Mid-Term Evaluation of the Kenya Emergency Hiring Plan

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List of Acronyms

AMREF	African Medical and Research Foundation
Danida	Danish International Development Agency
DMS	Director of Medical Services
DPM	Department of Personnel Management
EHP	Emergency Hiring Plan
EWM	Emergency Workforce Mobilization for Service Improvement Project
FBO	Faith-Based Organization
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOK	Government of Kenya
HBC	Home-Based Care
HR	Human Resources
HRH	Human Resources for Health
HRIS	Human Resources Information System
HRM	Human Resource Management
HRMIS	Human Resource Management Information System
IPCT	Integrated HIV/AIDS Prevention, Care and Treatment
JDM	Joint Design Mission
KEC	Kenya Episcopal Conference
KEPH	Kenya Essential Package for Health
KIA	Kenya Institute of Administration
KMTC	Kenya Medical Training Centre
KSh	Kenya Shillings
KWS	Kenya Wildlife Service
MCC	Millennium Challenge Corporation
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MPND	Ministry of Planning and National Development
MSF	Medecins sans Frontieres
MTEF	Medium-Term Expenditure Framework
NASCOP	National AIDS and STI Control Program
NHSSP	National Health Sector Strategic Plan
PEPFAR	President's Emergency Program for AIDS Relief
PLHIV	People Living with HIV
PMO	Principal Medical Officer
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission
PS	Permanent Secretary
PSC	Public Service Commission
PSRS	Public Sector Reforms Secretariat
PSRTP	Public Service Recruitment and Training Policy
RH	Reproductive Health
TA	Technical Assistance
TOT	Training of Trainers
WCI	Work Climate Improvement
WHO	World Health Organization

Executive Summary

Background

This mid-term evaluation report focuses on Capacity Project support to the Government of Kenya's (GOK) Emergency Hiring Plan (EHP). It assesses the main achievements, challenges and impact on service delivery and health systems improvement, from the plan's inception through the November 2007 mid-point. The report outlines all aspects of the approach used, providing clear recommendations on how the Ministry of Health (MOH) may strengthen its existing human resource systems on the basis of lessons learned, and provides additional insights to the process, which may be useful for informing similar country contexts. The in-country component of the evaluation involved engagement with a wide range of informants including primary stakeholders and clients, government agencies and implementing partners to obtain their views and understanding on the impact and effectiveness of the EHP. Additionally, an extensive desk review of reports, policy documents and relevant resource materials was completed.

The Capacity Project was instrumental in the conceptualization, development and implementation of the EHP for the public health sector in Kenya. This formal process began in April 2005; following a series of negotiations with the MOH, the EHP concept was endorsed and launched in January 2006. Initially supported by USAID through the Capacity Project, the EHP aimed to assist the MOH to rapidly hire, train and deploy a target of 830 health workers to critically underserved health facilities in rural areas in Kenya. Since its inception the EHP has been expanded by the MOH and is further supported by other implementing partners, notably Danida through the Clinton Foundation.

The EHP is an innovative recruitment model to rapidly hire, train and deploy health workers to facilities where there are persistent staffing shortages and a need to provide essential health services. It specifically targets underserved rural locations and further seeks to expand access to HIV/AIDS treatment and care. The initiative is implemented through the MOH and managed by the Capacity Project, which provides technical assistance and the coordination of public-private partnership support through Deloitte, Kenya Institute of Administration, Kenya Medical Training Colleges and African Medical and Research Foundation (AMREF).

The availability of an adequately skilled and motivated health workforce is an essential requirement for ensuring adequate access to service delivery, enhancing health system performance and improving health outcomes. The health sector in Kenya experiences persistent maldistribution and skills shortage as a result of its inability to effectively recruit, deploy and retain an appropriate workforce. The sector also faces the impact of HIV/AIDS on its existing workforce and restrictive public-sector staffing standards and norms as a result of human resources for health (HRH) planning and funding limitations. All this has led to overstretching of the health system and inability to adequately deal with increasing demand for public health services, in particular HIV/AIDS related scale-up interventions.

Achievements

The EHP process has enabled the MOH to address persistent shortcomings in existing recruitment and deployment systems and help to eliminate these through the development and application of effective controls using public-private partnership. Implementation was carried out through a structured 15-step sequence, involving the development of a comprehensive deployment plan, selection and deployment criteria, job descriptions and vacancy and interview announcements through national newspapers and other media. Using a decentralized approach to recruitment, the MOH received 6,568 applications, of which 4,456 were short-listed and 4,022 candidates were interviewed.

Through Capacity Project support to the EHP, a total of 849[1] health workers—enrolled community and registered nurses, laboratory technologists, pharmacy technologists and clinical officers—were rapidly hired by the MOH on

[1] Of a USAID-supported total of 866, which includes PEPFAR-funded posts.

three-year contracts, and deployed to 200 government health facilities and faith-based hospitals in 66 of the neediest districts in Kenya. Prior to commencing work, the new hires received induction training on MOH sector-wide plans, programs, mandates, operational procedures and guidelines. The health workers also received training in home-based care, prevention of mother-to-child transmission of HIV and integrated HIV/AIDS prevention, care and treatment, conducted by AMREF, Kenya Institute of Administration and Kenya Medical Training Colleges.

To support the management of the new hires, a computerized human resource management and payroll system was developed. The hiring process was concluded in a three-and-a-half month period, in comparison to over one year that it typically takes through public-sector processes. In terms of continuity and post-contract absorption of new hires, the Capacity Project has worked closely with the MOH Planning Unit and the Ministry of Planning and National Development to ensure that all EHP-supported posts are factored into the Government of Kenya's Medium-Term Expenditure Framework (MTEF) budget forecasts.

There is evidence emerging that the EHP is beginning to have a positive impact in transforming service delivery in remote health centers and hospitals with limited resources, both government and faith-based. Facilities that had previously closed due to lack of staff were reopened, and a number of facilities facing imminent closure remained operational. Reports indicate that there is a reduction in the length of queues for services, improvement in staff attitudes, faster treatment of patients and increased community outreach activities and HIV/AIDS prevention, treatment and care services. The new hires particularly appreciated the transparent and fair recruitment process, timely receipt of job descriptions, letters of appointments, training and prompt payment of salaries.

Key Findings and Lessons Learned

- GOK support and funding through the MTEF is critical in terms of continuity and sustainability of the EHP.
- There is agreement between the GOK and the EHP implementing partners that EHP-supported posts will be absorbed into the GOK/MOH payroll at the end of the three-year contracts, for which adjustments to the MTEF have been made.
- The EHP is having a positive effect on improving service delivery and attaining performance targets through the provision of critical health providers to areas of need, including a number of facilities that had previously closed due to lack of available staff.
- The EHP is helping to reduce the pool of unemployed health workers in Kenya—in particular, through the hiring of previously unemployed graduates.
- Fast-tracked recruitment expansion has been achieved, but is mainly focused on GOK health services. The EHP has increased the number of available health workers at understaffed facilities; however, there are continued urban-versus-rural imbalances within the system.
- Through proactive collaboration with government agencies and compliance with existing government recruitment processes, the Capacity Project-supported EHP initiative has engendered increased trust between key stakeholders and enhanced ability to influence change.
- A large amount of time, effort and resources are directed towards existing government recruitment processes, due to the number of different actors involved at various stages. Continued inefficiencies in the system affect service delivery by perpetuating delay in deploying health workers to areas of need.
- The selection and appointment process was perceived by a majority of respondents to be transparent and open. However, in some instances new hires were not posted to their preferred choices and others were recruited from faith-based facilities.
- Existing public-sector recruitment, appointment and promotion processes remain highly personalized and beset by frequent manipulation, and many of the informants perceive government recruitment and appointment decisions as unfair and lacking in transparency.
- The EHP shows that use of private-sector agencies can add value to the GOK's recruitment processes, specifically in terms of leveraging joint public-private sector partnership to establish and further develop best practices and institutionalize simpler and more efficient administrative systems and processes.
- Induction and training are seen as innovative aspects of the EHP and have been well received by the new hires, colleagues and staff at the facilities as well as other stakeholders. Although induction is a

requirement under the normal public-service recruitment process, the majority of informants claimed that it is an aspect that is commonly neglected.

