Evaluation of a Rapid Workforce Expansion Strategy: The Kenya Emergency Hiring Plan

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LIST OF ACRONYMS

ART	Antiretroviral Therapy
EHP	Emergency Hiring Plan
FBO	Faith-Based Organization
FP	Family Planning
GOK	Government of Kenya
HR	Human Resources
HRH	Human Resources for Health
MOH	Ministry of Health
NGO	Nongovernmental Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-to-Child Transmission
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing

EXECUTIVE SUMMARY

A shortage of skilled health workers in high-need areas dangerously limits access to care and impedes global goals such as scaling up antiretroviral therapy distribution and providing access to family planning. Those with the highest need are often left without adequate care because of cumbersome, inefficient and sometimes distorted systems to hire, train and deploy health workers. In Kenya the Capacity Project, along with the Ministry of Health, African Medical and Research Foundation, Deloitte and Touche, Kenya Institute of Administration and Kenya Medical Training Colleges, formulated and used an emergency hiring plan (EHP) to quickly hire, train and deploy workers to high-need areas.

The EHP consisted of open recruiting, fair interviewing, candidate short-listing and transparent hiring. Hired workers received orientation and a two-week HIV skills training and were deployed to districts with identified severe workforce gaps. Workers hired under this plan received the same salaries as those hired by the Government of Kenya (GOK).

This mechanism for rapidly hiring health workers has attracted a good deal of attention, but a quantitative evaluation of the approach's effectiveness has not been available until now. Thus our assessment and study questions included the following:

1. Was the plan effective in efficiently filling posts, generating local interest and carrying out a fair process?
2. What was the impact on the health sector in filling identified gaps and retaining workers?
3. What was the impact on individuals in terms of work attitudes?
4. What was the impact on facilities and services, according to coworkers' and supervisors' perceptions, client satisfaction and service access and delivery?

We tracked hiring, training and deployment of all new hires and compared these to identified gaps. We also collected facility statistics and new hire and coworker feedback in a sample of ten facilities at baseline and every six months for period of three years.

Through the EHP, 100% of the 830 positions identified were filled—including clinical officers, nurses, midwives, lab technicians and pharmacy positions. Time to hire was reduced from over a year to three and a half months. Workers, who were deployed to nearly 200 facilities in 63 districts across all seven provinces, reported that they were treated fairly during hiring, were being paid on time and felt well prepared and confident in their ability to perform job tasks. Supervisors reported new hires were well prepared and added value to the facility. Most coworkers reported no difference in treatment between themselves and the new hires, and there was little evidence of tension between the two groups.

Most importantly, the EHP improved access to HIV and other services in the hard-to-reach areas and high-volume facilities where previous studies had identified service gaps. Compared to baseline, more patients received prevention of mother-to-child transmission (PMTCT),

voluntary counseling and testing and antiretroviral therapy services, and facility hours increased for PMTCT, voluntary counseling and testing, family planning, child health and prenatal care.

Although the GOK initially had reservations about the approach, and implementation required months of negotiation, the Project addressed the Ministry of Health's concerns and developed an approach that could be adopted more broadly. For example, after postelection violence the GOK used the EHP to quickly deploy health workers to displaced persons camps, and the GOK now plans to use the same approach to hire 4,000 new contract health workers. The GOK included funding for EHP salaries in its budget, and new hires are now being transferred to the public service as full-time employees. Thus, what was initially intended as a three-year stop-gap measure to solve an urgent health care crisis now appears sustainable.

The EHP also had unexpected influence on GOK human resources for health systems. The process of implementing the EHP shined light on problem areas in the public sector hiring and recruitment process, and spurred more national-level comprehensive and strategic human resources for health action.

The EHP mechanism is effective, fair and flexible. Countries with the right political commitment and available unemployed health workers should consider the EHP as one of a comprehensive set of human resources for health strengthening tools and approaches to meet short-term health workforce gaps and increase health service access.

INTRODUCTION

Why Is This Study Important?

A worldwide shortage of health workers—particularly in low-resource settings—is challenging governments, donors and nongovernmental organizations (NGOs) to find effective solutions to meet growing health care demands. The Capacity Project-supported Emergency Hiring Plan (EHP) is one such solution, designed to quickly hire and train relatively large numbers of qualified health workers and deploy them where most needed. The approach has attracted substantial attention from donors, NGOs and national-level human resources for health (HRH) planners in low-resource settings as a promising mechanism to rapidly expand the health workforce to increase service access. The public health sector in Namibia implemented a similar approach in 2006, but this effort was not systematically evaluated (Frelick and Mameja, 2006). This report provides an important contribution to the HRH knowledge base by documenting the effectiveness of the EHP in helping Kenya meet its HRH gap and identifying conditions for the approach's success. Such information is critical to others facing similar challenges.

The Emergency Hiring Plan Context

The United States Agency for International Development (USAID)-funded Capacity Project strives to strengthen human capacity to implement quality health programming in developing countries. The Project works with governments and NGOs to strengthen HRH systems, and develops and tests innovative strategies to plan, develop and support the health workforce in line with national health priorities. The EHP was one such innovative strategy, designed to meet Kenya's health workforce crisis.

