**UNIVERSITY OF NAIROBI**

**DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK**

# FACTORS INFLUENCING NOMINATIONS AND APPROVALS FOR POST-BASIC AND POST-GRADUATE TRAININGS FOR HEALTH WORKERS AT THE COUNTY AND NATIONAL LEVEL: A CASE OF THE MINISTRY OF HEALTH KENYA

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# DECLARATION

This research project is my original work and has not been presented for a degree in this or any other University.

Signature …….. Date ……..……

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C50/9149 /2005

This research project has been submitted for examination with my approval as the University Supervisor.

**Professor Edward K. Mburugu**

Signature …….. Date ……..……

# DEDICATION

To my sons Gich and Kirin….For believing in me and pushing me on.

# ACKNOWLEDGEMENTS

This far the Lord God has brought me. All Glory and Praise to Him.

Special appreciation to my supervisor, Professor Edward Mburugu for the expert guidance, encouragement and patience throughout the completion of this project despite the difficult timelines I was working under.

To The Board of Post Graduate Studies (BPS), for giving me the final chance to complete the project. To Ms Susan D of Board of Post Graduate Studies (BPS), a big thank you for listening.

I would like to thank the Human Resource Development Officers in the Ministry of Health Training Unit for the insights and availing the necessary records and documents.

To my workmates, for the encouragement and invaluable contributions.

To my family, for always being there.

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# ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| **CHMT** | County Health Management Team |
| **CSSD** | Central Sterile Services Department |
| **EMS** | Emergency Medical Services |
| **FBO** | Faith Based Organizations |
| **HRD** | Human Resource Development |
| **ICU** | Intensive Care Unit |
| **MHRMAC** | Ministerial Human Resource Management Advisory Committee |
| **MOH** | Ministry of Health |
| **TNA** | Training Needs Assessment |
| **WHO** | World Health Organization |

# DEFINITION OF TERMS

**Capacity:** Ability of individuals, organizations or systems to perform appropriate functions effectively, efficiently and sustainably.

**Capacity Building:** A long term and continuous process of developing and strengthening the skills, instincts, abilities, processes and resources that organizations and communities need to survive, adapt, and thrive in the fast-changing world.

**County Health Management Team:** Refers to technical officers at the county department of health with technical mandate to guide and direct health services in key areas.

**Demand driven approach:** These are the skills development initiatives made to respond directly to specific job requirements for an employer.

**Human Resource Development:** A process by which continuous efforts are made to develop the employees for their present and future roles and to identify and utilize their inherent potentialities.

**In Service training:** This refers to professional or staff development training that an employee undertakes while in full time employment.

**Post- Basic Training**: This refers to training that is acquired after basic training. It could be a long or a short course including continuous professional development.

| | |
|---|---|
| **Post -Graduate training:** | This is the training that an employee has above undergraduate training and includes master and PHD courses. |
| **Skill Gaps:** | This refers to underperformance observed in an employee due to inadequate skills. |
| **Specialist:** | This refers to a health worker with post basic and additional specialization in a given field in health. |
| **Supply Driven:** | Supply driven is where individuals identify their training needs. |
| **Training:** | Deliberate and systematic learning experience designed to provide skills, knowledge and appropriate attitudes to an employee for performance of a particular job. |
| **Training Needs Assessment:** | The exercise of collecting, collating and analyzing data from employees to establish gaps in knowledge, skills and attitudes necessary for effective performance of their duties. |
| **Value for Money:** | This is the optimal use of resources to achieve the intended results. |

# ABSTRACT

Development and training are a continuous and systematic process. Training is not effective unless it has a purpose and that purpose can only be defined if the training needs of organisations and its employees are identified and analyzed (Staff development Manual, 2014). Training is seen as a participatory and collective responsibility of the national and county governments and other stakeholders. The study sought to determine the factors influencing nominations and approvals for post-basic and post graduate trainings for health workers at the county and national level, a case of the Ministry of Health Kenya. The study was guided by the following objectives: to determine the status of Training Need Assessments and training projections that are used by county training committee in nominating and selecting training applicants; to determine the criteria counties are using for identifying the training needs of the applicants they recommend for course approvals by the Ministry of Health at the national level; to outline the main post basic and post graduate specialized trainings being approved at Ministerial Human Resource Management Advisory Committee (MHRMAC) level; and to examine the extent to which the laid down course nomination and approval procedures are adhered to by the county and national governments. The study adopted a descriptive survey with a study population comprising of course applications from 78 Medical Officers 28 Clinical officers and 40 nurses. The study found that the training committees had few written down criteria, limited or no TNA or training projections that were available to guide nomination or approval decisions. The choice of courses was found to be more supply driven than demand driven. Officers would take the initiative of applying, getting admission and then seek course approval and study clearance. The study found that the justification of the applicants' immediate supervisors and training committees influenced the course approval decisions. Release of officers was pegged on availability of a replacement for the officer to ensure no compromise in service delivery.The study concludes that the factors influencing course approvals for post basic and post graduate trainings for health workers are not standardized but vary across the counties. In addition, the main post basic and post graduate training areas for Medical officers, clinical officers and nurses were found to concur with the critical training areas as per the TNA report 2015. The study also found there was limited resource allocation for training and furthermore, these resources were not equitably divided among the cadres. The study recommends that the National and County Governments improve their consultation and collaboration to ensure that requests for course approvals fit into training projections based on actual TNA from the counties and emerging issues and diseases or conditions. MHRMAC to rationalize equitable distribution of the training money across the cadres

# CHAPTER ONE: INTRODUCTION

## 1.1 Background to the Study

The health sector is labour intensive (WHO 2000). It relies on its workforce for precise application of knowledge and technical skills in the provision of health care services (Human Resource Development Policy, 2015). The quality of health care services delivery is however dependent on the availability and performance of a well-trained and motivated workforce (WHO 2006). The health workforce is defined as "all the people engaged in actions whose primary intent is to enhance health" (WHO Report 2006). These are the different kinds of clinical and non-clinical staff responsible for public health and individual health intervention (WHO 2000). They include the clinical staff such as physicians, nurses, pharmacists and dentists as well as health management and support staff (Zulu *et al*, 2014)

The Ministry of Health (MOH) training policy (2016) seeks to ensure that training of health workers is on a continuous and systematic process through short and long term courses, mentorship and on the job trainings. Armstrong, (2013) defines training as the "systematic application of formal processes to impart knowledge, skills and attitudes" required by an individual to adequately perform a given task or job". Training is seen as a participatory and collective responsibility of the national and county governments and other stakeholders. It is noted to be the most cost effective intervention for improving employee competencies (MOH Training Policy, 2016).

The HRD policy 2015 states that all trainings in the public service be based on a comprehensive training needs assessment (TNA) to be conducted every three years or as need arises. Training Needs Assessment refers to the exercise of collecting, collating and

analyzing data for employees to establish gaps in knowledge, skills and attitudes necessary for effective performance of their duties (MOH training Policy, 2016). The actual purpose of a TNA is to identify performance needs or requirements of an organization and direct resources to the areas that best meet the organization's goals and objectives, improve productivity and provide quality products & services (Mwawasi 2010).

The Human Resource and Development policy stipulates that any funds used for HRD should be focused on "prioritized, demand driven and cost effective programmes" based on national development priorities, strategic plans, county needs and individual career development needs.

### 1.1.1 Management and Coordination of Trainings at the National Level and County Levels

The management and Coordination of Human resource development in the Public service is the responsibility of the Public Service Commission (PSC). In respective Ministries, the PSC has mandated Cabinet Secretaries (CS) to coordinate HRD function as the Authorized Officers. The CS approves all HRD activities but can delegate functions appropriately (Human Resource Development Policy for Public service 2015). Human Resource development has two dual objectives: the growth of the organization and the growth of the employee. It seeks to continually and sustainably train its employees and upgrade their knowledge, skills, attitudes and competencies for effectiveness in their current or future responsibilities" (Recruitment and HRD policy, 2005). In Line Ministries, the Human Resource Departments are tasked with the responsibility of coordinating and developing annual training projections and HRD plans in consultation with user departments and county governments.

The Training Policy of May 2005 and Section P3 of the Code of Regulations (revised June 2006) provide that officers in the Public Service proceeding on authorized training will obtain a Course Approval. Approval of training for officers shall be in accordance with service regulations. Any officer with an approved training is considered to be on duty and is entitled to requisite benefits.

Authority for local training, including in-service training in the public service training institutions shall be granted by the respective Cabinet Secretary on recommendation of Ministerial Human Resource Management Advisory Committee (MHRMAC) at the national level. The MHRMAC is tasked with the responsibility of recommending for approval by the Cabinet Secretary the staff development strategies, training needs assessments, training projections and skills inventory. The Cabinet Secretary also tasks the committee with recommending individual and group training requests for approvals (HRD Policy 2015).

According to the delegated functions the management and co-ordination of training in the County is the responsibility of the County Public Service Boards who have delegated the training function to county departmental training committees.(County training policy). The County training Committees advise on optimal utilization of local and foreign training resources and opportunities. It also advices on the identification and selection of suitable applicants for various training Programme and submit training requests for approval by the Cabinet Secretary for courses sponsored by the National Government.

### 1.1.2 Criteria for Nominations and Approvals

The HRD policy 2015 stipulates that nomination and selection for individual and group training shall be based on prioritized training projections that address national, organizational and individual career development goals. Selection of trainees shall be in accordance with the national values and principles of governance (Article10), leadership and integrity (Chapter 6), Bill of rights (Article27) and values and principles of public service (Articles 232). The guiding principles for nominating officers seeking training opportunities include gender equity, transparency, meritocracy and other principles as provided for in the constitution and other government policies.

The identification and selection of suitable applicants has a set criterion to be used (MOH Training Policy, 2016). The first criterion is the relevance of the course to the individuals' cadre. Each cadre e.g. doctors and nurses have some prioritized areas in which training can be embarked on based on the officer's scheme of service, especially for career progression. The other criterion for the selection of courses is their relevance in addressing the performance gaps as identified in the TNA and the annual departmental training projections. The course should also be cost effective especially in regard to availability of funds that are used for sponsoring trainings (MOH Training Policy, 2016).

The exchequer funds some in-service courses for post graduate and post basic studies based on the following criteria. The officer should have served at least 2 years from date of first appointment and the skills being requested for are relevant to the duties of the officer. It is also noted that priority will be given to applications in fields where critical skills gaps exist and compliance with constitution article (MOH Training Policy, 2016).

## 1.2 Problem Statement

Development and training are a continuous and systematic process. Training is not effective unless it has a purpose and that purpose can only be defined if the training needs of organisations and its employees are identified and analyzed (Staff development Manual, 2014).