- EHP hires submit regular monthly timesheets as a pre-condition for payment, and a joint MOH/Capacity Project team conducts regular supervision visits. However, these initiatives are causing tension between the MOH and the Capacity Project, as the MOH sees this as interference in its core functions. Perceptions of other implementing partners are that Capacity Project-supported hires are singled out for preferential training, orientation, supervision, etc. and that these should be provided to all new hires to avoid unnecessary divisions.
- Despite assurances not to hire staff from faith-based facilities, a significant number of these applicants were short-listed, selected and appointed—a situation that arose as a result of insufficient checks and balances and further fuelled by perceptions of better salaries and working conditions at MOH facilities.

Recommendations

- Implementing partners must continue to engage with the MOH in order to establish and agree upon modalities and a comprehensive plan for the post-EHP absorption of all new hire posts within the MOH and faith-based facilities.
- Engagement and dialogue must be increased between the GOK and the private sector to further establish and institutionalize best practice standards in recruitment and deployment, supported and informed by accurate data and mechanisms to aid implementation.
- The targeted redeployment of the existing HRH base must be made in support of the Kenya Essential Package for Health through innovative strategies to attract, deploy and retain staff in underserved areas and hard-to-reach facilities. Prioritization and costing of this should be incorporated in both the national HRH strategic plan and proposed health sector deployment policy.
- The Capacity Project and other partners must lobby the MOH and the GOK on expanding the EHP support program toward meeting the service demands of the sector, in particular those of the faith-based organizations subsector, including the possibility of providing additional resources to address the planned financial gap for this.
- The Capacity Project must continue to lend support to the MOH to establish and implement appropriate strategies to address future recruitment restrictions on new posts, increase the number and type of established posts and mobilize additional resources toward financing of an expanded wage bill.
- Ongoing additional support from the Capacity Project should target MOH systemic and HRH management weaknesses through the adoption of best practice, in line with ongoing public-sector HR management reforms.
- Decentralization of the MOH recruitment and deployment process should be supported through the development and implementation of appropriate controls, checks and balances, including sensitization on how HR management roles and functions can support effective Kenya Essential Package for Health service delivery at provincial, district and facility levels.

1. Introduction

Human resources (HR) are a key element in ensuring adequate access to service delivery, enhancing health system performance and improving health outcomes. Kenya's health care delivery system, defined by the Kenya Essential Package of Health (KEPH), is highly labor-intensive and is constrained by a lack of available human resources, a poor distribution of health service providers and key support workers with an inadequate mix of skills. This hampers Kenya's ability to achieve its long-term health objectives, including the Millennium Development Goals. The Second National Health Sector Strategic Plan: 2005-2010 (NHSSP II) proposes a series of health sector reform initiatives to reverse the downward trends in Kenya's health indicators, and articulates the intent of the Ministry of Health (MOH) to develop its HR base through effective policy and strategic choices in the areas of human resource management (HRM) and human resource development in line with the Government of Kenya's (GOK) overall Public Sector Reforms Program and within the current Medium-Term Expenditure Framework (MTEF). Comprehensive measures are being taken to support improved health systems, including the utilization and performance of the existing workforce; the development of strategies to address health worker shortages, including re-deployment; and options to increase the size, quality and skills mix of the workforce, all of which are articulated in the national Human Resource for Health Strategic Plan (2007/08-2009/10).

There are approximately 16 doctors and 153 nurses per 100,000 population in Kenya, which compares favorably with other sub-Saharan African countries. Unfortunately, these health workers are inequitably deployed and distributed. High concentrations of doctors and nurses exist in urban locations, particularly in district and provincial hospitals, with resultant overstaffing and understaffing between various service levels. On average, there are 62 nurses per facility deployed to district and subdistrict hospitals, much higher than KEPH staffing norms that are set at a maximum of 14 nurses for Level 3 and 60 nurses for Level 4 facilities. In addition, new graduates from health training institutions experience persistent difficulty securing employment due to budgetary and recruitment restrictions.

Table 1: HRH Comparison with Selected Countries

Country	# Doctors /100,000	# Nurses & Midwives/ 100,000	# Health Workers[2] / 100,000
Kenya (2007)[3]	**16**	**153**	**169**
Uganda	8	73	82
Malawi	2.2	26.4	28.6
Mozambique	2.6	20	34
South Africa	74.3	393	468
USA	247	901	1,147
UK	222	1,170	1,552
WHO minimum standard	***20***	***100***	***228***

Sources: World Health Report (2006); Help Wanted: Confronting the Health Worker Crisis, MSF Experiences in Southern Africa, MSF (2007)

Despite ongoing efforts to strengthen service delivery inputs for the KEPH, the inadequate availability and skewed distribution and deployment of key human resources is perpetuating service gaps. The Kenyan health sector must address the long-standing issue of redeployment of the health workforce as it seeks to ensure that staffing needs are responsive to KEPH service delivery demands and gaps. While staffing norms and standards for delivery of the KEPH at all levels have been developed, these goals have not yet been reached and imbalances remain between various service delivery levels. The current MOH staffing gap for Level 2-5 KEPH delivery is approximately 55,000. The Joint Program of Work and Funding for the Health Sector: 2006/07-2009/10 aims to target 50% of the current

[2] Based on WHO standard of combined number of available doctors, nurses and midwives.
[3] Figures for Kenya based on MOH IPPD data as of June 2007.

staffing shortfall during the remaining period of NHSSP II, with specific focus on the targeted deployment of these health workers to hard-to-reach rural locations.

2. Background

The health sector in Kenya continues to experience a persistent shortage and maldistribution of skilled health workers and managers as a result of its inability to effectively recruit, deploy and retain an appropriate skill base. The GOK's decision in 1993 to freeze civil service hiring, along with the adverse effects of poor human resource planning, management and development systems and capacity, have further contributed to the situation, which has led to a current health system that is overstretched and unable to adequately deal with increasing demand for health services, and in particular, HIV/AIDS-related scale-up interventions. Continued staff attrition, outmigration and the impact of HIV on the existing health workforce is high, against a backdrop of inability to absorb graduates of health training institutions due to budget constraints and restrictions on personnel recruitment. It is further recognized that leadership continues to be a determining factor in the sector's ability to come to terms with the human resource shortages and performance weaknesses which constrain the achievement of health-related goals and objectives.

In April 2005, the USAID-supported Capacity Project/Kenya initiated formal discussions with the Kenya MOH regarding the design and development of a proposed Emergency Workforce Mobilization for Service Improvement Project (EWM). The stated objectives of the EWM were as follows:

1. Develop and implement a fast-track hiring and deployment model to mobilize 800 additional health workers and deploy them primarily in the public sector to urgently tackle the HIV/AIDS crisis
2. Develop and implement an accelerated "crash training program" to rapidly address gaps in skills and competencies for new hires as well as future in-service requirements for the wider health sector workforce
3. Design and implement a monitoring, quality assurance and support system that will enable the new health workers to increase their efficiency and effectiveness
4. Provide the MOH with ideas and strategies that will lead to the establishment of an independent Health Service Commission as well as provide an overall framework for comprehensive workforce planning, deployment and support.