When the Capacity Project began work in Kenya in 2005, the Government of Kenya (GOK) had committed to ambitious Millennium Development, President's Emergency Plan for AIDS Relief (PEPFAR) and National Health Services Strategic Plan goals that were unachievable without more health workers to implement an array of government- and donor-funded projects. The burden of HIV care in facilities was growing; for example, at Nyando District Hospital, 99% of adult patients had HIV/AIDS-related conditions, with 100 new patients a day treated by one doctor, 15 nurses and four clinical officers (Capacity Project, 2006). Kenya also had a surplus of unemployed health care providers because health worker production had outpaced recent hiring goals and hiring capacity. Therefore, the conditions were right to hire and deploy more workers.

In 2005, with support from USAID and HLSP Institute, the Kenya Ministry of Health (MOH) completed a detailed human resources (HR) mapping exercise for public sector health professionals (James and Muchiri, 2006). The results showed that although staffing norms were being met in high population density settings and in many provincial and district hospitals, staffing in rural areas was entirely inadequate. Nearly half of these health centers had fewer than three staff members, and one in ten dispensaries had no staff. Catchments in the poorest provinces greatly exceeded MOH norms, while staffing levels were far below the norms. In addition, training needs were high; only 9% of health workers had received training within the past two years. Based on data from this exercise combined with information on the private and

faith-based sectors, the MOH identified staffing gaps across facilities and districts for five cadres (registered clinical officers, registered nurses, enrolled nurses, lab technologists and pharmacy technologists) totaling 7,773 individuals.

The GOK requested USAID and the Capacity Project, among others, to help quickly hire and deploy health workers across the country. Although the GOK had concerns about the original design, and the situation required what Project staff referred to as "strategic patience" to engage partners and work through the many obstacles, the result was an effective, and ultimately popular, mechanism to hire workers quickly, fairly and transparently.

Intervention Description

Adano (2008) and Marsden and Chirchir (2008) have described the EHP process in detail elsewhere, thus we will summarize briefly here.

Capacity Project staff worked closely with the MOH, the Directorate of Personnel Management in the Office of the President, the Ministry of Education and the Ministry of Finance to design an acceptable recruitment and hiring process that outsourced hiring and employment management to a local private sector organization (Deloitte and Touche, Kenya). This process included:

- Identifying priority posts
- Advertising nationally and locally for open posts
- Tracking applicants using a database
- Developing and implementing a merit-based hiring system with a set of standardized criteria to objectively short-list applicants
- Conducting regional interviews and decision-making using a panel of relevant judges and an interview guide and scoring sheet
- Providing public notification of the short-listed and final selected candidates
- Deploying workers and taking into account candidates' preferences about where they wished to live and work.

Before deployment, new hires attended a standardized public service induction that provided information about the employment contract, job description and compensation, which was in line with the MOH's standards, terms and conditions of service. To prepare for their placements, new hires also received two weeks of training in integrated HIV care, treatment and support, consistent with national standards and guidelines and provided by local training organizations (African Medical and Research Foundation, Kenya Medical Training College and Kenya Institute of Administration). Facility managers from the sites where new hires were to be deployed also received a two-day site preparation workshop, informing them of the purpose and process of the EHP. This orientation helped with the rapid integration of the new hires when they reported for work.

Some common misconceptions about the EHP include:

- That it serves as a quick fix that takes the burden off of the MOH
- That it is an "off-the-shelf" model, complete with instructions and guidelines that can be easily replicated
- That it is quick and easy to plan and implement
- That it can replace existing hiring arrangements
- That it can work anywhere, even without a ready pool of unemployed health workers.

Once the new hires were in post, Deloitte and Touche managed payroll and benefits, and new hires were paid on time. The Capacity Project worked with the MOH to provide regular supportive supervision visits.

Study Overview and Study Questions

This report describes an evaluation of the EHP to quickly hire, mobilize and deploy 830 health workers, and to effectively increase service access. The evaluation tracked all new hires to determine where new hires were deployed, who left and why. Evaluators studied a sample of ten facilities in two provinces in more detail to assess the following research questions:

- How effective was the recruitment plan in achieving its goals? How effectively did the plan generate interest among qualified health workers, particularly at the local level (including rural and hard-to-reach areas)?
- What was the impact of the EHP on the health sector? In particular, did the EHP yield sufficient numbers of interested and qualified health workers from the full geographic domain of recruitment and both genders? To what extent were staffing gaps closed? Were EHP new hires retained in facilities? Did this vary by gender, region or facility type?
- What was the impact of the EHP on individual health workers in terms of job satisfaction?
- What was the impact of the EHP at the facility level on service delivery (particularly HIV services), on peer job satisfaction and on client service satisfaction?

METHODS

Design

We used a three-year prospective (longitudinal) design to assess the study questions in a purposively sampled set of ten facilities. We also collected data on all new prospective hires to monitor changes in employment status. Finally, we used qualitative methods to collect information on the broader facility and community context and effects of the EHP.

Sample and Procedures

Study designers purposively chose a sample of ten facilities in nine districts and two provinces (Nyanza and Western) to provide geographical, socioeconomic and disease-burden balance. In these facilities, interviewers collected information on new hires, a sample of coworkers, clients, facility managers and service statistics at baseline and every six months thereafter for three years.

All new hires completed baseline interviews before being deployed to their assigned posts. In addition, we interviewed all new hires present at the ten selected facilities during the six-monthly data collection.

We interviewed a representative sample of administrators and coworkers in the ten selected facilities at baseline and every six months to obtain information on the work climate, job satisfaction and the impact of the new hire on the facility.

We interviewed a convenience sample of clients in the ten selected facilities every six months on service satisfaction.

We obtained verbal informed consent from all participants at each data collection point.

Instruments

We used the following five research instruments to collect data for the longitudinal study in the ten selected sample facilities.