Mbijjiwe and Venkataiah, (2013) in a study assessing the success and failures of trainings with a case study of the Ministry of Education note that the public service is waking up to the realization that if you do not pay to train, you will pay in form of losses, damages, strikes, poor services, employee turnover and other ways. The study concluded that despite being a vital input to training, the Training Needs Analysis (TNA) is not adequately conducted; meaning the key areas of need might not be addressed.

According to Beardwell (2004), a lot of organisations are "throwing away" money as a lot of trainings are being conducted without analysis of training needs in relation to short term or long term business plans. Few really evaluate how training can be used to achieve organizational objectives

In her study on challenges of human resource at the Ministry of Public Health and Sanitation, Muoki (2012) noted that though there were training opportunities, staff did not feel they were accorded equal chances across the cadres. Training opportunities were not need based due to a lack of proper training needs assessment, and weak training projections and skills inventory. She recommended that the ministry should budget according to staff skills development needs and that TNAs should be conducted.

A few TNAs studies have been done at the national level to identify the performance and training gaps but no studies has been done to establish whether subsequent trainings are based on addressing identified performance gaps. Do the courses approved actually address a need and whose need is it.

This study sought to review the approved applications and establish what factors influenced the identification of the training needs for health workers at the county level and recommendations for course approvals at the national level.

### 1.3 Research questions

(i) What is the status of TNA and training projections that are used by county training committee in nominating and selecting training applicants?

(ii) Which criteria are counties using for identifying the training needs of the applicants they recommend for course approvals by the Ministry of Health at the national level?

(iii) What is the main post basic and postgraduate specialized trainings being approved at MHRMAC level as presented in the committee minutes?

(iv) What is the extent to which the laid down course nomination and approval procedures are adhered to by the county and national governments?

### 1.4 Objectives of the Study

#### 1.4.1 Aim of the Study

The aim of the study was to establish the factors that are used to identify the training needs of the health workers seeking course approvals at the county and national level.

### 1.4.2 Specific Objectives

The study was guided by the following specific objectives:

(i) To determine the status of TNA and training projections that is used by county training committee in nominating and selecting training applicants.

(ii) To determine the criteria counties are using for identifying the training needs of the applicants they recommend for course approvals by the Ministry of Health at the national level.

(iii) To outline the main post basic and post graduate specialized trainings being approved at MHRMAC level as presented in the committee minutes.

(iv) To examine the extent to which the laid down course nomination and approval procedures are adhered to by the county and national governments.

## 1.5 Justification of the Study

The Ministry of Health mandate is not only to provide health services but to also develop the relevant skills and competencies of its health workers at the national and county levels. Qualified health workers will spearhead the transformation of the country health status through efficient service delivery.

By ensuring the stipulated course nomination and approval process is adhered to, there is assurance that funds that are meant for training are focused on priority areas by addressing some identified need from the county levels. The study hopes that the findings will guide the MOH and counties in reviewing the effectiveness of their adherence to the stipulated nomination and approval process in identifying and addressing performance gaps.

## 1.6 Scope and Limitations of the Study

This study was conducted at the Ministry of Health Headquarters located in Afya House Nairobi. It specifically focused on approved post graduate and post basic trainings at the MHRMAC level, the specialized areas of training approved, and whether there was adherence to the laid down nomination and approval procedures. The information was sourced from the HRD Training Unit, Officers in charge of training data reports and files. The study reviewed the course applications as received from counties and the approved minutes of the MHRMAC.

This study was confined to the factors that influence the course nominations procedures and approvals at the MOH. It was limited to unpublished training records available at HRD Training Unit MOH headquarters. Due to time limitation, budget and the current devolved functions, the study did not access the county records except those included in the training applications approved at the national level.

The study focused on post basic and postgraduate trainings approved at the national level for 3 cadres namely Medical Officers, Clinical Officers and Nurses. The study only reviewed the 2016 training course approvals as by then counties had been in operation for 2 years after devolution and therefore had set some HRD systems in place.

# CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

## 2.1 Introduction

According to the Constitution of Kenya, 2010, "every person has a right to the highest attainable standard of health which includes the right to health care services, including reproductive health and emergency care" (Chapter 4, article 43 (a)). Good health plays an important role in boosting economic growth, poverty reduction and the realization of social goals. Over the last decade, Kenya has had mixed results in improving the overall health status of its population. Life expectancy has gone up; interventions to address specific diseases including HIV and AIDs, Tuberculosis and Malaria have yielded positive results (Vision, 2030). However, the country still lags behind in basic health indicators including high infant mortality (39 per 1,000 live births), under-five mortality (52 per 1,000 live births) and maternal mortality (362 deaths per 100,000 live births) Kenya Demographic Health Survey, (2014). The high infant mortality and under-five mortality may be attributed to HIV&AIDS and poverty while high maternal mortality is associated with inefficiency in delivery of health care services (Vision, 2030).

The government under Vision 2030 social pillar has prioritized 3 key focus areas that need to be worked on to improve the health sector. These 3 areas include (i) increasing access to health care services (through geographical and financial means); (ii) ensuring equity in regions and gender; and (iii) improving quality in service delivery, capacity and institutional frameworks. To achieve results in these focus areas, there is need to improve the quality, quantity and distribution of the health workforce (Human Resources Strategy 2014-2018).

### 2.1.1 Health Workforce

The health workforce is one of the building blocks of a health system alongside leadership and governance; health care financing; medical products and technologies; information and research and service delivery (WHO, 2006). A health system is defined as "all organisations, people and actions whose primary intent is to promote, restore or maintain health". Additionally, a good health system delivers quality services to all people, when and where they need them.

The Government of Kenya vision for health is to provide an efficient and high quality health care system at the best standard to her citizens (Kenya Vision, 2030). It also aims at having a well-trained and developed workforce which will provide quality services and be globally competitive (HRD, 2015). Kenya's health care system however, like in many African countries faces some challenges in her health workforce. Some of these challenges include inadequate and inequitable distribution of staff, high staff turnover, severe shortages of essential cadres, lack of appropriate skills, poor staff attitude, low morale and weak supervision (Human Resources Strategy 2014-2018) This compromises the quality of service delivery and eventually the health and development of a nation.

### 2.1.2 Training Policies

The existence of training policies in countries or organizations is an indication of the importance of training and is used to give guidance on limits and what actions should occur. It also ensures consistency in behaviour (Gakuru, 2006). The Kenya Public Service Commission (PSC) Human Resource Development Policy (2015) acknowledges the need for systematic improvement of knowledge, skills, attitudes, and values of employees so that they

can contribute to the realization of international and national development goals and objectives. It states that training should be aligned to the principles of Results Based Management (RBM) and based on clearly identified needs through conducting of TNA and training projections.

Training policies from other countries also portray the need for needs based trainings. Article 1-3 of the Rwanda Ministerial order on training procedures, note that civil servants training course must be in relation to the improvement of department and development of professional abilities related to the tasks and requirements of the post they hold. A TNA analysis should be done and the training course should fit into the national training plan. Selection should take into consideration the priorities of the TNA and be in line with the country's development (Rwanda Ministerial Order No 19/19 dated 08/07/2003 on Training procedures for Rwanda Civil Servants).

The Government of Lesotho Human Resource Management Department Policy states that training shall be on a needs based basis but the needs of the government and organisations shall take precedence before those of an individual. In line with this, all training applications are scrutinized to ensure that training undertaken is reflected in the TNA reports and training plans (Government of Lesotho: Human Resource Management and Development Policy Manual).

Before embarking on public service reforms, the Uganda Ministry of Public Service acknowledged that training was largely supply driven and public officials were undertaking training without due authority at the expense of the government (Uganda Public Service Training Policy 2006). They recommended the review of systems to ensure that training

addressed (i) institutional competencies and career development needs (ii) Used a demand driven approach where training is based on identified needs of the individual and government (iii) Training funds are optimally utilized for the benefit of the organization (Uganda Training Policy 2006).

The Limpopo Policy (2013) also note that training interventions' will be need based and guided by workplace skills plan that is derived from each employees' personal development plan (PDP), the departments strategic objectives and service delivery priorities. For career development, reference is made to employee's job descriptions, career development needs and personal development plans.

The Tanzania Training Policy 2013 notes with concern that many public service organizations view training as something to be implemented when time and budgets allow or as a remedial for fixing problems. It points out that much training has little relevance to improving staff and organizational performance and neither are they monitored or evaluated for their efficiency and effectiveness (United Republic of Tanzania Public Service Training Policy 2013).

### 2.1.3 Skills Gaps or Critical Training Requirements

The Ministry of Health has experienced skills gap in some critical areas of health over the years (MOH Training Policy, 2016). The current levels are 1 doctor for 1,000 populations and 12 nurses per 1,000 populations (PNA, Capacity Kenya 2010; State of Medical Education in Kenya FUNZO Kenya, 2013). The country falls short of the World Health Organization (WHO) recommended standard of 2.3 doctors and 21 nurses per 1000 population. Furthermore, not only does Kenya have inadequate crucial staff, there are also regional disparities in distribution with hard to reach areas having less staff.

In September 2014, The Ministry of Health sought to identify the skills types of staff needed for efficient implementation of health care services through the Managed Equipment Services Project (MESP) in 94 county referral services. The skills gaps are analyzed as ratios of health professionals at the national level as well as counties in relation to the recommendations of the norms and standards. The identified skills gaps included surgery, radiology, central sterile services department (CSSD), medical laboratory, ICU and renal dialysis.

During the development of the National Human Resource Strategy (2014-2018), the Director of Medical Services identified 4 critical training requirements needed for efficient delivery of services. The first requirement was for Anesthetists, Obstetrics/gynecologists, general surgeons, family physicians, ENT surgeons, eye specialists, psychiatrists, oncologists; general pathologists, radiologists, renal physicians and renal pediatricians. The second critical requirement was for cardiologists, critical care physicians, general physicians, dermatologists and orthopedic surgeons. The third critical gap was for training registered clinical officers in ENT, Ophthalmology, and Pediatrics, Reproductive health and lung and skin. The last requirement was for training nurses in pediatric, neonatal, theatre, renal, psychiatry, anesthetic, critical care, oncology, and Accident and Emergency (A&E).

### 2.1.4 Training Needs Assessments

Training Needs Assessment refers to the exercise of collecting, collating and analyzing data for employees to establish gaps in knowledge, skills and attitudes necessary for effective performance of their duties (MOH training Policy, 2016).

In 2015, the national government conducted a TNA in all the 47 counties with 3 main objectives. The first objective was the identification of the skills gap in health specialists' i.e. clinical and management staff at postgraduate and post basic levels needed for effective service delivery. The Table 2.1 below shows the gaps in the specialized areas for Medical officers, Clinical Officers and nurses.