Through the EWM, an innovative fast-track recruitment model was designed and implemented, incorporating a nongovernmental outsourcing mechanism to rapidly hire, train and deploy 830 health care providers to critically underserved rural public-sector health facilities. The MOH agreed to an operational plan that utilized technical assistance and support from the Capacity Project, and initial implementation of what is now referred to as the Emergency Hiring Plan (EHP) began in January 2006. Key partners in this developmental phase included the Ministry of State for Public Service's Department of Personnel Management (DPM), the Public Service Commission (PSC) and the Ministry of Planning and National Development (MPND). The EHP represents a joint public-private partnership, encompassing initiatives supported by Deloitte Consulting Limited, Kenya Institute of Administration (KIA), Kenya Medical Training Centre (KMTC) and the African Medical and Research Foundation (AMREF). Following identification and subsequent governmental approval of the local implementing partners, the MOH and Deloitte moved the process forward by way of the joint development of a Deployment Plan in February 2006. MOH approval of the plan included agreement on transparent recruitment and selection criteria and methodology, and a delineation of the categories and numbers of health workers needed, as identified on the basis of critical staffing and service delivery gaps. Implementation was planned over three phases, incrementally building on successes in mobilization and training, with supporting mechanisms in place for monitoring and quality assurance.

3. Purpose

This mid-term evaluation study focuses on Kenya's EHP, outlining all aspects of the approach used to assess its main achievements, challenges and impacts on service delivery and health systems improvement up to this point in the initiative. It makes clear recommendations on how the MOH may strengthen existing human resource systems

on the basis of lessons learned from implementation of the EHP and further provides insights to inform similar country contexts. The evaluation consultants carried out the in-country assignment over November 5-6, 2007.

4. Objectives and Methodology

The key objectives of the EHP evaluation are as follows:

1. To provide a detailed description of the process instituted to recruit, hire, train and deploy 830 emergency hires
2. To determine the extent to which the EHP's short-term objectives of transparently recruiting, hiring, training and deploying 830 health care providers in high-need areas were met
3. To summarize lessons learned to date on what works and doesn't work in creating an emergency response to human resource shortages
4. To determine and document the impact of the EHP on the wider labor market, with a special emphasis on its impact on faith-based organizations' staff availability
5. To identify any positive short-term collateral effects on the public sector (e.g., changes to the public sector hiring process, raising awareness of governance issues related to hiring) and any unintended negative short-term consequences (e.g., exposing inefficiencies, creating low morale among other health workers)
6. To identify any long-term effects on the country's human resources for health (HRH) work; e.g., pointing the MOH in the direction of core HRH issues that need to be addressed.

The in-country evaluation focused on engagement with a wide range of informants, including primary stakeholders and clients, government agencies and implementing partners, to obtain their views and understanding of the impact and effectiveness of the EHP. This was achieved through key informant interviews and consultations, both at central and provincial/district levels, including EHP hires, senior MOH officials, provincial and district-based management and staff, Capacity Project and USAID staff, representatives from faith-based organizations (FBOs), implementing partners including Deloitte, KIA and KMTC; representatives of government agencies including DPM, PSC, MPND and the Public Sector Reforms Secretariat (PSRS); development partners; and the National AIDS and STI Control Program (NASCOP). Field visits to a number of health facilities, including Isinya Health Centre in Kajiado district, Friends Mission Hospital in Kaimosi, Nyando District Hospital and Kisumu Medical Training College were also undertaken (see Annex B). Additionally, an extensive desk review of the EHP, including public sector and related health sector policy and documentation, was carried out (see Annex C).

5. Overview and Achievements of the EHP

In 2005, the Kenya MOH and the Capacity Project discussed the initial idea for establishing an emergency health workforce recruitment and deployment mechanism. This discussion led to a collaborative process of designing and developing a proposed EWM and initial implementation of the EHP was followed through. The MOH was fully supported by the Capacity Project in the design and implementation of the EHP as outlined in Table 2 below. One of the objectives of the EHP is to "transparently recruit, hire, train and deploy 830 health care providers in high need areas." The initiative targets approximately 200 facilities (Nyanza, Coast, Western, Rift Valley, Eastern and Northern Provinces) and has significantly reduced recruitment and deployment time, with the initial rapid hiring and deployment of the 830 health workers concluded in three-and-a-half months in comparison to the more than one year it can typically take using public sector processes. Newly recruited health workers under the EHP are on terms and conditions which are the same as those in the MOH and public service, with the exception of an end-of-contract gratuity, which is given in lieu of pension.

Table 2: Chronology of Capacity Project Support for EHP

Timeline	Activity
April 2005 to January 2006	Negotiation and agreement on process and methodology
January 2006	Identification of local implementation partners

Timeline	Activity
February 2006	Development of a Deployment Plan
May 2006	1,630 MOH vacancies advertised in national media (Capacity Project & Clinton)
June 2006	Computerized screening with short-listing published in national media
June 2006	Induction Handbook for New Hires developed
July 2006	Regional interviews conducted
July 2006	Work Climate Improvement initiative developed
August 2006	Successful candidates notified in national media
September 2006	Induction, training and deployment initiated
September to October 2006	Payroll processing initiated through Deloitte
December 2006	Recruitment and placement of 830 health workers completed
January 2007	HRIS development initiated
May 2007	Leadership Development Program initiated
May 2007	124 MOH "replacement" vacancies advertised in national media
November 2007	Capacity Project EHP mid-term evaluation

The EHP recruitment initiative was jointly planned with the MOH, DPM, PSC and MPND, and carried out using standard public service recruitment procedure in line with the Public Service Recruitment and Training Policy. The initiative is managed by the Capacity Project, implemented through the MOH, and supported by Deloitte. Agreed selection criteria and categories of health workers to be hired were established jointly, including a commitment on the part of the Capacity Project to exclude applicants already working in faith-based facilities. Vacancies and positions were advertised in May 2006 through a national media campaign, with candidates requested to submit their applications directly to the MOH. The selection process was designed to enable interviewees to indicate their preferred choice of deployment from a list of pre-selected sites. The MOH Department of Human Resources Management, working with Deloitte, employed an applications database for short-listing, in place of the standard manual format used. Following initial training on the profiling method used, the MOH short-listed 4,466 health workers from a total of 6,568 applications in approximately three weeks. The initial appointees were screened, interviewed through agreed criteria and appointed in post from August 2006, approximately three-and-a-half months after the positions were first advertised. In terms of transparency, the lists of both short-listed and successful candidates were published in the national media, a practice that is now becoming common in other line ministries and government agencies.

5.1 Emergency Hiring Plan Design and Implementation

The process of hiring 830 health workers under the EHP was carried out in a sequence of 15 steps. Main implementation partners included Deloitte, KIA, PSC, MPND, KMTC and AMREF. As the MOH was aiming to recruit 1,630 new hires during the same time period, with Clinton Foundation support, various aspects of the EHP such as vacancy advertisement[4] and interviews were undertaken jointly. This section describes the key implementation stages of the EHP process.

Deployment Plan

The first stage of the EHP was the development of a comprehensive deployment plan for the new hires in April 2006. Priority geographical areas with the most need were identified. Facilities in areas with high HIV prevalence that were located in hard-to-reach areas and experienced critical staffing shortages were selected. This information was reinforced by findings from the Kenya Services Provision Assessment Report and current deployment needs expressed by provincial and district health teams and FBO facilities in all provinces excluding Nairobi. The deployment plan identified staffing gaps for MOH and FBO facilities in seven priority provinces and was carried out in three phases by the Capacity Project.