New Hire Assessment. This instrument elicited new hires' attitudes toward work, including compensation and benefits, job satisfaction, workplace safety, HIV/AIDS protection and career development opportunities. We also asked new hires to discuss what effects they were having on the facility, and to what extent they were treated differently than their peers.

Coworker Assessment. The coworker assessment also measured work attitudes as described above (compensation and benefits, job satisfaction, workplace safety, etc.) for coworkers. We also asked coworkers to discuss the effects of the new hires on the facility and on their own job satisfaction.

Facility Assessment. We asked facility managers to describe the extent to which the new hires were prepared for and doing the jobs expected of them, and how they performed in comparison to other workers at the facility.

Facility Statistics. We collected weekly service statistics with a focus on HIV/AIDS services (such as voluntary counseling and testing [VCT], prevention of mother-to-child transmission [PMTCT] and antiretroviral therapy [ART] service provision) and family planning (FP) services. We also collected information about the range of services offered, and when they are offered.

Client Assessment. This instrument elicited information about clients' satisfaction with services, wait time and observations of the clinic compared to previous visits.

In addition to the five instruments above, we used a "new hire recruitment" measure to interview all new hires at baseline. This measure collected respondents' impressions of the fairness of the interview process, the extent to which job benefits, salary, responsibilities and tasks were explained and the extent to which respondents felt prepared for their assignments. The instrument also collected background demographic, training and employment information.

Finally, we conducted qualitative interviews with a convenience sample of facility managers, new hires, coworkers and community members in selected facilities.

Data Analysis

We used SPSS 13.0 for Windows, a quantitative statistical analysis software package, to obtain frequencies for all data, to determine the association between categorical variables (e.g. chi-square) and to compare average rates of facility statistics over time (ANOVA).

RESULTS

We present the results below according to study questions.

1. Effectiveness of the Recruitment Plan

1.1. Did the recruitment plan fill posts efficiently? The EHP reduced the time for recruitment from approximately one year (and sometimes as much as 18 months) to an average of less than three months.

1.2. Did the recruitment plan generate interest among qualified health workers, particularly at the local level? A total of 6,568 applicants from all provinces in Kenya responded to the several newspaper advertisements and announcements. Based on the original criteria posted in the advertisements, 4,456 applicants (68%) were short-listed, an indicator of the recruitment plan's success in attracting qualified applicants. Ninety percent of short-listed applicants (4,022) were interviewed in ten areas across the country, and 912 new hires (the targeted 830 plus replacements for those leaving posts) were chosen to fill the identified posts. The process yielded a diverse pool of health care providers (see Table 1) consisting of both men and women, both single and married and with a wide range in age. Most new hires had no previous training in HIV care.

Table 1: New Hire Demographic and Hiring Information

Variables		Sample (N=912)
% men		36
% married		55
Average age (and range)		29 (19-46)
% providing care to both child and older dependent		49
% new hires posted per province	Central	8
	Coast	11
	Eastern	12
	Nairobi	5
	North Eastern	8

Variables		Sample (N=912)
	Nyanza	18
	Rift Valley	20
	Western	17
% in each cadre	enrolled community nurse	56
	registered nurse	18
	clinical officer laboratory technologist	11 10
	pharmacy technologist	4
% posted to province considered "home"		61
% never before received HIV training		57
% whose last facility was of each facility type	private	52
	government hospital	15
	government health center	6
	faith-based organization (FBO) hospital	6
	FBO health center	8
	NGO facility	6
	none	7

1.3. How acceptable to participants was the EHP process? Table 2 provides some indication of new hires' satisfaction with the EHP process. First, as described in the introduction, the EHP was designed to be fair and transparent. The finding that 98% of new hires learned of the opportunity through the newspaper indicates this fairness. Respondents also reported they were treated fairly during the interview process and that job responsibilities were explained sufficiently. Respondents agreed that the EHP followed good HR management practices (e.g., providing written job descriptions and presenting salary and benefits information in the contracts). Further, respondents reported feeling well prepared for their jobs, and confident in their skills and ability to perform job tasks.

According to qualitative evidence, applicants were both surprised and pleased with the openness, transparency and fairness of the recruitment and hiring process. Some applicants reported that the questions asked in previous interviews were irrelevant, and they were pleased that these sets of questions were appropriate and that the make-up of the interviewing panel was balanced and fair. Others stated that in the past, because they lacked certain political ties, they had been unable to secure a post even though they were qualified. One new hire posted to Kajiado District Hospital, who had tried for several years to get a post, noted that in previous instances "candidates were never told why they failed." Some new hires especially appreciated the induction process. One new hire, who had previously worked for six months without compensation or a day off, was glad to learn of her rights; "[W]hen you know your rights, you know what to expect…That motivates you as you set out to work." The MOH's senior HR officer said "[t]he recruitment, hiring and posting process was very fair; indeed the

regional balancing was good. Such a fair and open process earns the government credibility and improves its image" (Capacity Project, 2007).

Although applicants in the first phase were not asked to identify their preferred placement districts, all subsequent applicants were asked. Accordingly, 94% of new employees hired in phases two and three reported they had a choice in selecting the district to which they would be deployed. This practice has been shown to increase job satisfaction and retention (Yumkella, 2006). It is worth noting that only 61% of new hires reported being posted to a province they considered "home." (As comparison, note that at follow-up only 61% of coworkers lived in the same district as their spouse and dependents; see Table 8).