**Table 2.1: Gaps in Specialists**

| Cadre | Norms and Standards Ideal Number | Actual Number | Percentage |
|---|---|---|---|
| General Practitioners, Medical Officers | 6,428 | 1,719 | 26.7% |
| Anesthetist | 590 | 106 | 18% |
| Surgeons- Obstetric/Gynecologists, Ear Nose and Throat (ENT), Orthopedic | 1,445 | 200 | 13.8% |
| General Internists/ Physicians | 945 | 1,656 | 175% |
| Specialists- Internal Medicine, Neonatologists, Urologists, Gastro enterologists | 375 | 11 | 3% |
| Clinical Officers | 14,270 | 1,907 | 13.4% |
| Clinical Officers specialists- Bachelors | 4,584 | 934 | 20.4% |
| Lung and skin | 1,885 | 227 | 12% |
| Anesthetists | 1,740 | 215 | 12.3% |
| Nurse and nurse specialists | 123,800 | 19,755 | 16% |

*Source (Author, Report of the Training Needs Assessment of Kenya's Health workforce 2015)*

The post basic and post graduate specialist is as defined by the regulatory authorities as well as specialists in different professional categories. The TNA findings showed that only 22.7% or 31,412 out of the ideal 138,266 of health workers were employed in public, private and FBOs health facilities. There were fewer numbers of general practitioners, clinical officers

and nurses employed than those recommended in the health norms and standards guidelines. The numbers for specialists in internal medicine and surgeons lie at 3% and 13.8% respectively. The TNA noted the need to train in more specialist focus areas for Cardio-surgeons, Neuro- Surgeons, oncologists, nephrologists, lung and skin clinical officers, anesthetists' clinical officers, cardiology nurses, forensic nurses, dental, accident and emergency and oncology nurses (TNA 2015) The study also found that there were no cardiologists, oncologist, nephrologist employed in the counties.

### 2.1.5 Demand Driven vs. Supply Driven Training

Mwawasi (2010) noted that though the HRD policy provides that training be based on comprehensive TNA, many organizations have not been doing this. Training has thus been more supply driven than demand driven. Supply driven training is where individuals identify their personal training needs while demand driven training is when organizations identify their skills development needs. Ndivo (2003) concurs when she notes that most organisations are relying on staff to identify the skills they think they may need (supply driven) as opposed to what the organisations requires.

According to Mbijjiwe (2013), the absence of TNAs in most organizations means trainings are supply driven. Organisations do not collect information to determine the usefulness of their own instructional programmes. He concludes that it is high time the training procedures are evaluated to ensure key areas of need are targeted by trainings to make them effective. Otherwise, without strict adherence to the set policy, guidelines and directions, training will more often than not result to losses.

### 2.1.6 Aligning Staff Trainings to Organizational Needs

Oyunge's (2012) study reviewed the extent to which departmental objectives in KRA influenced the training programs. She quotes Kaufman (1985), who had observed that to achieve organizational goals, there was a need to align staff training programs with departmental objectives. If the training is not linked to what an organization does, needs or hopes to achieve, then it is useless. KRA was found to conduct specific departmental needs assessments e.g. (for Income Tax, Value Added Tax, Customs Department) and then a training program was planned and implemented to address the specific needs of the department and not necessarily the whole organizations.

In her survey on the extent to which large manufacturing companies in Nairobi align their training and development programs to their business strategies, Onyonka (2008) found out that 73.3% of the firms actually did this. The study showed that the most important consideration for choosing a training and development program was the aligning to the business strategy. Gakuru (2006) says the role of management is to ensure that resources are used in an efficient and effective manner. She notes that organisations have spent considerable time, effort and money on trainings with no visible improvement in performance. This is because the trainings have no direct link to the needs of the organisation thus their effect on performance is minimal, if any.

Ngure and Njiru, (2013) in a study assessing the effectiveness of the senior management course at the Kenya School of Government, which is meant to impart knowledge to public servants to prepare them to offer better services, concluded that most senior officers were driven by the need for promotion and not knowledge acquisition. They observed that many public ministries do not have TNA to guide their training projections and priorities. They point out that in the Ministry of Education there is little or no evaluation done on the training programs and evaluation of job performance after training.

### 2.1.7 Requirements' for Course Approvals

There are several laid down requirements that are considered before course approval is given (MOH HRD procedure guidelines 2015). It is recommended that an officer should have served for a minimum period of 2 years from date of commencement of internship and should also have completed 2 years after completion of previous long course.

Any officer intending to study overseas training should show proof of financial ability to sustain the training. Some key supportive documents should be presented alongside the application letter or request for approval. These include letters of admission to a recognized training institution and copies of the minutes of the County Health Training Committee recommending the officer for the training. For career progression, there should be copies of relevant sections of the scheme of service or career progression guidelines (HRD Procedure guidelines 2015).

It therefore clear that there are some factors that determine approval. However, the main criteria is that counties should use TNA to make evidence based decisions when addressing skills needs of its workforce in relation to the available resources and ensure prudent use.

## 2.2 Theoretical Framework: Human Capital Theory

The theoretical framework explains the Human Capital theory and how the study fits into it. One of the basic principles of HRM is that there is need to invest in people to develop the human capital required by an organization and hence increase its stock of skills and knowledge (Armstrong 2013). Human Capital is defined in the Oxford Dictionary as the "skills the labor force possesses "and is regarded as a resource or asset.

Economist Schultz (1961) in his paper “Investment in Human Capital” coined the Human capital term. He noted that people acquire useful skills and knowledge, which is a form of capital. Munyendo quotes Bontis et al, (1999) who observed that human capital represents the human factor in the organization, the combined intelligence skills and expertise that they give to the organization. The theory generally views the people in an organization as an asset, which if trained and motivated can generate worthwhile returns. Skills, knowledge and other attributes affect human capabilities to do productive work. Any direct expenditure done to enhance such capabilities will add value to the human labour and increase the value of productivity. This will in the long run contribute to the welfare of the organization by yielding positive returns.

To Schultz, health is a kind of human capital as well as an input in producing other forms of human capital. Not only does health contribute to well-being, but it is also an investment good that increases the future productive power of the individual and the economy. Being unhealthy depresses the ability to work productively. Human resource in the health sector represents both strategic capital and a critical resource for the performance of the health system.

Classic human capital theory states that firms should only pay for the development of skills and knowledge that directly benefits the organization. Gakuru quotes Johnson 1989 who argues that organizations should achieve maximum returns on their capital investments by ensuring the resources are used in the most effective and efficient way. The implication is that there should be a return in investment for every individual trained. Thus where there are limited resources, those trained should be able to return the greatest returns in terms of strategic success of the organization (Syanda & Nyamanga, 2014). Training should therefore be viewed as a long-term investment in the growth and development of any organization.

## 2.3 Conceptual Framework

### 2.3.1 Health Related Training Needs Assessments

Planning for training in the MOH and county shall be guided by the TNA. This should capture the organizational, task and individual career progression needs, which should link any training to closing of such gaps.

### 2.3.2 Availability of Training Plans/ Training Projections

Counties are expected to develop training plans and projections for their staff based on the results of the TNA. These should be evidence based and high Impact. From the projections, the counties have a clear profile of who needs training and in which areas.

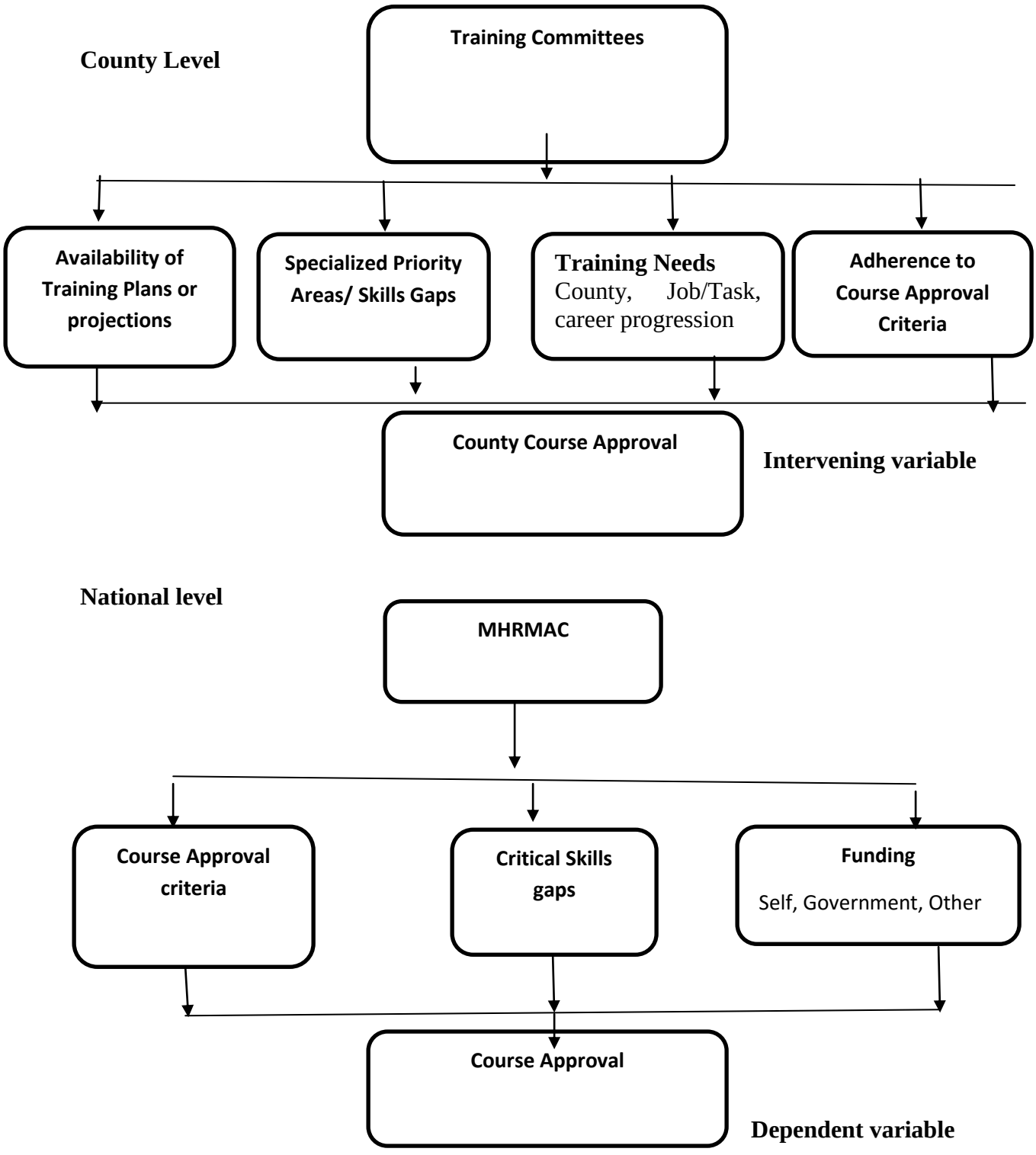
### 2.3.3 Specialized Priority areas/ Skills Gaps

With devolution and as counties develop their facilities to offer specialized services and with acquisition of EMS equipment, the Ministry of Health needs to train more specialists in several priority areas. Such training should improve performance and service delivery and eventually raise effectiveness and quality of services.