[4] 1,630 MOH vacancies, on three-year contract term supported by the Capacity Project and Clinton Foundation, advertised in national media on May 10, 2006.

Selection and Deployment Criteria
Deployment was carried out in three phases. In Phase I, the MOH provided the Capacity Project with 374 applications that they had received prior to the May 10, 2006, job advertisements. All 374 applications were rapidly screened and entered into the EHP database. A total of 113 of these health service providers were selected and hired, leaving a balance of 717 health workers from a set target of 830 (see Table 3 below).

Table 3: Proposed Capacity Project Deployment Schedule

	Phase I	Phase 2	Phase 3	*Total*
Enrolled Nurse	82	291	187	***560***
Registered Nurse	0	21	37	***58***
Clinical Officer	36	27	23	***86***
Lab Technologist	12	36	42	***90***
Pharmacy Technologist	0	17	19	***36***
Total	***130***	***392***	***308***	***830***

To achieve this target in Phases II and III, the positions were advertised to elicit applications. The MOH, Capacity Project and Clinton Foundation jointly developed and agreed on selection and eligibility criteria for deploying the additional new hires. It was agreed that candidates would be posted to their preferred choice of site from a list of identified priority regions. At this point it was further agreed that the Capacity Project would not select candidates currently working at an FBO facility. The rationale for this criterion was to avert movement of health workers away from FBO facilities, which would adversely affect service delivery.

Job descriptions were developed for the vacant positions using MOH schemes of service, job titles, grades and salaries that these posts would attract. The job descriptions specified the reporting relationships and desired qualifications and were forwarded to MOH heads of departments for review and comments. This represents a new aspect brought into the recruitment process by the MOH with the support of the Capacity Project, since existing schemes of service have not been able to clearly define all of these parameters.

Vacancy Announcements
An advertisement announcing 1,630 vacant positions (see Table 4) was prepared and published by the MOH in the national daily newspapers on May 10, 2006, with a closing date of May 31, 2006. The advertisement explicitly listed 630 of these vacancies as being supported by USAID/Capacity Project and the other 1,000 supported by the Clinton Foundation, despite attempts by both organizations to maintain anonymity in the process. Specific notes were included in the advertisement with regard to the following:

- Terms of service of three-year contract
- Indication of consolidated salary for each position
- Instruction that applicants currently employed with the MOH or any of its projects should not apply
- All of those engaged for a six-month period during the health worker strike (in 2005) were encouraged to apply, attaching documentary proof of where they worked
- Instruction that successful candidates would be deployed to designated sites for a minimum period of three years
- Notice that provincial interviews would take place and that short-lists would be placed in newspapers between June 19-23, 2006
- Applications to be submitted in own handwriting, to include copies of certificates, testimonials, CVs and national identity card.

Table 4: Breakdown of MOH Vacancy Advertisement

	Capacity Project	*Clinton Foundation*	*Total*
Nursing Officer III	58	300	*358*
Enrolled Community Nurse III	445	600	*1,045*

	Capacity Project	*Clinton Foundation*	*Total*
Medical Laboratory Technologist III	47	0	*47*
Clinical Officer III	44	100	*144*
Pharmaceutical Technologist III	36	0	*36*
Total	***630***	***1,000***	***1,630***

Source: Daily Nation, May 10, 2006

Almost all new hires reported that they learned of the vacancies through the newspaper[5]. This was a relatively new approach of hiring in the MOH and was positively received by applicants. Many informants indicated this as the first time they had seen positions for the MOH advertised in the media. A senior-level MOH official commented that although the process was designed as comprehensive and transparent, a major challenge in replicating this approach on a regular basis is that the posting of advertisements, short-lists, etc. through the national press is highly expensive due to the cost of publishing multiple pages, particularly where financial resources for this are scarce[6]. On May 17, 2007, a further advertisement was placed, announcing positions for 124 replacements on an 18-month contract, to fill EHP posts that had since become vacant due to attrition (Table 5).

Table 5: Advertised MOH Replacement Vacancies

Nursing Officer III	Enrolled Community Nurse III	Medical Laboratory Technologist III	Clinical Officer III	Pharmaceutical Technologist III	*Total*
2	90	8	14	10	***124***

Source: Daily Nation, Thursday May 17th, 2007

The advertisements were fully paid by the MOH and widely circulated to all constituency office and district public office notice boards nationwide. The exact breakdown in cost involved in this exercise is difficult to ascertain. However indications are that that the MOH paid in the region of KSh 14 million in advertising and associated implementation costs[7] in the hiring of these 1,630 health workers and additional 124 replacement posts; around KSh 6 million of which was supported in cost-share by the Capacity Project/Kenya. The highly monetized manifestation and nature of the overall recruitment and selection process raises serious financial sustainability implications for the MOH.

Applicant Short-Listing

Over a three-week period in June 2006 all of the 6,568 applications received in response to the MOH advertisement were entered onto a database and a meeting held between the MOH and Deloitte to establish criteria for short-listing and electronic candidate screening, following which 4,456 candidates were short-listed. In June 2006, a list of all 4,456 candidates was placed in the national newspapers, including the interview venue, date and time for each candidate. In addition, the short-list explicitly stated which group of posts were Capacity Project- or Clinton Foundation-supported. The short-list advertisement further served to announce that all of those hired by the MOH on a six-month contract (i.e., during the 2005 health worker strike) should present themselves to their Provincial Headquarters venue along with documentary evidence, "even if they are not in the short-list."

Interviews

Preparatory work for the interviews was carried out by the Capacity Project, MOH and Deloitte in terms of preparing interview questions and briefing members of the selection panels on the process to be followed. The

[5] 99% of a sample of new hires surveyed read the job advertisement in the national newspapers (Source: Capacity Project Preliminary Report for EWM Plan Evaluation Data, July 2007).

[6] Discussions with the incumbent HRM Director at the MOH.

[7] From interview with the incumbent MOH director, Human Resource Development (November 8, 2007) in which KSh14 million cost of advertising, short-list publishing and provision of allowances and associated costs for implementation of district-based interviews, etc. were discussed.

interviews were conducted at the provincial level over a three-week period in July 2006 in the following ten cities (and provinces): Kisumu (Nyanza); Nairobi (Nairobi); Kakamega (Western); Isiolo (Eastern); Embu (Eastern); Nakuru (Rift); Eldoret (Rift); Garissa (North Eastern); Mombasa (Coast); and Nyera (Central).

Interview panels consisting of 10 people each were formed, drawn from MOH central and provincial MOH officers and KMTC, with Deloitte participating as an observer. Of a provisional total of the 4,466[8] applicants who were called for interviews, 4,022 interviews took place, and the process was jointly monitored by MOH headquarters and Capacity Project staff to ensure equity, transparency and validity of documentation. The decentralized interviewing reduced travel-related logistics for participants and further enabled active participation of provincial health management teams in the process. The majority of interviewees (81%) were asked to choose three preferred districts/facilities at which they would wish to be posted.