Table 2: New Hires' Assessment of the Recruitment Process

Statement	% agree (N=912)
Learned of the job through newspaper ad	98
Treated fairly during the interview process	99
Job responsibilities were explained in sufficient detail	95
Received a written job description	88
Salary was presented in the contract offer	97
Benefits were presented in the contract offer	91
Had a choice in selecting the district	82
Understand job tasks expected	98
Confident in ability to perform job tasks	100
Confident in skills to provide HIV services	99
Confident can protect self from HIV/AIDS in assigned facility	96
Confident will be safe from violence in assigned facility	66

Qualitative data reinforced the finding that the induction and training prepared new hires for their jobs. One new hire said "before I came here I was not even sure how to administer [antiretrovirals] to children. With the knowledge I have gained, I feel equipped to manage a comprehensive care center." Another said "In the medical college, we never covered anything on HIV. This training was such an eye opener."

2. The EHP's Impact on the Health Sector

2.1. Did the EHP fill identified workforce gaps? As stated above, in 2006 the MOH identified a gap of 7,773 health workers across five key cadres. The MOH approached several donors and projects, including the Capacity Project, to reduce this gap. Given the availability of USAID mission funds, in particular PEPFAR funds, and based on the MOH staffing needs analysis, the MOH worked with the Capacity Project to identify a subset of 830 high-priority posts in 193 facilities (79% of which were public sector facilities) across the country's seven provinces (see Table 3). The Capacity Project filled 100% of the total 830 identified cases over three hiring phases, placing workers in 63 districts and hiring replacements to fill vacated posts. The distribution across provinces and cadres was slightly, though not substantially, different from that identified.

Table 3: Planned and Filled Posts in Seven Provinces by Cadre

Province	# registered nurses		# enrolled nurses		# clinical officers		# lab technicians		# pharmacy techs		**Total**	
	plan	filled	plan	filled	plan	filled	plan	filled	plan	filled	**plan**	**filled**
Coast	6	7	83	104	16	14	12	13	5	4	**122**	**142**
Eastern	13	11	82	78	9	8	15	14	8	6	**127**	**117**
North Eastern	4	3	79	67	5	4	8	6	2	2	**98**	**82**
Nyanza	15	15	101	88	20	16	17	15	6	4	**159**	**138**
Rift Valley	8	8	98	137	17	22	15	18	8	9	**146**	**194**
Western	7	7	106	81	14	10	15	13	6	2	**148**	**113**
Central	5	5	11	10	5	5	8	6	1	0	**30**	**26**
Total	**58**	**56**	**560**	**565**	**86**	**79**	**90**	**85**	**36**	**27**	**830**	**812**

In addition to those listed in Table 3, the MOH requested the Project to recruit and hire 27 district tuberculosis and leprosy coordinators. The total number of active new hires fluctuated slightly throughout the project, but when the total fell below 830, the number requested by the GOK, replacements were hired and posted. There were 829 active workers as of October 20, 2008.

The new hires had an immediate impact; at least one facility, Lopiding Sub-District Hospital in remote Turkana District, remained open as a direct result of 14 new hires posted there. The nursing officer in charge said that despite the MOH's previous efforts to post staff there, few actually reported for work, and "the others would not commit to work in this hard-to-reach area. Service delivery just went down and our clients responded by shunning the hospital" (Capacity Project, 2007).

2.2. Were workers retained? This study was not designed to collect data on coworkers in all facilities in which EHP workers were posted to compare retention rates of EHP workers with their coworkers. However, we do know which EHP workers resigned and which remained in their posts (see Table 4). In late March 2007, the GOK transferred 83 EHP new hires to the public service. Of the 900 remaining providers hired during all phases of the EHP, 94% were still employed by the end of the final data collection period in October 2008.

Our analysis of the variables associated with retention revealed only one association: HIV prevalence within the province. Proportionally, more new hires left the province with the lowest HIV prevalence, which was North Eastern Province. We should note here that this is only an association, and that the authors do not believe that workers left *because* the HIV rate was lower in North Eastern Province. North Eastern Province is different from other provinces in many ways other than the HIV rate, which in this analysis is most likely a confounder (please also see Discussion section).

Table 4: Percent of New Hires Retained, by Variables

Variables	**Values**	**% retained N=900**
Overall		94
Gender	Women	94

Variables	Values	% retained N=900
	Men	92
Cadre	Enrolled nurse	95
	Registered nurse	93
	Clinical officer	91
	Pharmacy technologist	90
	Laboratory technologist	92
Marital Status	Single	95
	Married	92
Province	Coast	95
	Eastern	96
	North Eastern	88
	Nyanza	92
	Rift Valley	93
	Western	96
	Central	94
HIV Prevalence*	37% (Nyanza) 21% (Rift Valley)	92 93
	13% (Coast, Eastern, Western)	96
	2% (North Eastern)	88
Facility type	Health center	94
	District hospital	93
	Provincial hospital	98
	FBO hospital/ clinic	92

From qualitative interviews, it appears that the EHP strategy to recruit locally and post according to preferences was helpful in keeping workers in their posts. For example, in the remote Turkana District, one new hire said "What I do is a calling to serve my people, and this requires dedication."

Fifty-eight EHP workers resigned, and we obtained data regarding the reasons for most of these resignations (see Table 5). Sixteen percent of resigning employees accepted posts at health facilities supported outside of government. Twelve percent returned to school and another 14% quit because of the site they were assigned to (e.g., four declined to transfer to North Eastern Province, two left because they weren't transferred to preferred site, one feared postelection-related trouble if he stayed). Nine percent of this group died, most in car accidents. Twelve percent quit their jobs for personal reasons, such as to take care of sick family members. Only one employee migrated outside of the country for work. We were unable to determine a reason for the remaining 24% of those leaving.

