies and interventions to retain health workers; Å identify how these strategies are being introduced and resourced and assess their sustainability; Å analyze management, monitoring and evaluation systems to measure the impact of the health worker retention incentive regimes; and Åidentify lessons learned and appropriate guidelines for non-financial incentive packages to promote the retention of health workers. We reviewed existing strategies for recruiting and retaining health workers over time in Kenya. We looked at the Ministry of Health (national public health sector), national referral and teaching hospitals, Nairobi Hospital (private medical institution), Kenya Medical Training College (KMTC), the University of Nairobi (College of Health Sciences) and an NGO, the Adventist Development and Relief Agency (ADRA). Focus group discussions and interviews were held. The existing health worker retention incentive schemes, government policy and strategies on retention of health workers were analyzed in the form of policy documents, terms and conditions of service for each institution and questionnaires that were filled in at selected institutions. Challenges facing the recruitment and retention of health workers in Kenya were also analyzed to understand how these policies were implemented. Facilities offered a number of financial incentives to their staff, such as paid leave and overtime pay, access to house or car loans at lower negotiated market rates (for highly skilled public sector workers) and numerous allowances, such as transport, entertainment, hardship, responsibility, special duty and uniform allowances. Some staff worked in bonding agreements, whereby the institution paid for their studies but they had to work for a specific numbers of years in return. Non-financial incentives for health workers included housing

training and continuing medical education, life
er working hours, membership to the National Social Security Fund (NSSF), medical cover (includes nuclear family) and the introduction of HIV and AIDS treatment in some workplaces. Terms and conditions of service in private and teaching facilities were reviewed regularly and health workers were informed on any changes of services through improved human resource management. Private medical institutions, national hospitals and training institutions had implemented non-financial incentives by improving working conditions through renovations, upgrading the facilities (re-equipping the medical facilities with new technology) and making medical supplies accessible to the communities. However, in public facilities, there were many unfilled positions despite high unemployment rates for health workers in the country. Primary health care facilities were severely understaffed, with relative over staffing of hospitals (district, provincial and national hospitals). This imbalance causes health workers in public institutions to migrate from primary health care (PHC) facilities to district hospitals, provincial and then national hospitals. The data presented shows a need to address the maldistribution between urban and rural areas, and between levels of care, as well as to stem the internal migration from poorer to richer areas. Poorer areas generally have worse living and working conditions, and better non-financial incentives propel the health workers to migrate to bigger health facilities (provincial and national hospitals) situated in towns and cities across the country. In these urban areas, they work fewer hours (due to higher staffing levels) and can also engage in private practice for more money. The incentives introduced to retain health workers often depend for their effective implementation on the facility, with better organized facilities, often in higher-income areas, more successful in providing incentives. Yet, ironically, it is at the lower levels of the health system (in rural and poorer areas) where incentives are more urgently needed to counteract the strong push factors that force workers out of these areas. We recommend that government put in place national-level policies to retain health workers in rural areas, in lower-income districts and at lower levels of the health system to ensure that all areas reach minimum standards with regard to numbers of personnel per population (such as the WHO recommended minimum standard of 20 doctors per 100,000 patients). We stress that such incentives are not only financial. According to the feedback we received from health workers, a number of non-financial incentives are highly valued: Åimproved working conditions; Åtraining and supervision; and Ågood living conditions, communications, health care and educational opportunities for themselves and their families. The government needs to invest not only in its health workers but in its facilities, by ensuring regular medical supplies, upgrading facilities and improving working conditions in rural and poorer areas. Continuous medical education in specific areas is required, depending on service needs, in response to areas of increasing public health burden, such as antiretroviral therapy (ART), voluntary counseling and testing (VCT), and services for tuberculosis, epilepsy, mental health, diabetes and hypertension. Management practices also appear to be important. However, the strategic information needed for effective management was often missing in the facilities that needed it most. We set out to assess the impact of incentives, but were not able to access the sort of routine information needed to make this assessment. This information gap puts human resource managers at a disadvantage for their own strategic planning, and makes it harder for them to argue for further resources needed for retention incentives. The reasons why health workers resign or leave facilities should be routinely documented to assist policy makers to address the causes of internal and external migration. Health information management systems should be used to track the flows of health workers and inform the planning and distribution of health workers. Particularly in the public

sary to be able to monitor implementation and assess the