Table 6: MOH Interviews by Category

Position	Number of advertised posts	Number of applicants interviewed
Enrolled Community Nurse	1,045	1,957
Registered Nurse	358	1,350
Lab Technologist	47	353
Pharmacy Technologist	36	131
Clinical Officer	144	231
Total	***1,630***	***4,022***

Source: Capacity Project EHP Process Documentation, 2007

Selection and Deployment

Following the interviews, a selection committee met from August 3-4, 2006, to finalize and agree on the selection criteria, which is based on geographic representation, interview scores and candidate suitability to the position. Additionally, it was agreed that none of the Capacity Project-supported new hires would be selected from FBO organizations. The outcome of the selection process was published in the *Daily Nation* and *Standard* newspapers, which again made specific reference that these appointments were for "the Ministry of Health, USAID Capacity and Clinton Foundation project positions." Successful applicants were requested to report over a four-month period from September 4 to December 1, 2006. Despite having established criteria for selection, 209 health workers from FBOs[9] were recruited by the MOH. In addition, successful candidates were posted outside their choice of three preferred sites which compelled the Capacity Project and Deloitte to recommend that the MOH make amendment to its deployment decisions.

A total of 849 health workers have been hired over two years by the MOH, through Capacity Project support. The table below shows the numbers each month on the payroll, hired and exited employment during this period. On passing the interview, 15 employees never reported to their facilities. Of the 58 who exited employment during this period, the largest number (30) left for MOH employment through the PSC on a permanent basis. Other reasons given for leaving were: for personal issues related to their families (8); to work at Clinton Foundation-supported facilities (3); because they were unable to get a transfer (3); and to work with an FBO (2). One employee resigned for personal reasons and one died.

Table 7: MOH Health Workers Recruited Through the Capacity Project, 2006–2007

Month in 2006	# On Payroll End of Month	# Hired During the Month	# Exits During the Month	Month in 2007	# On Payroll End of Month	# Hired During the Month	# Exits During the Month
Jan	0	0	0	**Jan**	701	77	0

[8] This figure excludes any of the six-month contract hires (2005 strike) invited for interview.

[9] Data collected by FBOs indicate that a total of 209 health workers were recruited by the MOH: 114 from CHAK and 95 from KEC. (Source *CHAK Times*, January 2007)

Month in 2006	# On Payroll End of Month	# Hired During the Month	# Exits During the Month	Month in 2007	# On Payroll End of Month	# Hired During the Month	# Exits During the Month
Feb	0	0	0	**Feb**	734	33	0
Mar	0	0	0	**Mar**	755	21	29
Apr	0	0	0	**Apr**	726	0	18
May	113	113	0	**May**	708	0	3
Jun	113	0	0	**Jun**	705	0	6
Jul	113	0	0	**Jul**	699	0	2
Aug	117	4	0	**Aug**	697	0	0
Sep	120	3	0	**Sep**	697	0	0
Oct	269	149	0	**Oct**	790	93	0
Nov	383	114	0	**Nov**	791	1	0
Dec	624	241	0	**Dec**	-	-	-
Total		**624**	**0**	**Total**		**225**	**58**
Total Hired 2006/07 = 849							

Letters of appointment were sent out to all new hires detailing the terms of employment and contractual requirements as well as instructing appointees to report first to the District Medical Officer of Health, who would then assign them to report to their respective work stations, either at the District Hospital, Health Centre or faith-based facility. All new hires were required to report to their respective health facilities by November 2006. Letters of acceptance were submitted along with personal details to facilitate salary and statutory remittances. Efforts were made to ensure that all sites were informed in advance of the new arrivals; however, from discussions with staff from three different facilities visited, it appears that this was not done in time, and the confusion that arose served to highlight the importance of adequate site preparation, coordination and liaison between all of parties involved the process, and in particular with the district medical officer for health.

The Recruitment, Selection and Deployment Process from a Nurse's Perspective

When asked what she thought of the recruitment and selection process under the EHP, a recently appointed registered nurse said, "The process was very fair." After she sent her application letter to the MOH, she read in the national newspaper that she was to be invited for interview. During the interview, she was asked which location she would like to work in and selected her home district as the first choice. She passed the interview and was posted to her local District Hospital. She reflects that "the whole process was quick."

Before joining the MOH, she worked at a private hospital. She had always been interested in working with the MOH, as she viewed their terms and working conditions as better than those in the private sector. "When you work with the private hospitals, you work long hours with low pay," she explains. "When I saw the Ministry of Health advertisement, the opportunity of working on contract for three years with the prospect of becoming a permanent employee could not be missed."

The District Hospital she is posted to is one of the priority facilities selected to receive staff under the EHP. The hospital was in dire need of staff and received six additional nurses, supported by the Capacity Project. These nurses rotate among different departments, offering out-patient, in-patient, maternal and child health, family planning and maternity services. They also cover pharmacy, laboratory and patient support services. With six additional nurses, service delivery at the hospital has significantly improved, client waiting times have reduced and staff workloads are no longer unmanageable.

Asked about her experiences and the challenge of working in the local community, she doesn't hesitate: "The work is good, but I wish I could be with my husband and two young children. My husband is unable to relocate because of the type of job he does…I find it hard to work away from my family." She has had to relocate some 400 km. away from her family in Nairobi, but has applied to the MOH for a transfer. She hopes that sometime in the near future she will be able to live and work nearer her family and reduce the high cost of frequent travel to Nairobi.

Human Resource Management and Payroll Issues

To track the location, contract status, leave and benefits of all the Capacity Project-supported new hires, Deloitte developed an HRM database. This database has four management modules: job applications; employee files, training details, timesheets and payroll; reports and statistics; and system and security administration. The database is adapted to suit the needs of different stakeholders and end-users, including professional associations and FBOs. Within the database is a payroll module for managing salaries and benefits. The associated payroll cycle (Table 8) was developed to ensure that all new hires are promptly paid by the 30th of each month. Almost all of the new hires commended the regular and prompt payment of salaries through their respective bank accounts, and appreciated that there was a specific individual at the Capacity Project they could contact to address any issues relating to their payment.

Table 8: Monthly Payroll Cycle

Due Date	*Activity*	*Responsible*
1st to 18th	Timesheets received from previous month	Capacity Project/employee
1st to 18th	Telephone confirmation of employee status	Capacity Project/facility
1st to 18th	Payroll updated and approved	Capacity Project
18th	Payroll instruction sent by HR manager to Deloitte	Capacity Project
20th	Draft payroll returned by Deloitte to HR manager	Deloitte
23rd	Payroll approved and advance requested	Capacity Project/Deloitte
24th	Salary wired to Deloitte	Capacity Project
25th	Salary wired to employee account	Deloitte
30th	New hire salaries received	Deloitte/Bank

Source: Capacity EHP Process Documentation, 2007

Working in partnership with the MOH, the Capacity Project and Deloitte are monitoring progress of the new hires in the field on an ongoing basis through telephone, e-mail and site supervision visits. Health service statistics are regularly collected from a sample of the 200 health facilities in which the new hires are working, and information on different aspects of human resources management compiled. Through this monitoring mechanism, the impact of the new hires on service delivery may be assessed and effective communication maintained between the project and heads of facilities. The information from the monitoring process may be used to support the rationale for deployment and provide an evidence base for making recommendations on improving HRM within the MOH.

Induction

The Capacity Project, with input from Deloitte, the MOH and KIA, developed an induction program and handbook consisting of both an "offsite" and an "on-site" portion. The focus of the induction is to orientate officers to the MOH, standardize the content and process of induction and provide guidelines for inducting officers joining ministries or departments on their specific operations. Specifically the induction aimed to assist staff in understanding the key requirements and contexts of their jobs; enable staff to find and access the tools and resources they need; understand the mission, vision, purpose and core values of the MOH; and develop strong working relationships with other staff. A total of 819 new hires (95%) received induction training. The onsite component comprised a one-week orientation to the facility. The audience for the training was newly appointed, transferred, re-designated and promoted officers under the Capacity Project and other MOH staff. In addition to the Capacity Project handbook, participants were provided with a copy of the standard MOH induction handbook.