Table 5: Reasons for Leaving EHP Employment

Reason for leaving	# (%) reporting (N=58)
Reported elsewhere (i.e., Clinton Foundation, FBOs)	9 (16%)
Site considered unacceptable	8 (14%)
Obtained another job	7 (12%)
Returned to school	7 (12%)
Personal issues	7 (12%)
Died	5 (9%)
Fired	1 (2%)
Disagreed with administration	1 (2%)
Reasons unknown	14 (24%)

3. Impact of the Emergency Hiring Plan on Individuals

We interviewed new hires at ten facilities about their attitudes toward their jobs (see sample information in Table 6).

Table 6: EHP Sample Information

Variables		Interim N=27	Final N=40
# facilities		10	10
% men		44	18
% married		63	83
% providing care to both child and older dependent		59	71
% type of facility	Government hospital	82	85
	FBO hospital	19	15
% of informants in each cadre	Midwife	37	35
	Nurse	26	30
	Clinical officer	19	10
	Lab technologist/technician	11	17
	Pharmacist/pharmacy technologist	7	5

In both the interim and final interviews, EHP workers reported that they felt prepared to do their jobs and most looked forward to work each day (see Table 7). Most informants also agreed that their presence helped coworkers provide longer hours and more services. However, the majority of respondents also agreed that quality services were not being provided at the facility, and that there were insufficient numbers of health workers and support staff to provide services.

Although EHP respondents agreed that they received salaries on time, they believed the salary was not appropriate for the work.

Fewer than half of respondents felt safe from physical harm working in and traveling to the facility; however, most agreed that the organization had taken steps to protect them from HIV/AIDS and knew that related policies and procedures were in place.

Table 7: EHP Attitudes toward Work

Variables	% strongly agree	
	Interim N=27	Final N=40
Work duties: preparation and satisfaction		
Know what expected to do on the job	100	97
Look forward to coming to work each day	89	85
Expected to do more, different tasks than in job description	63	68
Services provided in this facility meet quality standards	33	30
There are enough health workers to provide services to the community	4	15
There are enough support staff in this facility	7	10
Supervision and feedback		
Receive constructive feedback so know how well performing tasks	74	48
Someone can help teach tasks if unsure how to do them	89	85
Compensation and benefits		
Receive salary on time	100	83
Paid a salary appropriate for the work	15	13
Safety, security and gender-related concerns		
Know of facility policies to protect workers from harassment	30	45
Feel safe from physical harm working in facility	44	50
Feel safe from physical harm traveling to work	48	43
HIV/AIDS protection		
The organization has taken steps to protect you from HIV/AIDS	52	80
Policies, procedures are in place to protect you from infection from HIV/AIDS	70	90
Career development, advancement opportunities, job fulfillment		
Job is challenging and interesting	93	85
Your work is important to the organization, the community and the country	96	90
Your work has a real, positive impact on the people served by this facility	93	88
Your work is valued by the community	89	80
Satisfied with work-personal life balance	37	30
Facility provides opportunities to help improve professional skills	30	45
Training is provided in skills critical for success	37	30
Training opportunities are distributed fairly	19	33
Considered switching to job outside facility	11	43
Thinking of stopping work as health worker	7	3
"I am treated differently than those who have been here longer, and who do the same kind of work in terms of..."		
Ability to negotiate working hours	8	8
Ability to select the tasks to which s/he is assigned	4	3
Opportunity to attend conferences or educational meetings	15	5
Effects on the facility		
Your presence has helped coworkers provide longer hours	79	73
Your presence has helped coworkers provide more services	74	70

Respondents considered their work challenging, interesting and important to and valued by the community. They also reported that they were not treated differently than their coworkers (in the areas mentioned).

However, respondents were not satisfied with other features of the job, such as work-life balance, professional skill development and the availability of training opportunities. At the final data collection, although very few respondents considered stopping work as a health worker, nearly half were considering switching facilities.

4. Impact of the Emergency Hiring Plan on Facilities and Services

We interviewed peers and supervisors in the same facilities as the sampled new hires to explore the effects of the new hires on the facilities and services. In general, the demographic information for the sample of peers in Table 8 is similar to that of the sampled new hires in Table 6, except that peer informants included a wider range of cadres of workers from the facility.

Table 8: Peer Sample Information

Variables	Baseline N=261	Interim N=242	Final N=246
# facilities	9	9	9
% men	45	43	20
% married	84	86	83
% providing care to both child and older dependent	77	77	72
% of informants in each cadre			
Clinical officer	8	9	9
Doctor	3	4	4
Lab technologist/technician	6	5	4
Midwife	3	11	12
Nurse	38	34	32
Other health worker	17	15	16
Other worker	26	20	23
% live in district where spouse/dependents live	67	73	61

Peer attitudes (see Table 9) were also quite similar to the new hires' attitudes in Table 7. In general, peers also knew what was expected of them and looked forward to their work. Like new hires, peers felt strongly that their jobs were challenging, interesting and made important contributions to the community they served. They also agreed with the new hires that facility services did not meet quality standards, that insufficient staff were available to provide and support needed services and that they were not paid an appropriate salary. Only about a third of peers were satisfied with work-personal life balance; again, similar to new hires. The numbers of respondents agreeing that HIV/AIDS protections were in place in the facility increased over time for both new hires and peers.