### 2.3.4 Adherence to Laid Down Nomination And Approval Criteria

Some set criteria are followed when determining approval and whether the officer will be funded. This includes the officer having served for 2 years since completion of internship or completion of a previous course. The course should also be relevant and addressing prioritized skills gaps.

**Figure 2.1: Conceptual Framework for Course Approvals at the County and National Level**



# CHAPTER THREE: RESEARCH METHODOLOGY

## 3.1 Introduction

This chapter describes the research methodology used in this study, the study site, study population, sampling design, methods of data collection and analysis procedure.

## 3.2 Site Description

The study was conducted at the Ministry of Health Headquarters' Nairobi. The fourth schedule of the constitution has given it authority to capacity build and gives technical assistance to the counties. For course approvals, health workers from the Counties forward their training applications to the Human Resource Development Department and specifically the Training Unit, which coordinates the MHRMAC meetings. The training unit is thus the custodian of the applications from the counties and of MHRMAC minutes and records.

## 3.3 Research Design

A research design is a program that guides the investigator in the process of collecting, analyzing and interpreting observations (Nachmias & Nachmias 2005:99). This study used descriptive research design. Mugenda and Mugenda, (2003:160) describe descriptive research as involving collection of data in order to test a hypothesis or determine and report the current status of the population or a representative subset under study. A descriptive research determines and reports the way things are and attempts to describe such things as possible behavior, attitudes, values and characteristics, Mugenda and Mugenda, (2003). The primary use of descriptive statistics is to describe information or data using numbers (create a number of pictures of the information).

## 3.4 Unit of Analysis and Unit of Observation

### 3.4.1 Unit of Analysis

The unit of analysis refers to those units that a researcher initially describes for the purpose of aggregating their characteristics in order to describe some larger group or abstract phenomenon (Rubin and Babbie 1997 pg. 114). It is the main entity that is being analyzed in a study. In this study the units of analysis are the factors that influence nominations and approvals of health workers for post basic and post graduate trainings at the county and national levels.

### 3.4.2 Unit of Observation

Mugenda and Mugenda (2003) describe the unit of observation as the subject, item or entity from which we measure the characteristic or obtain the data required in the research study. The units of observation in this study were medical officers, clinical officers and nurses who had applied for post basic and post graduate trainings and whose applications had been deliberated on in the MHRMAC meetings for the calendar year 2016.

## 3.5 Population of the Study

According to Mugenda & Mugenda (2003 pg. 9), a population is an entire group of individuals, events or objects with some common observable characteristics. Cooper and Schindler (2006 pg. 402) also express a similar view when they define a population as the total collection of elements about which one wants to make inferences.

The study population comprised all the Medical Officers, Clinical Officers and Nurses from all counties who had applied and successfully gotten course approvals for their post basic and post graduate training at the MHRMAC level for year 2016.

## 3.6 Population Size and Sampling Procedure

### 3.6.1 Population Size

This refers to the actual number of items or people in the population (Kothari, 2008). The population comprised 146 applicants including 78 medical officers, 40 nurses and 28 clinical officers who had gotten their course approval and funding either through self, sponsorship or government means.

### 3.6.2 Sampling Procedure

The study used a census survey which is a complete enumeration of a population or a group at a point in time with respect to well defined characteristics (OECD). This included all applicants from counties who had gotten their course approvals from the National level and who had been funded by the Government of Kenya, others sponsors or through self-sponsorship.

## 3.7 Methods of Data Collection

The study used primary sources and secondary data. The primary sources were Key informants interviews while secondary data was accessed from the HRD training unit and other technical divisions

### 3.7.1 Collection of Quantitative Data

Quantitative data was collected through data collection tools available in Annex 1. It was used to review the training applications databases and copies of the signed MHRMAC minutes available at the HRD training unit.

### 3.7.2 Collection of Qualitative Data

The study used a key informant interview guide attached in Annex II to interview The Human Resource officers in the HRD department, the Nursing Division, and other officers from the 2 National levels Hospitals namely National Spinal Injury Hospital and Mathari National Teaching and Referral Hospital.

## 3.8 Data Analysis

After collection of data, it was cross checked for completeness and consistency to ensure it addressed the research objectives. The data was tabulated, categorized into purposeful themes or categories and analyzed using descriptive statistics. The quantitative data from the data collection tools was coded and analyzed to produce frequencies and percentages in form of tables, and figures. The quality data was organized into emerging themes.

# CHAPTER FOUR: DATA ANALYSIS, PRESENTATION AND INTERPRETATION

## 4.1 Introduction

This is a report based on a study of the factors influencing nominations and course approvals for post basic and post graduate trainings for health workers at the County and National Level at the Ministry of Health Nairobi Kenya. This chapter presents findings based on the specific objectives below:

(i) To determine the status of TNA and training projections that are used by county training committee in nominating and selecting training applicants,

(ii) To determine the criteria counties are using for identifying the training needs of the applicants they recommend for course approvals by the Ministry of Health at the national level.

(iii) To outline the main post basic and post graduate specialized trainings being approved at MHRMAC level as presented in the committee minutes.

(iv) To examine the extent to which the laid down course nomination and approval procedures are adhered to by the county and national governments.

The chapter also includes the interpretation and discussion of the study findings based on the research objectives.

### 4.1.1 Response Rate

The study targeted all the populace of 167 applicants comprising of 80 medical officers, 60 nurses and 27 clinical officers who had gotten course approvals from the Ministry of Health and funding either through self or government or other means. The study accessed a total of

146 applicants' complete data comprising of 78 medical officers or doctors, 28 clinical officers and 40 nurses. This constituted 87.4 % response rate which is acceptable to make conclusions for the study. According to Mugenda and Mugenda (2003), a response rate of 50% is adequate for analysis and reporting, a rate of 60% is good and a response rate of 70% and over is excellent.

### 4.2 Social and Demographic Characteristics of the Applicants

This section covers the demographic characteristic of the applicants involved in the study and includes their designations, gender and age as shown in the tables below.

#### 4.2.1 Designation of the Applicants

The study sought to determine the designations of the 146 applicants. The Table 4.1 below shows the distribution of the applicants by their professional qualifications or cadres.

**Table 4.1: Cadres/Professional Qualifications of Applicants**

| Cadres | Frequency (N) | Percentage (%) |
|---|---|---|
| Medical Officer | 78 | 53.4 |
| Clinical Officer | 28 | 19.2 |
| Nurse | 40 | 27.4 |
| Total | 146 | 100.0 |

The results showed that of all the courses approved, 53.4% of the applicants were medical officers 27.4% were nurses while 19.2 % were clinical officers. From this study, it means more Medical Officers are pursuing their post graduate trainings than Nurses and Clinical Officers pursuing post basic courses. From the Report of the TNA of Kenya's Health workforce 2015, only 22.7% or 31,412 out of the ideal 138,266 health workers are employed in public, private and NGOs. Out of this, there were 1,719 medical officers, 1,907 Clinical Officers and 19,755 nurses.

### 4.2.2 Gender of the Applicants

One of the guiding principles for course nominations and approvals state that there should be gender equity in the selection of trainees. Table 4.2 shows the gender distribution.

**Table 4.2: Gender Distribution**

| Cadre | Female | | Male | | Total | |
|---|---|---|---|---|---|---|
| | **N** | **Percent** | **N** | **Percent** | **N** | **Percent** |
| Medical Officer | 39 | 50.0 | 39 | 50.0 | 78 | 100.0 |
| Clinical Officer | 15 | 53.6 | 13 | 46.4 | 28 | 100.0 |
| Nurse | 36 | 90.0 | 4 | 10.0 | 40 | 100.0 |
| **Total** | **90** | **61.6** | **56** | **38.4** | **146** | **100.0** |

Out of the 146 health care workers, 61.6% were female and 38.4 % were male. Among the Medical officers, 50% were female while 50% were male. There were 53.6% female and 46.4% male clinical officers. Female nurses constituted 90% with only 10 % being male. This finding indicates there were marginal variations among the two genders for medical officers and clinical officers. These figures also meet the two-third gender rule as stipulated in the constitution. However, this rule was skewed among the nurses as traditionally nursing has been a female dominated profession.

### 4.2.3 Age of the Applicants

Age is considered to be a factor influencing training and development decisions. The table below shows the distribution of the applicants according to their age brackets and their cadres.

**Table 4.3: Age Distribution by Type of Cadre**

| Age Group | Type of Cadre | | | | | | Total | |
|---|---|---|---|---|---|---|---|---|
| | Medical Officer | | Clinical Officer | | Nurses | | | |
| | Frequency | Percent | Frequency | Percent | Frequency | Percent | Frequency | Percent |
| **25-30** | 24 | **30.8** | 1 | **3.6** | 1 | **2.6** | **26** | **17.8** |
| **31-35** | 44 | **56.4** | 13 | **46.4** | 3 | **7.9** | **60** | **41.1** |
| **36-40** | 5 | **6.4** | 10 | **35.7** | 9 | **15.8** | **24** | **16.4** |
| **41-50** | 4 | **5.1** | 4 | **14.3** | 16 | **42.1** | **24** | **16.4** |
| **51-60** | 1 | **1.3** | 0 | **0** | 11 | **31.6** | **12** | **8.3** |
| **Total** | **78** | **100.0** | **28** | **100.0** | **40** | **100.0** | **146** | **100.0** |

As shown in the table above 41.1% of the applicants were aged between 31-35 years with a further 17.8% aged between 25-30 years. This means 58.9 % of all applicants are below the age of 35, falling in the age bracket of the youth of the country, with a lot of potential and productive years ahead. The age distribution among the cadres for ages 36-40 stands at 16.4% the same percentage with those aged between 41-50 years. Only 8.3 % of the applicants are aged between 50-60 years.

From the findings 87.2 % of medical officers were between the ages of 25-35 with only 12.8% aged between 36-60 years. This implies a relatively young population of medical officers. Among the clinical officers 82.1% were between the ages of 31-40 years, 14.3% were aged 41-50 with only 3.6 % below 30 years of age. This case was different among the nurses with 89.5% being above 36 years and 31.6% above 50 years of age. This means medical officers and clinical officers are making informed decisions on their post basic and post graduate degrees at a fairly young and productive age. There may be need to find out why nurses are undertaking their post basic trainings late in their careers.