All the newly recruited hires were inducted within the first three months of employment, as required by the PSC. Almost all of the key informants indicated that this is an aspect of recruitment that has been largely ignored by the MOH, with the majority of long-term MOH health workers consulted at the facility level not having undergone any form of induction or orientation. The induction program was seen to be innovative and has been well received by the new hires, colleagues and staff at the facilities, as well as other stakeholders. One informant said the induction program was "very innovative;" another mentioned that it was "a good initiative." In general, the induction initiative is appreciated by the new hires, their colleagues, managers at the health facilities and stakeholders alike.

Training

More than 20 years into the epidemic, HIV/AIDS has not been integrated into the basic training pre-service curriculum of health workers, including nurses and clinical officers. To ensure that the new hires were adequately inducted into the MOH system and to enhance the skills of the health workers to deliver HIV/AIDS prevention, care and treatment service, the Capacity Project conducted the following four types of training in three phases:

- Induction Training (two days offsite plus one week at facility or on-site)
- Home-Based Care (HBC) for people living with HIV (PLHIV) (nine days)
- Prevention of Mother-to-Child Transmission of HIV (PMTCT) (eight days)
- Integrated HIV/AIDS Prevention, Care and Treatment (IPCT) (eight days).

The training was attended by a total of 819 new hires, as shown in this table summarizing the participants and courses attended.

Table 9: Distribution of Participants (New Hires) by Course

Phase	Dates	IPCT	PMTCT	HBC	Total
I	May 15 to 26, 2006	80	-	-	***80***
	June 26 to July 7, 2006	32	-	-	***32***
II	September 11 to 22, 2006	82	17	229	***328***
III	November 13 to 24, 2006	74	29	198	***301***
	February 12 to 23, 2007	28	-	50	***78***
	Total	**296**	**46**	**477**	***819***

Training of Trainers (TOT) in IPCT: Prior to conducting the IPCT training, the project carried out TOT activities in order to develop a core team of trainers. This course aimed at imparting participants with requisite knowledge, skills and attitudes to provide comprehensive care of PLHIV including counseling and testing, preventive therapies, diagnosis and treatment of opportunistic infections, rational use of antiretroviral agents, care of children and women infected with HIV and programmatic issues in HIV/AIDS care; it also covered ethical and legal issues in care of PLHIV, commodity management for HIV/AIDS programs and monitoring and evaluation (M&E) of HIV/AIDS program interventions. In addition the course aimed to enable participants to facilitate effective learning and knowledge transfer to other health workers. Conducted by AMREF, the 12-day course was held from March 27 to April 11, 2007, and was attended by 15 participants from Coast, Eastern, Central, Nyanza, North Eastern, Rift Valley, Western and Nairobi provinces. Participants were drawn from the various cadres (i.e., nurses, clinical officers, pharmaceutical technologists and laboratory technologists). On successful completion, trainees subsequently cascaded training to newly hired health personnel in different government facilities in Kenya.

Integrated HIV/AIDS Prevention, Care and Treatment: The main objective of this course was to equip health personnel in primary care settings to deliver effective holistic HIV treatment, care and support. A typical health worker in a primary care environment in the region will be working in the delivery room in the morning, at Maternal and Child Health in mid-morning and at the Out-Patient Department in the afternoon. The approach of this course was to equip such a worker to integrate HIV prevention, care and support as part of a standard package for those seeking care. Specifically the eight-day course aimed at imparting participants with requisite knowledge, skills and attitudes to enable them to provide comprehensive care of PLHIV including counseling and testing, preventive therapies, diagnosis and treatment of opportunistic infections, rational use of antiretroviral agents, care of children and women infected with HIV/AIDS and programmatic issues in HIV/AIDS care. This course was offered by AMREF and targeted for a wide range of cadres including medical laboratory technologists, registered clinical officers, pharmaceutical technologists, registered nurses and enrolled nurses. A total of 296 participants attended this program.

PMTCT: The goal of this course was to build the capacity of health workers to offer PMTCT services. This course, conducted by AMREF, offered participants the background to provide comprehensive care and support to HIV-infected women and implement integrated PMTCT services in health facilities to improve the quality of care to all women and children. The course targeted registered nurses and was attended by 46 participants. The eight-day course also included a half-day field practicum in a clinical site at the Mbagathi District Hospital. The pre-test

assessment indicated that the knowledge level was fair, with a mean score of 68%. The post-test mean score of 90% indicated there was significant improvement in the knowledge level and attitude of the participants.

HBC: The aim of this nine-day training was to improve the care of people infected and affected by HIV/AIDS by the multidisciplinary care team through networking, linkages and multisectoral collaboration. During the six days of the taught unit, participants were encouraged to begin focusing on their work stations in view of transferring theory into practice when they returned to their areas of work after clinical placement. Participants were placed for three days within nine clinical placement sites in Nyanza province, from where they observed best practices they could replicate back at their work stations. A total of 477 Kenya enrolled nurses attended this course. It was adapted for the new hires from existing training materials from KMTC, Kisumu. Evaluation of the training indicated that there was marked improvement in post-test scores as compared to the pre-test scores.

The following case study from Lopiding Sub-District Hospital in Turkana, prepared by the Capacity Project's Knowledge Management unit, provides an example of the impact the new hires are having on service delivery.

Making an Impact: Transforming Service at a Remote Hospital in Kenya (Excerpted from Voices from the Capacity Project no. 7, May 2007)

"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," recalls Nakalale Lesomoe, who lives in Kenya's remote Turkana District. She is describing the difficult transition when the International Committee of the Red Cross handed over Lopiding Sub-District Hospital to the Kenya Ministry of Health in June 2006, after running it for 19 years primarily to treat war victims from Sudan.

The change-over left the hospital with good equipment but few resources and even fewer workers. The Ministry posted permanent staff but "only one reported," says David Simiyu Nalianya, a nursing officer in charge at Lopiding. "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.

"But after a few months, community members found a remarkable improvement. "Around October, we started noticing a change in service delivery," reports community leader Phillip Ekwam. "Attitudes of the staff are now positive and patients are treated faster." The improvement came about due to the 14 health workers sent to Lopiding through the Emergency Hiring Plan (EHP) developed by the Capacity Project in collaboration with the Ministry of Health. Designed to increase the number of qualified professionals working in Kenya's public health facilities, the plan helped the Ministry expand access to treatment and care through the rapid hiring, training and deployment of 830 health workers at 198 sites.

At Lopiding, the EHP hires arrived to find a deteriorating facility. They quickly established order by insisting on cleanliness, updating inventories and producing regular documentation. Nalianya recounts that with the arrival of these motivated workers, the hospital embarked on community outreach. "We are now using the local chiefs to enlighten the communities through barazas [public meetings] about health issues and encourage them to come for services." The Capacity Project provided the hires with two weeks of training in integrated HIV prevention, care and treatment. "Before I came here, I was not even sure how to administer ARVs to children," admits Joseph Chebii Kiano. "With the knowledge I have gained, I feel equipped to manage a comprehensive care center." Cornelius Machage agrees. "In the medical college, we never covered anything on HIV. This training was such an eye opener!" The training also prepares the workers to improvise in hardship areas with limited electricity and resources.

One of the new hires, Peter Lomurukai, acknowledges the difficult conditions but asserts that "What I do is a calling to serve my people, and this requires dedication." Like Lomurukai, most of the EHP hires posted to Lopiding had personal ties with the community and requested the site. In the past, the Ministry of Health had deployed and transferred workers without considering such preferences, contributing to high attrition. The EHP interviews were held in sites across the country, helping to recruit workers with roots in rural areas who will be far more likely to thrive—and remain—in remote postings.