The notable difference between the two groups is seen in the extent to which respondents received salaries on time; the large majority of new hires reported receiving salaries on time compared to less than a third of their peers.

Table 9: Peer Attitudes toward Work

Variables	% strongly agree		
	Baseline N=261	Interim N=242	Final N=246
Work duties: preparation and satisfaction			
Know what expected to do on the job	94	94	97
Look forward to coming to work each day	87	90	80
Services in facility meet quality standards	26	24	29
There are enough health workers in this facility to provide services to our community	10	7	8
There are enough support staff in this facility	12	13	13
Supervision and feedback			
Receive constructive feedback so know how well performing tasks	61	66	69
Someone can help teach tasks if unsure how to do them	73	78	72
Compensation and benefits			
Receive salary on time	24	28	32
Paid a salary appropriate for the work	5	2	13
Safety, security and gender-related concerns			
Know of facility policies to protect workers from harassment	32	42	59
Feel safe from physical harm working in facility	41	44	47
Feel safe from physical harm traveling to work	37	36	47
HIV/AIDS protection			
The organization has taken steps to protect you from HIV/AIDS	51	67	76
Policies, procedures are in place to protect you from infection from HIV/AIDS	57	70	79
Career development, advancement opportunities, job fulfillment			
Job is challenging	81	88	80
Job is interesting	80	83	81
Your work is important to the organization, the community and the country	91	92	88
Your work has a real, positive impact on the people served by this facility	87	89	91
Your work is valued by the community	82	82	74
Satisfied with work-personal life balance	35	34	37
Facility provides opportunities to help improve professional skills	35	34	55
Training is provided in skills critical for success	35	39	44
Training opportunities are distributed fairly	29	34	45
Considered switching to job outside facility	NA	39	37
Thinking of stopping work as health worker	NA	18	16

Table 10: Peer Attitudes toward New Hires

		% strongly agree		
		Baseline N=261	Interim N=242	Final N=246
The new employee…				
• Was prepared to do the job assigned		80	84	73
• Fill(s) a position that needed to be filled		73	82	81
• Is the type (cadre) of worker we needed		75	76	51
To what degree has the new employee helped decide to stay?	Not at all	NA	35	27
	Somewhat	NA	27	19
	Very much	NA	18	14
	Missing	NA	20	40

	% strongly agree		
	Baseline N=261	Interim N=242	Final N=246
The new employee is treated differently than those who have been here longer, and who do the same kind of work, in terms of…			
• Compensation (salary)	13	17	25
• Benefits, for example medical coverage	8	8	9
• Ability to set his/her own working hours	9	4	5
• Ability to select the tasks to which s/he is assigned	9	4	7

In general, peers reported that the new hires were needed, well prepared for their assignments and treated much like other workers in terms of compensation and benefits (see Table 10). A substantial percentage of peers interviewed even reported that the new hires influenced their decision to remain working at the facility. Although it is likely that positive response bias is responsible for some of this, open-ended comments strongly suggest that coworkers genuinely appreciated the new hires and their contributions. In response to the question "Is there anything else you would like to tell us about the new employees that were hired through the EHP?" 105 (43%) at the final data collection responded with a comment, and all but four were positive[1]. Typical responses included "they are hardworking and committed," "they perform well and are good to work with" and "they have really assisted and more should be employed." Many respondents noted new hires' effects on workload and service provision: "they are doing well and are helping in reducing workload," "they have erased staff shortage but we still need more," "they are assisting very much in service delivery" and "they have helped to provide more services like comprehensive care." Some respondents even said "give us more Capacity hires. They are the best workers in the hospital" and "the employees are the most hardworking of the workers."

Table 11: Facility Manager Attitudes

Variables	Interim	Final
Facility sample information		
# facilities surveyed	10	10
% facility type		
Government hospital	80	80
FBO hospital	20	20
# of health workers placed in facilities in each cadre by EHP[2]		
Clinical officer	6	6
Lab technologist/technician	6	6
Midwife	5	5
Nurse	18	18
Pharmacist/pharmacy technologist	1	1
% EHP employees are absent from their assigned duties:		
Less often than other employees of their same worker cadre	50	60
About equally often as other employees of their same cadre	40	40

[1] The four nonpositive comments were: they are not paid uniform allowance and have higher salary scale; contractual issues are causing panic among Capacity Project staff; nurses are complaining of breach of contract; and some employees have problems in transfers being unfair.

[2] Approximately 97 health workers were also added to these facilities using other mechanisms.

Variables	Interim	Final
More often than other employees of their same worker cadre	10	0
% agreeing that new hires are:		
Good team workers; they pitch in and help out	100	100
Flexible and adaptable; they do what needs to be done	100	80
An added value to the facility	100	70
Willing to take on new and additional responsibilities	80	60
Not adequately prepared for responsibilities assigned	10	0
Too slow learning new responsibilities	0	0
Treated better than other employees	0	0
Taking more time off than peer employees	0	0
% agreeing that:		
Overall workload has reduced or is more manageable	80	100
Number of clients served each week has increased	70	100
Services were added at times not previously offered	80	90
Types of services offered have changed	60	90
Number of clinic sessions offered each week increased	60	70
Hours of service clinic operates have been extended	30	70

Interviewers asked managers from the same ten facilities to assess the effects of the new hires on the facility (see Table 10). Managers reported that new hires were good team workers, adaptable and well prepared for their jobs and added value to the facility. They also noted that the new hires reduced facility workload and increased the type and quantity of services provided. In open-ended responses, managers said new hires were reliable, hardworking, ready-to-work, well-behaved, neat and helped boost morale of peer workers.