### 4.3 Training Course Approvals in the Counties

Training is a participatory and collective responsibility of the national and county governments and is noted to be the most cost effective intervention for improving employee competencies. The counties take the responsibility of giving initial course recommendations before the applicants seek for course approval at the national level. The study sought to find out the distribution of Counties from which the course applicants who had gotten their course approval at the national MHRMAC level came from. The table 4.4 below shows the distribution of the course applicants that were approved, their designations and their counties.

**Table 4.4 Approved Course Applicants per County**

| | County | Medical Officers | Clinical Officers | Nurses | Total | Percent |
|---|---|---|---|---|---|---|
| 1 | Baringo | 0 | 1 | 0 | **1** | **0.68** |
| 2 | Bungoma | 1 | 1 | 0 | **2** | **1.37** |
| 3 | Busia | 2 | 0 | 1 | **3** | **2.05** |
| 4 | Elgeyo Marakwet | 0 | 1 | 0 | **1** | **0.68** |
| 5 | Embu | 0 | 0 | 1 | **1** | **0.68** |
| 6 | Garissa | 4 | 0 | 0 | **4** | **2.74** |
| 7 | Isiolo | 0 | 1 | 1 | **2** | **1.37** |
| 8 | Kakamega | 2 | 0 | 0 | **2** | **1.37** |
| 9 | Kericho | 2 | 1 | 0 | **3** | **2.05** |
| 10 | Kiambu | 9 | 2 | 7 | **18** | **12.30** |
| 11 | Kilifi | 4 | 3 | 2 | **9** | **6.16** |
| 12 | Kirinyaga | 6 | 2 | 1 | **9** | **6.16** |
| 13 | Kisii | 3 | 0 | 0 | **3** | **2.05** |
| 14 | Kisumu | 2 | 0 | 0 | **2** | **1.37** |
| 15 | Kitui | 2 | 0 | 0 | **2** | **1.37** |
| 16 | Kwale | 0 | 1 | 0 | **1** | **0.68** |
| 17 | Laikipia | 2 | 0 | 0 | **1** | **0.68** |
| 18 | Lamu | 1 | 0 | 0 | **1** | **0.68** |
| 19 | Machakos | 2 | 3 | 2 | **7** | **4.79** |
| 20 | Makueni | 3 | 1 | 0 | **4** | **2.74** |
| 21 | Malindi | 2 | 0 | 0 | **2** | **1.37** |
| 22 | Meru | 1 | 0 | 0 | **1** | **0.68** |
| 23 | Migori | 1 | 2 | 0 | **3** | **2.05** |
| 24 | Mombasa | 2 | 0 | 1 | **3** | **2.05** |
| 25 | Murang’a | 3 | 0 | 0 | **3** | **2.05** |

| | County | Medical Officers | Clinical Officers | Nurses | Total | Percent |
|---|---|---|---|---|---|---|
| 26 | Nairobi | 3 | 3 | 6 | **12** | **8.20** |
| 27 | Nakuru | 7 | 0 | 1 | **8** | **5.50** |
| 28 | Narok | 3 | 0 | 0 | **3** | **2.05** |
| 29 | National | 3 | 0 | 16 | **19** | **13.01** |
| 30 | Nyamira | 1 | 0 | 0 | **1** | **0.68** |
| 31 | Nyandarua | 0 | 1 | 0 | **1** | **0.68** |
| 32 | Nyeri | 1 | 0 | 1 | **2** | **1.37** |
| 33 | Taita Taveta | 3 | 0 | 0 | **3** | **2.05** |
| 34 | Tana River | 0 | 1 | 0 | **1** | **0.68** |
| 35 | Tharaka Nithi | 1 | 1 | 0 | **2** | **1.37** |
| 36 | Uasin Gishu | 0 | 3 | 0 | **3** | **2.05** |
| 37 | West Pokot | 2 | 0 | 0 | **2** | **1.37** |
| | **No** | 78 | 28 | 40 | **146** | **100.0** |
| | **Total %** | **53.4** | **19.2** | **27.4** | **100.0** | |

The 146 applicants whose applications were approved were drawn from 36 (constituting 76.6%) of the 47 counties and some from the National level namely National Spinal Injury Hospital, Mathari National Teaching and Referral Hospital and other National Programmes. Out of the 146 applicants, 13% were from the National level, 12.3% from Kiambu County and 8.2% from Nairobi County. It is noted that 10 of the 36 counties had only one successful applicant approval. This also means that 23.4 % of the counties did not have any applicants who got course approval implying there was no post basic or post graduate trainings for the health workers in those counties for the financial year 2016/2017, the focus of this study. A discussion with officers in the training section showed that the unit only processes the applications that have been sent to them with all necessary documents from the counties. The training unit does not influence where the applications are derived from. The responsibility of sending applications lies with the individual officers and the counties. This should be of concern to the national and county level as it raises the issue of why there were no training course approvals for some regions. Does it mean they never applied and if so, what are the reasons?

### 4.4 Management and Coordination of Training at the County Level

According to the County Human Resource Manual 2013, the management and coordination of training is the responsibility of the County Public Service Boards who have delegated these functions to County Department Training Committees. Training Committees advise on optimal utilization of local and foreign training resources and opportunities. The committees also provide advice on the identification and selection of suitable applicants for various trainings. The study sought to find out the availability of the training committees in the counties.

#### 4.4.1 Availability of Training Committees

The study found out that the course approval applications in 36 counties were reviewed by different levels of training committees. There were committees at the Facility, Sub County, County Health Training Committee, County Human Resource Advisory Committee and finally the County Public Service board level. Table 4.5 shows the distribution of counties according to the different levels of training committees.

**Table 4.5: Distribution of Counties according to Levels of Training Committees (N=36)**

| Training committee | Frequency | Percent |
|---|---|---|
| Facility Level | 14 | 38.9 |
| Sub County Level | 5 | 13.9 |
| County Health Training Committee | 18 | 50.0 |
| County HRMAC | 15 | 41.7 |
| County Public Service Board | 4 | 11.1 |

As shown in Table 4.5 above 11.1% of the Counties had County Public Service Boards deliberating and giving training course approvals. In 50% of the counties, this function had been delegated to County Health Training committees which are the technical department where the health workers fall. Fifteen Counties (41.7%) relied on decisions of County Human Resource Management Advisory Committee (HRMAC) which were made up of County Directors of Health and directors from other departments or Ministries. For 8 Counties, approvals would start from the facility level with onward transmission to either the County MHRMAC or County Health Training Committee. The findings indicate that course approval decisions in about 9 counties were not made by County Department Training committees'. This finding corresponds with the TNA report on Kenya's the health workforce 2015 that had noted that 8 Counties did not have functional training committees. All counties therefore need to ensure they have functional training committees as they are the ones mandated to select individuals and ensure optimal use of resources.

## 4.5 Availability of County Training Needs Assessments (TNA) and Training Projections

The first objective of the study sought to determine the status of Training Need Assessments and training projections used by county training committee in nominating and selecting training applicants for post basic and or post graduate training The Human Resource Department Policy 2015 stipulates that nominations and selection for individual or group training shall be based on prioritised training projections that address national, organisational and individual career development goals.

The HRD policy 2015 states that all trainings in the public service be based on a comprehensive training needs assessment (TNA) to be conducted every three (3) years or as need arises. The County Human Resource Manual (2013) state that each county department should conduct a TNA every 2 years and prepare training projections to guide the training committees in making evidence based decisions and nominations. The study accessed communication from one County Governor to the Principal Secretary of Health forwarding their training projection and requesting that their staff be trained in Oncology for their proposed cancer centre. The study was however not able to access any TNA report or training projections from any County in the Training Projections file at the Ministry of Health Headquarters.

A review of the training application forms found that 6 out of the 36 counties with course approvals made some reference to the need for Training Needs Assessment. The other 30 counties did not explicitly mention or refer to TNA but gave approvals using other criteria which will be discussed in the next section 4.5.2. The study found that in one of the 6 counties, the County Director of Health chairing the Training Committee noted the challenges they were facing in training "as there was no structured way of identifying staff it needs to train at a certain time". The Committee agreed on need to conduct a TNA to identify skills gap. Another County Human Resource Advisory Committee advised on the need to put clear guidelines in place concerning course approval requests on training to ensure "the courses are relevant to the line of duty and have value addition to work performance and career progression".

Two counties' Training committees had training guidelines available that they used. The 2 Counties however also recommended that departmental heads identify the training needs and forward them to the Training committee. In another County Health Training Meeting, members agreed to request departmental heads to conduct TNA starting at the sub counties level and present to the committee for deliberations. The study was however not able to establish the status of these recommendations and whether the TNAs were actually conducted.

The study conducted key informant interviews with the Human Resource Officer and Continuous Medical Education Officers at one of the National Teaching and Referral Hospitals. The findings showed that their Human Resource Development Plan did not have training projection for Post Graduate and Post Basic training. What were available were projections for topics for Continuous Medical Education. A discussion with an Officer from the other National Hospital showed a similar trend where there was no specific training projection for post graduate and post basic courses. Medical Officers were reported to apply at their own time and in courses of their own interests.

The study did not access County specific prioritised training projections for post basic and post graduate courses addressing national and county needs. This could be attributed to the fact that the study was relying on secondary data and was not able to visit or contact the counties so cannot conclusively say there are no plans. The lack of TNA or training projections finding however is in line with the TNA report 2015 which found only 2 County HRD work plans with post basic and/or post graduate trainings. Muoki's (2011) findings also noted the lack of Training Needs Assessment documents or charts within the Ministry of Public Health and sanitation.

### 4.6 Criteria Used by Counties to Approve Training Needs and Requests

The Second objective sought to determine the Criteria that Counties used for approving the training needs and requests of the applicants. The study relied on review of training application forms and attached documents that had been received, deliberated on and filed in the Ministry of Health Training Section. From the target population who had received their approval and been funded either through self or government sponsorship, the study was only able to access 72 out of the 146 hard copy applications from 27 counties. The study could not get hold of the remaining 74 forms though ideally they should be filed in the Training unit. The study was informed that the challenge of missing hard copies was attributed to changes in personnel in the training section and these files not all handled from one single office. Documentation was thus noted to be a challenge within the training section at the national level.

#### 4.6.1 Reasons given for Course Approvals

The study picked up the following as the justifications or reasons that either the immediate supervisors in the bio data form or the training committee in the training minutes put down for approving the course applications. The table 4.6 below shows some of the reasons given for course approvals in the 27 Counties where the 72 hard copies of application documents were accessed.