5.2 Post-Contract Absorption of New Hires

The EHP is intrinsically a stop-gap measure aimed at filling critical service delivery gaps that cannot immediately be met as a result of the nonavailability of the financial resources needed to increase staffing. From the outset,

agreement has been sought between the MOH and its implementing partners in terms of the absorption of EHP hires into the MOH's regular personnel emoluments (PE) budget beyond the three-year fixed term contract period. This necessitates that requisite approval and funding of these posts be adequately incorporated within the MTEF, which must be achieved against a backdrop of GOK-adopted wage expenditure limitations. These limitations, although not specifically targeted at the health sector, require that the government's overall wage bill be kept in check[10]. However, recent GOK concessions have enabled the health sector to hire additional health workers on the condition that it is able to secure the extra funding needed from donors and development partners.

From a practical perspective, the GOK has given leeway to the permanent secretary (PS) of the MOH in terms of the delegation of authority to hire. A process of lobbying on health sector staffing issues at both government and international levels was undertaken in 2003/04, with agreement made on the hiring of additional staff through external support, on the condition that this fit with existing schemes of service and that these new hires would be absorbed. EHP new hires, therefore, require GOK commitment on the appropriate budgetary provision for the post-contract period, which, following its approval, would then be reflected in a revised MOH staffing establishment for the coming years. In terms of the MTEF, this includes the need for three-year rolling budget projections with annual recurrent budget allocations to ensure that current EHP hires are reflected in both the proposed 2008/09 budget and subsequent budget planning cycles. This helps leverage the necessary fiscal space required to circumvent GOK PE ceilings for the duration of the three-year contract period, thus enabling the GOK to be in a position to absorb these staff at end of contract.

To date, the Capacity Project has worked closely with the MOH Planning Unit and the MPND to ensure that all of the EHP-supported posts are factored into MTEF budget forecasts. It is anticipated that the PE budget for 2007/08 and subsequent years will increase as the costs of EHP-contracted staff funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Clinton Foundation/Danida and USAID (including the Capacity Project and PEPFAR) are absorbed within the government payroll. The absorption of these staff means that an additional KSh 206m ($3.35 million)[11] is required for 2007/08. In 2009/10 a further 1,815 staff, recruited in September 2006 and funded by the Clinton Foundation/Danida and USAID, will be absorbed within the payroll at a cost of KSh 588m ($9.55 million) per year. The anticipated financial resources required for this are set out in Table 10 below.

Table 10: Financial Requirements for Contract Staff MTEF FY 2007/8-2009/10

Funding Source	Project	No.	Contract Start Date	Contract Expiration Date	Financial Requirements			
					2006/7	2007/8	2008/9	2009/10
GFATM	Malaria	344	Mar. 06	Mar. 08		14,442,327	57,769,308	57,769,308
	NASCOP	829	Mar. 06	Mar. 07	46,358,868	185,435,472	185,435,472	185,435,472
Clinton Foundation	HIV/AIDS	115	Mar. 06	Mar. 09			6,963,420	27,853,680
	Others	1039	Sept. 06	Sept. 09				192,647,295
USAID	Capacity Project	661	Sept. 06	Sept. 09				117,772,497
	PEPFAR	30	Mar. 06	Mar. 07	1,752,255	7,009,020	7,009,020	7,009,020
Total (KSh)		**3018**			**48,111,123**	**206,886,819**	**257,177,220**	**588,487,272**
Total (USD)					$781,551	$3,360,817	$4,177,770	$9,559,807

Source: MOH Human Resources for Health Strategic Plan: 2007/8 – 2009/10

5.3 Linkages to Other Capacity Project-Supported Interventions

During this period the Capacity Project has supported interventions that will have long-lasting fundamental change and transform HRH in Kenya through focusing on strengthening HRH policy, practice and procedures. The Project

[10] GOK current wage expenditure ceilings (i.e. set targets of 8.5% of GDP in 2006 and 7.2% of GDP in 2007) compare favorably with other African countries, where wage/GDP percentages are typically around 8% to 9% and above.
[11] Based on rate accessed June 11, 2008: 1 Kenyan shilling (KSh) = 0.01624 US dollar; 1 US dollar = 61.55849 KSh.

undertook activities to develop HR planning, leadership and management capacity as well as HRM systems, encouraged public sector reform and strengthened the performance of professional associations and regulatory bodies. These initiatives included:

- Piloting the Work Climate Improvement (WCI) initiative, an innovative site-based model for supervision and performance improvement
- Conducting the face-to-face Leadership Development Program
- Engaging in communication skills-building for professional associations and regulatory bodies
- Providing technical assistance to the GFATM in Kenya
- Managing USAID-funded local technical advisors that are seconded to the MPND and the Division of Reproductive Health and National AIDS Control Program in the MOH
- Strengthening long-term HRH systems through:
    - Facilitating the development of a national Human Resources for Health Strategic Plan: 2007-2010 for the health sector
    - Developing a National Health Sector Training Plan
    - Developing a Policy for Continuous Professional Development
    - Developing a human resources information system (HRIS)
    - Working to strengthen HRM by supporting audits, assessments and action plan development.

6. Key Findings and Lessons Learned

GOK support and funding through the MTEF is critical in terms of continuity and sustainability of the EHP. There is a conditional agreement between the GOK and EHP implementing partners (Capacity Project/USAID and Clinton Foundation/Danida) that all of the EHP-supported posts are to be absorbed into the GOK/MOH payroll at the end of the three-year contract, and in this regard the necessary adjustments to the MTEF have been made. However, there is no formal written agreement with the MOH to absorb these new hires. Following discussions in 2003/2004 with the GOK on health sector staffing issues, it was agreed that new hires be recruited to fill service gaps through external support, and later absorbed through subsequent establishment revisions as long as the posts fit within existing GOK schemes of service. As nursing schemes of service were only recently developed, this should make absorption of EHP-supported posts easier.

Respondents overwhelmingly agree that the EHP is having a positive effect on improving service delivery and attaining performance targets through the provision of critical health providers to areas of need; including an unknown number of facilities that had previously closed due to lack of available staff. However, given that the EHP is still in its infancy, any possible attribution of its impact on service delivery and health outcomes is difficult to ascertain at this stage.

The EHP has had a beneficial effect in reducing the pool of unemployed health workers. In particular, a significant number of unemployed graduates have been hired, thus providing a positive return on the investment in their training. Of the 4,466 suitably qualified applicants who were short-listed under the Capacity Project-supported EHP, 2,064 (46%) were unemployed (see Table 11); 71% of these were under the age of 30, which suggests that for many, their hiring through the EHP may have been their first employment after graduation.

Table 11: Status of Capacity Project Short-Listed Candidates

Status	Number	Percentage (%)
Unemployed	2,064	46%
In Private Employment	1,110	25%
In FBO Employment	465	10%
In MOH Employment	166	4%
Other	661	15%
Total	***4,466***	***100%***

Source: Adapted from Capacity Project figures (2007)

In addition to 866 EHP new hires through the Capacity Project and USAID, the Clinton Foundation, supported by Danida, achieved its planned EHP recruitment target of 1,120 health workers (680 enrolled community nurses, 340 registered nurses and 100 clinical officers). The planned recruitment target of 2,615 health workers for F/Y 2006/07, as laid out in the Joint Program of Work and Funding for the Kenya Health Sector, 2006/07-2009/10, was exceeded by around 65%, as 3,904 new recruits joined the MOH. Some of these were recruited to fill vacant MOH posts, but the majority (83%) are supported by EHP implementing partners (Table 12). Although fast-track recruitment expansion has been achieved through the EHP, this is mainly focused on GOK health services. The EHP is steadily helping to increase the number of available health workers at understaffed facilities[12]; however, there continues to be urban versus rural imbalances within the system, where many urban health centers continue to benefit from having more nurses available than there are approved posts. Although it remains difficult to secure employment in MOH facilities, direct MOH recruitment is carried out on a lesser scale; 670 posts were hired in F/Y 2006/07. These posts provide mainly for the replacement of corresponding annual staff losses, which are estimated at around 1,200 per year.