Table 12: Client Sample and Service Satisfaction

Variables		Baseline N=218	Interim N=201	Final N=203
Client sample information				
% men interviewed		25	32	31
% clients interviewed per facility type	Government hospital	80	80	79
	FBO hospital	20	19	21
# facilities surveyed		10	10	10
% received services before at the facility		71	72	68
Client satisfaction % agreeing with statement…				
Very satisfied with services today		42	50	48
Less satisfying than previous experience		11	5	10
Types of services have been added		63	44	56
Time wait is reduced		44	51	64
Hours of service are extended		28	29	38
Fewer supplies are available		43	20	29

Interviewers also assessed clients' observations of changes in the facility over time. Data from clients do not provide a clear picture of improved facility services; however, more clients believed wait time had been reduced and hours of service extended, and fewer clients reported supply shortages.

Qualitative interviews with clients in specific facilities revealed marked changes, though. For example, in Lopiding, one client said that before the14 new hires were posted "we had to queue too long for services and at the end of the day most of us were referred to another hospital because Lopiding could no longer perform certain activities." Another said "around October we started noticing a change in service delivery. Attitudes of the staff are now positive and patients are treated faster."

Table 13: Facility Statistics Averaged across 12 Weeks

Variables		Baseline Jun. 2006	Interim Mar. 2007	Final Oct. 2008
Facility sample information				
# facilities surveyed		10	10	10
% facility type	Government hospital	80	80	80
	FBO hospital	20	20	20
# weeks of service data		12	12	12
HIV/AIDS service statistics				
Average # days/week outpatient services offered	VCT	2.9	4.8	5.0
	PMTCT	2.1	4.7	5.0
Average # services provided/week	VCT outpatients	16	22	22
	PMTCT	18	31	25
	PMTCT +	8	17	18
	PMTCT receiving test results	23	28	37
	Males tested HIV	9	18	10
	Females tested HIV	15	29	20
	Males newly prescribed ART	2	4	11
	Pregnant females newly prescribed ART	2	4	4
	Not-pregnant females newly prescribed ART	3	5	13
	Lab tests performed: HIV initial	27	36	10
	Lab tests performed: syphilis	15	18	26
	Male condoms distributed/week	130	140	251
% facilities providing postexposure prophylaxis (PEP)		80	96	100
FP service statistics				
Average # days/week outpatient FP/STI services offered		2.0	4.8	5.0
Average # FP/sexually transmitted infection outpatients seen		37	42	42
FP indicators (weekly average)	New clients starting pill	6	9	9
	Client revisits on pill	19	32	23
	New clients started on injectables	25	23	37
	Client revisits for injectables	107	72	102
	New clients started on implants	2	10	2
	Female clients for bilateral tubal ligation	1	3	7
	Male clients for vasectomy	0	0	0
Other Services Statistics				
Average # days/week outpatient services offered	Child health	2.2	5.4	7.0
	General medical/surgical	2.8	6.5	5.5
	Prenatal	2.0	5.0	5.0

Variables		Baseline Jun. 2006	Interim Mar. 2007	Final Oct. 2008
Average # outpatients seen	Child health	146	180	154
	General medical/surgical	267	389	353
	Prenatal	61	62	51

Thirty-six weeks of data collected from the ten sample facilities suggest that the addition of the new hires increased service access across a variety of services. Facilities increased the average number of days per week VCT and PMTCT services were offered from less than three to five. The average number of services provided increased for 11 of the 12 HIV services monitored, including VCT, PMTCT and new ART patients. Additionally, facilities offered child health, general medical/surgical and prenatal services more days per week after the new hires were deployed, and served more child health and general medical/surgical patients. For FP services in particular, facilities increased the number of days per week services were available; however, the data do not clearly show an increase in FP services provided.

DISCUSSION

This evaluation found that the Capacity Project-led EHP was a successful innovative strategy to rapidly expand the workforce and increase service access in Kenya. The mechanism effectively generated substantial interest among a wide range of health workers across the country in the locations where the postings needed to be filled, and rapidly filled identified posts nationwide. Respondents perceived the process to be fair and transparent in contrast to the status quo. Most importantly, service provision improved: more patients received PMTCT, VCT and ART services, and facility hours increased for PMTCT, VCT, FP, child health and prenatal care in hard-to-reach and high-volume areas.

Facilities retained posted health workers at a high rate, most likely because the workers were well prepared for their jobs, paid on time and assigned to locations they had requested. New hires felt their jobs were interesting and challenging, and they were making an important contribution to the community; very few were considering ending work in the health care field. However, much like their coworkers, new hires felt salaries were too low, numbers of support staff were insufficient and the quality of services was generally low at facilities. This may explain why, at the final data collection, nearly half reported considering switching jobs, though not careers.

The study found that although retention of new hires was high overall, new hires in the remote North Eastern Province were most likely to leave. In reality, North Eastern Province continues to bleed its workforce, not just in the health sector but in others as well, due to a complex set of variables that collectively make worker retention extremely difficult. These include lack of basic infrastructure and social amenities, lack of security, geographical isolation, cultural barriers and harsh terrain and climate. Clearly, workers require special incentives and support under these conditions. Still, 88% (82) of the new hires assigned to the province remained in their post throughout the three years. As noted in personal communications with Ann Rono, deputy

director of HR (2007), the overall health workforce attrition rate is thought to be approximately 18% in Kenya—a striking comparison.