**Table 4.6: Reasons for Approval of Training Applications (n = 27 Counties)**

| Cadre | Reasons | Frequency | Percent |
|---|---|---|---|
| Medical Officers | County Needs | 16 | 59.3 |
| | Course Relevance | 5 | 18.5 |
| | Career Progression | 6 | 22.2 |
| | Number of Years Served | 7 | 25.9 |
| Clinical Officers | County Needs | 5 | 18.5 |
| | Course Relevance | 3 | 11.1 |
| | Career Progression | 4 | 14.8 |
| Nurses | County Needs | 3 | 11.1 |
| | Course Relevance | 4 | 14.8 |
| | Career Progression | 6 | 22.2 |

### 4.6.2 County Needs

A review of the Medical officers' applications shows that 59.3 % of the Counties considered the future benefits to the county of the courses already applied for. One County in Coast region justified that the approved training for a Paediatrician and Paediatric surgeons would mean less referrals to Kenyatta National Hospital. One other county in North Eastern region justified that the Course was beneficial as they had only one paediatrician in the whole region and no female Obstetrics and Gynaecologist. One county justified the need for Internal Medicine Physicians "due to the setting up of the oncology and Renal units". Justifications were also given for other specialised courses including Psychiatry, Oncology, and Radiology. Radiology was prioritised due to the installation of Emergency Medical Supplies equipment. Among the Clinical Officers, 18.5 % of the courses were deemed to be addressing county needs with majority undertaking Anaesthesia.

### 4.6.3 Demand Driven vs. Supply Driven Courses

The study findings indicate that in most cases, the requests for course approval and release were from health workers who had applied for and already been admitted in various training institutions for post basic and post graduate courses of their own choice. This means the trainings were more supply driven or individual based, with the applicants determining their own training and development needs. This means that though the courses may be skills gaps in the Counties, the counties did not initiate the course selection process based on their county needs and priorities. Individuals were making their own course choices rather than falling back on county training projections which may not be available or documented. This view is in line with Muoki (2011) who noted that training projections are weak and thus officers would only benefit from training opportunities if they applied.

### 4.6.4 Course Relevance and Career Progression

Course relevance to the duties of the officer was given in 18.5 % of medical officers' approval and a further 22.2 % were approved for career progression reasons. The study found 2 counties whose Health Departmental Advisory committee had recommended that doctors should get study approvals to reduce the critical skills gaps that existed in their areas of specialisation. This means that some counties considered the training of doctors as necessary and also acknowledged the skills gaps they would address.

The justification for Career progression course relevance for clinical officers covered 14.8% and 11.1% respectively. For the nurses, the main justification was career progression at 22.2 % with 14.8% undertaking a course considered as relevant to their duties. The study was informed by the Nursing Unit in the Ministry that there had been a concerted effort to

upgrade nurses from the certificate to Diploma and Degree levels and thus the increased career progression justification. This means that Continuous Professional Development was considered an important factor justifying course approval.

### 4.6.5 Availability of Staff Replacement

The study found that Counties were concerned about staff shortage while giving course approvals. Training applications were approved after training committee was satisfied that arrangements for duty coverage have been made so that service delivery is not compromised after release of the officer. In some cases, despite admissions to recognised institutions, officers were released a few at a time after officers in charge confirmed there was a replacement who will seal the gaps. Some 2 counties deferred training for some applicants to avoid shortage of medical officers. Two counties also considered the number of officers who had been released the previous year. This means that the granting of course approval and release of health workers was influenced by the availability of staff to take up their normal duties. This therefore means that there are some officers whose post basic or post graduate trainings are withheld as they have no replacement to relieve them of their service delivery duties.

## 4.7 Main Post Graduate and Post Basic Training Areas

The third objective sought to outline the main post graduate and post basic courses that were being approved by the MHRMAC. The HRD Training Policy of 2015 notes that the exchequer funds will give priority to applications in fields where critical skills gaps exist.

### 4.7.1 Training of Medical Officers

Attaining a post graduate degree is one of the career progression goals for medical officers and determines their specialities and future earning capabilities. Table 4.7 shows the post graduate courses the medical officers are undertaking.

**Table 4.7: Training Areas for Medical Officers**

| No | Area of Training | Gender | | Total | |
|---|---|---|---|---|---|
| | | Male | Female | Frequency | Percent |
| 1 | Mmed Anaesthesiology | 5 | 6 | 11 | 14.1 |
| 2 | Mmed Radiology and Imaging | 9 | 2 | 11 | 14.1 |
| 3 | Mmed Internal Medicine | 6 | 3 | 9 | 11.5 |
| 4 | Mmed Oncology | 4 | 3 | 7 | 9.0 |
| 5 | Mmed in Obstetrics and Gynaecology | 1 | 6 | 7 | 9.0 |
| 6 | Mmed in Family Medicine | 2 | 4 | 6 | 7.7 |
| 7 | Mmed in General Surgery | 5 | 1 | 6 | 7.7 |
| 8 | Mmed in Paediatric and Child Health | 0 | 4 | 4 | 5.1 |
| 9 | Mmed in Psychiatry | 2 | 2 | 4 | 5.1 |
| 10 | MBA | 0 | 3 | 3 | 3.7 |
| 11 | Mmed Reproductive Health | 0 | 2 | 2 | 2.6 |
| 12 | Mmed Orthopaedic Surgery | 2 | 0 | 2 | 2.6 |
| 13 | MSC Epidemiology | 0 | 2 | 2 | 2.6 |
| 14 | MSC | 1 | 0 | 1 | 1.3 |
| 15 | MPH | 0 | 1 | 1 | 1.3 |
| 16 | Fellowship in Gyne-oncology | 1 | 0 | 1 | 1.3 |
| 17 | PHD | 1 | 0 | 1 | 1.3 |
| | **Total** | **39** | **39** | **78** | **100.0** |

From the study 14.1 % of medical officers were undertaking Masters in Medicine (Mmed) in Anaesthesia and 14.1 % in Radiology and Imaging. Internal Medicine was taken by 11.5% while Oncology, and Obstetrics and Gynaecology had 9% each. This means that 57.7% of all approvals were concentrated in the 5 specialist areas above. Family Medicine and General Surgery had 7.7% each. The findings are in line with what the Director of Medical Services had identified as critical training requirements needed for efficient delivery of services in the National Human Resource Strategy (2014-2018).

In terms of gender, the study shows more men undertaking post graduate training in Radiology and Imaging, Oncology, General surgery and Internal medicine. Female doctors were more in such fields as Obstetrics and Gynaecology, Family Medicine, Paediatric and Child health and anaesthesiology. This is an area that requires future research to determine what influences choice of speciality areas across the genders.

### 4.7.2 Training of Clinical Officers

Training should improve performance and service delivery and eventually raise effectiveness and quality of services. The findings show that 28.6% of clinical officers were undertaking Higher National Diploma (HND) studies in Anaesthesiology while 21.4% were studying mental health and psychiatry. A further 10.7% were undertaking HND in Lung and Skin disease and 10.7% in Ear Nose and Throat. Bachelor's degrees studies were being undertaken by 10.7% of clinical officers who were sponsoring themselves. These speciality areas are reflective of the skills gaps among clinical officers as reflected in the National Human Resource Strategy (2014-2018) and the TNA report 2015.

Table 4.8 shows the post basic courses taken by clinical officers.

**Table 4.8: Training areas for Clinical Officers**

| No | Area of training | Gender | | Total | |
|---|---|---|---|---|---|
| | | Male | Female | Total | Percent |
| 1 | HND Anaesthesia | 6 | 2 | 8 | **28.6** |
| 2 | HND Mental Health and Psychiatry | 0 | 6 | 6 | **21.4** |
| 3 | HND Lung and Skin Diseases | 1 | 2 | 3 | **10.7** |
| 4 | HND in Ear, Nose and Throat (ENT) | 1 | 2 | 3 | **10.7** |
| 5 | Bachelors | 3 | 0 | 3 | **10.7** |
| 6 | Masters | 1 | 1 | 2 | **7.1** |
| 7 | HND in Clinical Medicine and Surgery | 1 | 0 | 1 | **3.6** |
| 8 | HND Ophthalmology | 0 | 1 | 1 | **3.6** |
| 9 | HND in Paediatrics | 0 | 1 | 1 | **3.6** |
| | Total | 13 | 15 | 28 | **100.0** |

### 4.7.3 Training of Nurses

The table below shows the post basic courses taken by nurse applicants. From the findings, the main specialised course undertaken by nurses is Psychiatry with 35% of the applicants.

Fifteen percent (15%) were undertaking their Masters programme, 12.5% were undertaking courses in Critical Care and 12.5% in Nephrology. Other courses like Anaesthesia, Reproductive Health, Peri-operative, Neonatal, Palliative Nursing and Accidents and Emergency had only one applicant approved. This means that despite the skills gaps in these critical areas, the training of nurses in these critical areas was very low.

**Table 4.9: Post Basic Courses Taken by Nurses**

| No | Course Title | Male | Female | Total | Percent |
|---|---|---|---|---|---|
| **1** | HND Psychiatric Nursing | 1 | 13 | 14 | **35** |
| **2** | Masters | 0 | 6 | 6 | **15** |
| **3** | HND Critical Care Nursing | 1 | 4 | 5 | **12.5** |
| **4** | HND Nephrology | 1 | 4 | 5 | **12.5** |
| **5** | Bachelors | 0 | 3 | 3 | **7.5** |
| **6** | KRCHN | 0 | 1 | 1 | **2.5** |
| **7** | HND Anaesthesia | 0 | 1 | 1 | **2.5** |
| **8** | HND Reproductive Health | 0 | 1 | 1 | **2.5** |
| **9** | HND Peri Operative | 1 | 0 | 1 | **2.5** |
| **10** | HND Neonatal | 0 | 1 | 1 | **2.5** |
| **11** | HND Accidents and Emergency | 0 | 1 | 1 | **2.5** |
| **12** | HND Palliative Nursing | 0 | 1 | 1 | **2.5** |
| | Total | 4 | 36 | 40 | **100.0** |

The study interacted with the Nursing Division within the Ministry who concurred that these courses were in line with the critical training areas necessary for nurses' career progression.

### 4.8 Adherence to Course Nomination and Approval Procedures

The last objective sought to examine the extent to which the laid down course nomination and approval procedures are adhered to by the county and national governments.

The study established that Course approvals for post basic and post graduate trainings are given by Ministerial Human Resource Advisory Committee (MHRMAC) whose chairman is the Cabinet Secretary of Health and the Principal Secretary who is the authorised officer. The

membership of MHRMAC comprises all heads of department from the Ministry to ensure that their interests are represented in the meetings. The findings found out that though the MHRMAC meetings are scheduled to be held monthly, the frequency of meetings varies depending on the volume of work or applicants and the availability of the Chairman.