EHP implementers were concerned about possible tensions between the new hires and coworkers, but this evaluation found no evidence of resentment or differential treatment, perhaps because of the alignment of salaries and benefits. Both peers and facility managers thought the new hires decreased the overall workload and improved service access. Facility service statistics confirmed this perception.

We were somewhat surprised that, according to the study, the EHP did not result in improved FP service in our ten sample facilities. However, in Kenya this service has been crowded out over the years by the attention paid to HIV/AIDS, tuberculosis and malaria. Also, the vast majority of new hires worked in general inpatient wards and outpatient departments—only a few worked in specialized clinics, and these were not among the clinics chosen for the study sample. We do know, though, of at least one EHP facility with increased FP services: after the posting of a new hire to an FP clinic in a small sub-district hospital in North Eastern Province where the rate of modern contraceptive methods was less than one percent, FP service visits reportedly increased from five or ten per month to 100 or more per month (Capacity Project, 2008). Given the many demands on health workers, only through this type of dedicated human resource will changes occur, at least in areas resistant to FP.

In general, clients didn't notice an increase or decrease in service provision. At certain specific sites, though, clients did remark on improvements in this area. For example, at Lopiding, which would have closed without the addition of the new hires, clients noted tremendous improvement in services.

This evaluation found that new hires were very satisfied with the recruitment and deployment process, and that retention levels were quite high. However, mainstreaming a specified set of HR practices, such as fair and open recruitment and deployment, will not in itself lead to organizational success or keep health workers at post.

Unlike the outsourced hiring mechanism implemented in Namibia, which was initiated and championed by the government, in Kenya the Capacity Project catalyzed and provided the mechanism and the GOK agreed to its implementation only after long negotiations. Although launching the EHP in Kenya required steadfast patience, the GOK ultimately embraced the hiring approach wholeheartedly. The GOK adopted its usage, for example, during postelection violence in early 2008, when nurses were needed quickly to provide care in camps for displaced Kenyans. Subsequently, other organizations within Kenya (e.g., Clinton Foundation, The Global Fund to Fight AIDS, Tuberculosis and Malaria) have used the EHP approach, and variations of the plan are being used in Uganda and Tanzania. Most recently, the GOK made plans to hire 4,000 additional health workers on contracts using this mechanism.

The EHP also had unexpected influence on the GOK's HR systems. Because of the plan, the MOH began a review of current processes and policies, and is considering the adoption of new, more transparent hiring and deployment approaches used in the EHP. Although the plan originated as a stop-gap measure to quickly infuse a large number of workers into the

workforce to provide desperately-needed HIV care, the government has since pledged to hire all new EHP hires as full-time public sector employees.

Approaches such as the EHP are often necessary because longer-term HRH initiatives either failed or did not exist. Therefore, one of the most important effects of the EHP was to raise the profile of HRH in Kenya and generate attention and action to address long-term HRH challenges. Additionally, the processes used to implement the EHP became troubleshooting tools that helped the MOH and the Capacity Project explicate problem areas, which in turn could be programmed for medium- to long-term HRH interventions. Ultimately, approaches like the EHP should be used in conjunction with:

- Regular strategic HRH planning
- Leadership and management capacity-building efforts
- Efforts to professionalize HR departments and units
- Efforts to ensure that HR staff have input into strategic decisions and HR innovations that will strengthen the performance of the health system.

Organizational performance and access to health services can only be improved by such a "bundle" of mutually-reinforcing HR policies and procedures.

Finally, we should note that *how* something is done is equally important as *what* is being done, despite the fact that evaluation studies (including this one) ask questions and design approaches to assess the latter. For example, in the area of HRH strengthening, entrenched systems and people who have benefited from inequitable, inefficient and poorly monitored systems often stand in the way of reform. The process by which effective reformers go about engaging and changing the system needs to be carefully documented and studied to see whether these predict the system's success better than features of the reform alone.

CONCLUSION

This evaluation fills an evidence gap in the HRH knowledge base about how effective such mechanisms are at rapidly expanding the workforce to address national health priorities. We recommend that countries with the right political commitment and available unemployed health workers consider the EHP as one of a comprehensive set of HRH strengthening tools and approaches to meet short-term health workforce gaps and increase health service access.

For what country circumstances are EHPs most suited?

- Countries with surplus unemployed health workers
- Countries prepared to take risks with unusual measures
- Countries that demonstrate significant political will and commitment to support change
- Countries with HR departments that are adept at mobilizing external resources and expertise required to implement the plan
- Countries with civil service recruitment and deployment procedures that may be slow but working (and there are guidelines)
- Countries in which an existing dynamic private sector company can be a partner or a source of best HR practices in HR functions.

Under what circumstances are EHPs not advised?

- If there are no health workers to mobilize
- If health workers are mobilized in an environment that is neither safe nor productive
- If the HR department lacks sufficient capacity to take on the task and provide necessary leadership to manage change that requires alignment and support of multiple stakeholders
- When the necessary resources to design and manage the plan are not sought and lined up in advance
- If the health sector is fragmented or sharply segmented into disease-specific efforts
- If coherence is lacking between career paths, salaries and allowances
- If poor institutional arrangements exist in linking central to district or facility-level operational networks.

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The Capacity Project is an innovative global initiative funded by the United States Agency for International Development (USAID). The Capacity Project applies proven and promising approaches to improve the quality and use of priority health care services in developing countries by:

- Improving workforce planning and leadership
- Developing better education and training programs for the workforce
- Strengthening systems to support workforce performance.

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