### 4.8.1 Course Approval Requirements

The study found that the Ministry of Health HRD had in July 2015 sent out a letter to the Counties explicitly outlining requirements for County post graduate and post basic trainings. Each applicant was to attach a Training application; Admission letter from a recognised Institution; Minutes of recommendations from the Facility or training committee; Training bio data form duly filled by the Head of Department or Supervisor, and a Bonding form committing to work for Public service after training. The study found all the approved application forms had met these requirements and attached the necessary documents. The study found out that the national level also requires commitment that the county level will continue paying the salaries of the released officers while in training.

The MOH Training Policy 2016 outlines the following as the criteria for identification and selection of suitable applicants. There should be gender equity and the course should be relevant to the duties of the officer or in addressing performance gaps. The course should be consistent with the results of TNA and annual training projections. The course should also be cost effective and consider availability of funds. Other requirements for course approval are that the officer should have served for duration of 2 since commencement of internship and completion of a previous long course.

#### 4.8.1.1 Availability of TNA and Training Projections

The study found that the MOH HRD unit has a data base of training projections for promotional courses. This includes Senior Management Course, Strategic Leadership Development Programme (SLDP), Supervisory and Customer Care. However, the study found no data base or training projections at the National level for the post graduate training needs of medical officers and post basic trainings of health workers. The Nursing unit however has group projections for post basic trainings in specialised training areas like paediatrics, nephrology, and critical care. This means that the Ministry of Health National level has gaps in documenting the training needs and training projections of health workers at the national or county levels against which the HRD secretariat reviews applicants and makes recommendations for course approval.

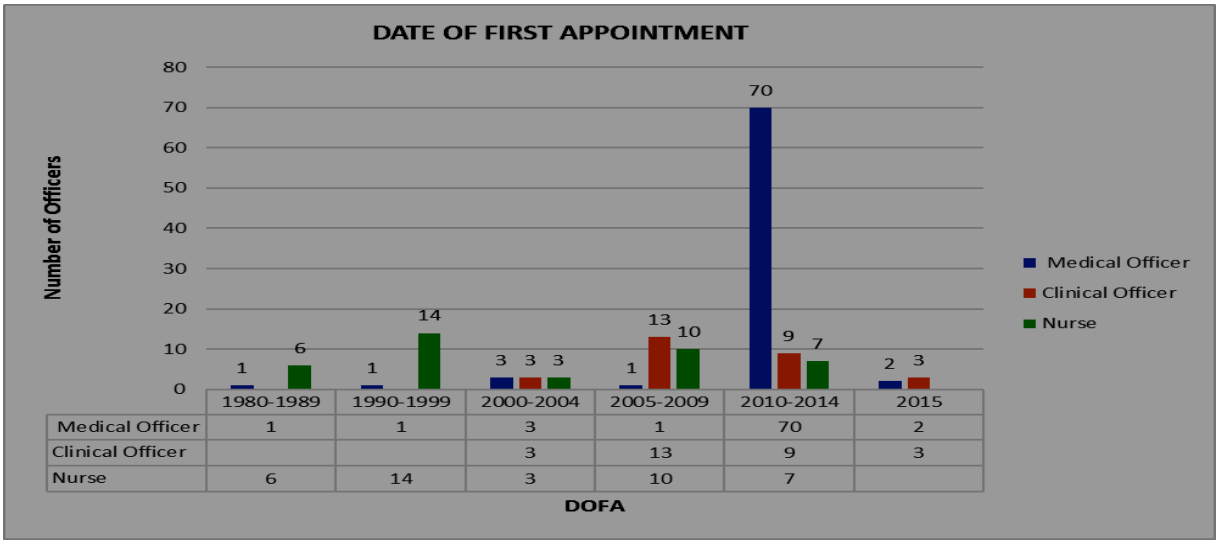
The study found that the national level has no control on who applies from the counties and in which training areas. The training section therefore reviews what has been sent. The study found that in most cases the officers have already been admitted in a recognised institution, some released from the counties and sometimes even started training. This technically means that the mutual coordination and collaboration between the counties and national level regarding training is weak.

The study therefore concludes that recommendations for trainings are not necessarily supported by identified and documented training needs and training projections of the national or Counties.

### 4.8.1.2 Duration of Years in Service

One of the criteria requirements for course approval is that an Officer must have served in public service for a minimum of 2 years apart for those seeking for course approval in anaesthesia and oncology. Figure 4.1 shows the date of first appointment of the respective officers.

**Figure 4.1: Date of First Appointment**




| | 1980-1989 | 1990-1999 | 2000-2004 | 2005-2009 | 2010-2014 | 2015 |
|---|---|---|---|---|---|---|
| Medical Officer | 1 | 1 | 3 | 1 | 70 | 2 |
| Clinical Officer | | | 3 | 13 | 9 | 3 |
| Nurse | 6 | 14 | 3 | 10 | 7 | |

From the findings 58.9% of the applicants have been in service for between 1 and 5 years. The findings indicate that 92.3% medical officers have worked for less than 6 years and so have 42.9% clinical officers and 17.5% nurses. A further 22.6% of the applicants had been in service for between 6-15 years while 15.1% have been in service for between 16 and 35 years. This means that the criteria for having served for 2 years were met except those undertaking priority courses on oncology and anaesthesia.

#### 4.8.1.3 Availability of Funds

The study found that the Ministry of Health had prepared a training budget of Ksh 481,550,000 that had been forwarded to the exchequer for funding for the year 2016/2017. The budget had projections for post basic, post graduate, promotional, retirement and induction courses. The study was informed that the Ministry received only Ksh 199,000,000 out of the requested figure. This therefore meant that fewer staff would be trained.

The HRD policy stipulates that any funds used for HRD should be focused on "prioritized, demand driven and cost effective programmes" based on national development priorities, strategic plans, county needs and individual career development needs. For post graduate and post basic studies, priority would be given to applications in fields where critical gaps exist.

Key Informant Interviews with officers from the HRD Training section revealed that the MOH prioritises courses based on emerging issues and the disease burden. When there is demand and urgency for a particular speciality i.e. with the rise in Cancer cases, more oncology specialists are trained. With the setting up of new theatres, Intensive Care Units and new Emergency Medical Supplies (EMS) equipment in the devolved county hospitals, Anaesthesia, Radiology, critical care and oncology are priority courses. The study found that nephrology due to the rise of need for dialysis and psychiatry because of the increase in mental conditions have become priority training areas.

The Government fully sponsors the priority courses and in some cases even in external universities. This is evident as there were external full scholarships for Oncology and Radiology for some medical officers.

For any self-sponsored courses, the training policy notes that officers will be granted study leave so long as the course is approved, relevant and undertaken in a recognized institution (MOH Training Policy 2016).

From the findings, 74% of applicants will be sponsored by the government through the exchequer. Twenty-four (24%) will sponsor their own study with only 2 % being sponsored by other donors. The GOK is thus still the greatest sponsor of post basic and post graduate trainings. The study however found MHRMAC deliberations where course approvals were deferred due to lack of release of funds from the exchequer. These cases would be reviewed later when funds were accessed.

#### 4.8.1.4 Distribution of Funds among Cadres

From the table below, it is evident that 75.8 % of all funding is utilised by the medical officers. The clinical officers receive 10.4% and nurses receive 13.8%. This means that the Medical Officers receive the bulk of the government funding. A review of the training budget show the training of medical officers is more costly and takes a longer duration. The findings show some unbalanced sharing of resources. Considering that the health sector has more nurse and clinical officers with courses that take a shorter time, there may be need for the Ministry to consider equitable allocation of resources across the cadres.

**Table 4.10: Distribution of funds (n=Ksh 113,370,076)**

| **Cadre** | **Amount (Ksh)** | **Percent (%)** |
|---|---|---|
| Medical Officer | 85,948,076 | 75.8 |
| Clinical Officer | 11,763,600 | 10.4 |
| Nurse | 15,658,400 | 13.8 |
| **Total** | **113,370,076** | **100** |

The study found that the national level adhered partly to the laid down course nomination and approval procedures. All the required attachments prior to deliberations were available. The criteria for the number of years served was also adhered to except in priority areas. However, the funding for priority areas was skewed towards the medical officers training at the expense of the other cadres critical training areas. However, there was no evidence that training was based on documented training needs as stipulated in the HRD Procedure Guidelines 2015 and MOH Training policy 2016. Training was still more supply driven with applicants taking the initiative of applying, getting admissions to courses and institutions of their choice.

# CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

## 5.1 Introduction

This chapter presents the summary, conclusions and recommendations of the study findings on factors influencing course approvals for post basic and post graduate trainings for health workers.

## 5.2 Summary

Development and training are a continuous and systematic process. Training is not effective unless it has a purpose, and that purpose can only be defined if the training needs of organisations and its employees are identified and analyzed (Staff development Manual, 2014). Training is a participatory and collective responsibility of the national and county governments and other stakeholders and the most cost effective intervention for improving employee competencies (MOH Training Policy, 2016).

The study accessed a total of 146 applicants' data comprising 78 medical officers, 28 clinical officers and 40 nurses. Out of the applicants, 61.6% were female and 38.4 % were male. From the study 58.9 % of all applicants are below the age of 35, a very young population with a lot of potential and productive years ahead. Only 8.3 % of the applicants were aged between 50-60 years.

There were 36 out of 47 counties who had applicants with course approvals. That means that 11 counties did not have any post graduate or post basic training. The study found that training requests were reviewed by different levels of training committees ranging from the Facility, Sub County, County Health Department, County Human Resource Advisory Committee and the County Public Service board level.

### 5.2.1 Availability of County Training Needs Assessments (TNA) and Training Projections

The study found out from the training committee meetings that there were very few written down criteria or TNAs that the counties were using to guide them in the nomination process. From the study, 6 counties mentioned the need for a TNA and out of these; only 2 had clear training guidelines or criteria they were adhering to in their selection process. From a review of the applications, the counties also did not have training projections that showed the number of health workers eligible for post graduate and post basic trainings. One county however had training projections for their new Cancer Center and had communicated this to the national level.

### 5.2.2 Criteria Used by Counties to Approve Training Requests

The choice of courses was found to be more supply driven than demand driven. Applicants would take the initiative of applying for courses of their choice and on getting admission would request for course approval and release. The major reasons given for approval included the course being beneficial to the facility or county. Course relevance and career progression were also given as reasons. The study found that the justification of the applicants' immediate supervisors and training committees influenced the course approval

decisions. The study also found that decisions by the training committees at the facility and county level to release the officers were pegged on the availability of a replacement for the officer to ensure no compromise in service delivery. Where no replacement was available, course approvals would be deferred until a replacement was identified.

### 5.2.3. Main Post Graduate and Post Basic Training Areas

The main post basic and post graduate training areas for Medical officers, clinical officers and nurses were found to concur with the critical training areas as per the TNA report 2015. Among the medical officers, the main courses were Anaesthesiology, Radiology and Imaging, Internal Medicine, Oncology, Obstetrics and Gynaecology prioritised in that order. For the clinical officers, the main courses were Anaesthesiology, Mental Health, Psychiatry, Lung and Skin disease and ENT. The main courses for the nurses were Psychiatry, Master's Degree, Critical care and Nephrology. The study found these were priority areas due to the devolved health system that necessitated the setting up of new facilities, new equipment and theatres. The Courses were thus addressing emerging diseases and conditions.

### 5.2.4 Adherence to Course Nomination and Approval Procedures

The MOH Training Policy 2016 has outlined some criteria to be followed in course approvals. Apart from gender equity, the course should also be relevant to the duties of the officer or in addressing performance gaps. The course should also be consistent with the results of TNA and annual training projections and be cost effective considering the availability of funds. The study can conclusively demonstrate that there were no filed training projections for post graduate trainings available at the national level. The Nursing division within the Ministry had group projections for specific priority areas like nephrology, psychiatry and critical care but not for other basic courses.

The study established that all officers had served their mandatory 2 years to become eligible for training except those taking priority courses like oncology and anaesthesia. The government was also funding the health workers to a tune of Ksh 113,370,076. Out of this, 76% was funding medical officers, 10% for clinical officers and 14% for nurses. There is some inequity in distribution of resources among the cadres.

### 5.3 Conclusion

The study concludes that the factors influencing course approvals for post basic and post graduate trainings for health workers are not standardized but vary across the counties.

#### 5.3.1 Availabilty of TNA and Training Projection

It can be concluded that there was limited or no TNA or training projections that were available to guide nomination or approval decisions. Only 2 counties had clearly stipulated and documented criteria or guidelines that they use for selecting their training applicants as derived from the committee meetings. Therefore, this is a major gap as the needs being addressed may not necessarily be county specific.

However the finding that there is a lack of TNA or training projections is in line with the TNA report 2015 which found only 2 County HRD work plans with post basic and/or post graduate trainings. Muoki's 2011 findings also noted the lack of Training Needs Assessment documents or charts within the Ministry of Public Health and sanitation. The study thus concludes that training projections still remain a gap and training needs are more individual based or supply driven than demand driven. The study also concludes that in the absence of the projections, it would be impossible to know how many are eligible and qualify for post basic and post graduate training and thus plan according so that there is no gap in service delivery.

### 5.3.2 Criteria Used by Counties to Approve Training Requests

The study concludes that in most counties, there were no standardized criteria that were used for nominations. The officers would take the initiative of applying, getting admission and only then would they seek course approval and clearance. The study also concludes that decisions of their immediate supervisors would influence the whole process as they had to give a justification as to why they thought the officer should go for the course. This system therefore means that one can miss training opportunities if the justification is not favourable. If there are no replacements, it also means one can stay in a station even after getting admitted to a recognised institution.

### 5.3.3. Main Post Graduate and Post Basic Training Areas

The study concludes that the main post basic and post graduate training areas for Medical officers, clinical officers and nurses were found to concur with the critical training areas as per the TNA report 2015. This means that the health workers may have some knowledge or insight of what courses are required. However, one of the Key Informant Interviewees noted that some applicants take the currently "marketable" or "famous" courses. There is need to find out what influences the applicants' choice of courses and how this can benefit the national or county performance gaps or needs. This could also assist the recognised training institutions tailor make courses that address emerging issues, diseases and conditions.

### 5.3.4 Adherence to Course Nomination and Approval Procedures

The study concludes that the national level does not have documented county specific post basic and post graduate critical training areas apart from what was in the TNA report 2015. The national level may also not gauge whether the courses applied for are consistent with

county TNA results and training projections as so far there are no copies of the same sent to MHRMAC level. It is also noted that when the national level gave the county a list of requirements to be adhered to when seeking course approval, the need to attach TNA results or TNA was not included.

The study thus concludes that the collaboration and consultation of the two levels of governments when it comes to identifying national or performance gaps is limited to the request for course approvals. Government funding is also skewed to the medical officers training.

## 5.4 Recommendations

From the study, the following are the recommendations:

### 5. 4.1 Availabilty of TNA and Training Projection

#### National Level

The study recommends that the national level gives clear guidance to the counties on the need to conduct TNA and clearly document county specific post basic and post graduate trainings.

The National level should also provide technical support to the counties or assist to capacity build the county staff to conduct their own TNA.

The study recommends that the national level make it a requirement for all county applications to be accompanied by training projections.

**County Level**

The study recommends that counties conduct TNA, identify the county training priority areas, and develop training plans and projections.

It is recommended that counties establish a data base of training needs for the various cadres: medical officers, clinical officers and nurses.

The study also recommends that counties establish a data base of eligible candidates for various post basic or post graduate trainings and a suggested timeline so that service delivery is not compromised.

### 5.4.2 Criteria Used by Counties to Approve Training Requests

The study recommends that the national level in collaboration with the counties develop clear standardized criteria or guidelines to follow when convening course approval training committees.

### 5.4.3. Main Post Graduate and Post Basic Training Areas

It is recommended that the MOH proactively communicates national priority areas depending on emerging conditions so that the staff at those levels can apply accordingly.

The study also recommends that the Ministry engages training institutions to ensure that if necessary they prioritise the training areas addressing emerging conditions or diseases.

Group trainings could be conducted in the critical training areas for post basic courses.

### 5.4.4 Adherence to Course Nomination and Approval Procedures

The study recommends that the National level and County improve their consultation and collaboration so that the requests for course approvals fit into a training projection based on actual TNA from the counties and emerging issues and conditions.

## 5.5 Suggested Areas for Further Research

Research to establish whether the individuals trained actually return to the counties to apply the knowledge acquired.

There may be need to find out why nurses are undertaking their post basic trainings late in their careers.

There is need to find out what influences the applicants choice of courses and how this can benefit the national or county performance gaps or needs. This could also assist the recognised training institutions tailor make courses that address emerging issues, diseases and conditions.

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# APPENDICES

## APPENDIX 1: Data Collection Tools for Officers Nominated for Course Approvals

### Appendix 1.1: Availability of Training Needs Assessments and Approval Criteria

Criteria counties using for selecting and nominating the officers for post basic and post graduate training and recommend for course approvals

**(To be derived from training applications)**

| County | Availability of Documented TNA | Availability of Training Plans and Projections | Other criteria documented |
|---|---|---|---|
| 1-47 | 1.Yes<br>2.No | 1.Yes<br>2.No | 1. Task<br>2. County needs<br>3. Career progression<br>4. Others Specify |

**Appendix 1.2: Main Post Basic and Post Graduate Training/ priority areas approved by MHRMAC**

**A. Medical Officers Training areas**

| Key Training area | Number Trained | Gender |
|---|---|---|
| 1. Psychiatry | | |
| 2. Obstetrics/ gynecologist | | |
| 3. Internal medicine | | |
| 4. General surgeon | | |
| 5. Oncologists | | |
| 6. Family medicine | | |
| 7. Anesthesiology | | |
| 8. Pediatric and Child Health | | |
| 9. Radiology and Diagnostic imaging | | |
| 10. Orthopedic surgery | | |
| 11. Reproductive Health | | |
| 12. Field Epidemiology | | |
| 13. MPH | | |
| 14. MBA | | |
| 15. Health care management | | |
| 16. Plastic reconstructive Surgery | | |
| 17. Ear, Nose and Throat | | |
| 18. Human Pathology | | |

**B. Registered clinical officers' training areas**

| Training area | Number | Gender |
|---|---|---|
| 1. Masters | | |
| 2. Bachelors | | |
| 3. Higher ND in Clinical Medicine | | |
| 4. Lung and skin | | |
| 5. Anesthesia | | |
| 6. Ear, Nose and Throat | | |
| 7. Mental health and psychiatry | | |
| 8. Ophthalmology | | |
| 9. Pediatrics | | |
| 10. Reproductive Health | | |
| 11. Others; Specify | | |

**C. Nurses' training Areas**

| Training area | Number | Gender |
|---|---|---|
| 1. Nephrology | | |
| 2. Critical Care nursing | | |
| 3. Mental and Psychiatric nursing | | |
| 4. Palliative Nursing | | |
| 5. Reproductive Health | | |
| 6. Anesthesia | | |
| 7. Neonatal nursing | | |
| 8. KRCHN | | |
| 9. Bachelors | | |
| 10. Masters | | |
| 11. Field Epidemiology | | |
| 12. Accident and Emergency (A&E) | | |
| 13. Peri operative | | |
| 14. Pediatric critical care | | |
| 15. Ophthalmic Nursing | | |

## Appendix 1.3 Adherence to course approval requirements

### National Level MHRMAC records

| Date of First Appointment | Designation | Gender | Age | Current Course Title | Institution | Duration of Course | Cost of Course (Kshs.) | Sponsorship |
|---|---|---|---|---|---|---|---|---|
| 1. 2015<br>2.2014-2010<br>3. 2005-2009<br>4. 2000-2004<br>5. 1990-1999<br>6. 1980-1989 | 1. Medical Officer<br>2. Clinical Officer<br>3. Nurse | 1. Male<br>2. Female | 1. 25-30<br>2. 31-35<br>3. 36-40<br>4. 41-50<br>5. 51-60 | Refer to Appendix 1.2 | 1. UON<br>2. K.U<br>3. KMTC<br>4. Moi TRH<br>5. JKUAT<br>6. KNH<br>7. Moi University<br>8. Mount Kenya U<br>9. KEMU<br>10. MMUST<br>11. Gertrude's<br>12. Other Local Universities<br>13. Other External Universities<br>14. Colleges | 1. 1yr<br>2. 2-3yrs<br>3. 4-6yrs | 1. 100,000-300,000<br>2. 301,000-500,000<br>3. 501,000-700,000<br>4. ≥ 700,001 | 1.GOK<br>2.Self<br>3. Donor |

Institution Key:

4. Moi Teaching and Referral Hospital

9. Kenya Methodist University (KEMU)

10. Masinde Muliro University of Science and Technology (MMUST)

12. Other Local Universities - Maseno, Strathmore, Aga Khan

13. Other External Universities- Muhimbili, University of Alexandria, University of Edinburgh, Makerere, Imperial College London, Queen Mary

14. Colleges. Kijabe AIC, A MREF

## APPENDIX II: Key Informant Interview Guide

**To be filled by Respondents from the Training Unit of the HRD department MOH**

1. How often are MHRMAC meetings held?
2. Who are the members of the MHRMAC as currently constituted?
3. Do you have copies of any training needs assessments or training projections from the counties?
4. What criteria are used for approving training requests for officers?
5. What factors influence whether an approval will be given to an officer?
6. Are there priority training areas that are considered for funding?
7. What determines whether an officer will get government sponsorship and amount?