Table 12: MOH Staff Recruitment 2006-2007

Cadre	GOK	Capacity Project/ USAID	Clinton Foundation	GFATM/ NASCOP	GFATM/ Malaria	Total Recruitment 2006/07
Enrolled Community Nurse	300	560	680	119	390	***2,049***
Registered Nurse (Degree)	0	0	0	27	0	***27***
Registered Nurse (Diploma)	100	58	340	89	28	***615***
Clinical Officer	130	86	100	87	0	***403***
Pharmacy Technologists	80	36	0	23	0	***139***
Lab. Technologist	60	126	0	47	49	***282***
Social Workers	0	0	0	27	0	***27***
VCT Counselors	0	0	0	232	0	***232***
Health Records Officers	0	0	0	52	0	***52***
Accountants	0	0	0	78	0	***78***
Totals	***670***	***866***	***1,120***	***781***	***467***	***3,904***

Source: JDM Report: 2007, including MOH Integrated Personnel and Payroll Database November 2007 updates

The PS has the delegated authority to hire under the EHP on condition of available donor support. All direct hiring is carried out by the MOH in compliance with relevant public sector recruitment policies and guidelines, where recruitment and secondment is guided by the DPM's Public Service Recruitment and Training Policy: May 2005 (PSRTP). The guiding principles of the PSRTP state that "meritocracy be promoted in recruitment; with competitive selection on the basis of merit; transparency applied in the selection process, both at the level of entry and promotion; and that promotion be made on the basis of acceptable appraisal results." In terms of staff secondment, the PSRTP outlines that "guidelines will be developed and issued to indicate deserving areas for staff secondment; procedures established on selection of staff for secondment; all permanent and pensionable staff are eligible for secondment; and, that secondment is strictly limited to 3 years." By ensuring proactive collaboration with government agencies and compliance with these existing government recruitment processes, the EHP initiative has engendered increased trust between key stakeholders and thereby enhanced ability to influence change within the sector.

A large amount of time, effort and resources are directed towards existing government recruitment processes. This is due, in most part, to the number of parties involved at various stages of the recruitment and deployment

[12] Given that the EHP is only at the mid-term stage of its implementation, attribution of impact is difficult to ascertain at this point in time.

cycle, including bodies external to the health sector such as DPM, Treasury and PSC. For example, of a total of 571 health sector vacancies advertised by the PSC in May 2006, only 230 had been successfully appointed by February 2007, fully nine months later. In addition, there are persistent delays in terms of confirmation of appointment for employees; according to the MOH HR Mapping and Verification study of 2004, 40% of positions experienced some delay. These continued inefficiencies in recruitment and deployment waste time and resources, which ultimately affect service delivery as they ensure perpetual delays in rapidly deploying health providers to areas of need.

A majority of respondents perceived the selection and appointment process to be transparent and open. Interviews were held at various provincial locations, with interview panels set up to conduct the process, chaired by the provincial medical officer. These panels included a representative from Deloitte as an observer of the process. Despite this perceived transparency, it was noted that in some instances applicants were not posted to their preferred choice, candidates were selected from FBOs and that preference was given on the basis of home district.

Informant discussions suggest that nepotism, political patronage and cronyism remain significant factors for access to employment in the public service, promotion and posting to favored urban locations. There are indications that despite moves towards increased transparency and openness (e.g., the publication of short-lists, interviews, successful candidates, etc.), public sector recruitment, appointment and promotion processes remain highly personalized and beset by frequent attempted and actual manipulation. Given the frequency and widespread nature of external manipulation of the prevailing public sector recruitment process, it is not surprising that informants often perceive government recruitment and appointment decisions as unfair and lacking in transparency.

The emphasis placed on transparency in staff hiring is a direct response to the long-standing problems and inconsistencies experienced in government recruitment. To give an example, back in 2004 the Kenya Wildlife Services (KWS), under the Ministry of Tourism and Wildlife, undertook the recruitment of an estimated 2,000 game rangers. The results of this recruitment process were controversial; the exercise was riddled with irregularities that eventually led to the dismissal of the executive director of the KWS. Three years later, the associated court case continues to attract the attention of the national media. The time spent developing systems and procedures for the EHP are therefore justifiable, given these types of problems. While the Capacity Project was establishing a case for the EHP with the MOH, the GOK was in the process of negotiating an agreement with the Millennium Challenge Corporation (MCC). The ongoing MCC pact negotiations and added public opinion against corruption meant that the timing was ideal to make changes within the MOH, in particular as the MCC was looking towards the MOH as a benchmark for approving a pact with Kenya.

External recruitment and appointment is not a new phenomenon in the public service. Recruitment of qualified and experienced individuals from the private sector has regularly taken place through professional recruitment and executive placement agencies. Therefore, the use of Deloitte as a key implementation partner for the EHP represents nothing new to the public service. The use of private sector agencies adds value to the GOK's recruitment processes, specifically in terms of leveraging joint public-private sector partnership to establish and further develop best practice in recruitment. Additionally, the inputs of Deloitte have helped facilitate and institutionalize simpler and more efficient administrative systems and processes in recruitment, as well as the innovative use of electronic-based short-listing and screening, all of which have significantly reduced the amount of time and resources required.

The management and implementation of the Capacity Project EHP payroll through Deloitte ensures that not only are new hires efficiently fast-tracked into government service, they are in most cases paid both regularly and on time. However, long-standing delays and infrequent payment of salaries permeates the public sector, and this has also had an effect on EHP hires supported through Danida/Clinton Foundation, where the payroll is both managed and processed by the MOH. Given that the ongoing public sector reforms program is embracing and rolling out results-based management interventions, including the use and application of individual performance contracts, it is imperative that delays in payment of salaries and other systemic shortcomings are eliminated if these interventions are to be effectively implemented and institutionalized.

In contrast to the external payroll management function provided by the Capacity Project and Deloitte under the EHP, MOH ownership is being supported under Danida/Clinton Foundation through the transfer of funding to

treasury and the direct payment of salaries through the MOH. This is carried out using a separate payroll and personnel system, administered by the MOH HRM Department, specifically designed to support implementation of this initiative. However, there have been logistical problems in that salaries are often paid late and in cash. To counter this, the Clinton Foundation and Danida are putting in place an electronic payroll system to ensure that all EHP hires receive electronic payment direct to their bank accounts when this system was to go live from January 2008.

Following a prolonged health worker strike in 2005 over terms and conditions of service, an estimated 600 nurses, doctors and clinical officers were rapidly recruited by the MOH on six-month contracts to fill gaps in service delivery[13]. However, this exercise was carried out in haste, and consequently many recruitment procedures were not properly followed. The MOH failed to follow up with the MPND (Treasury) and the DPM to ensure that mechanisms for regularizing their employment with the MOH on a long-term basis were in place. Immediately following the strike, around 1,600 health workers, mainly nurses and clinical officers, were dismissed from service, including these 600 contract health workers.

The majority of respondents view induction and training as innovative aspects of the EHP. The induction program has been very well received by the new hires, colleagues and staff at the facilities as well as by other stakeholders. Although induction is a requirement under the normal public service recruitment process, according to a majority of informants it is an aspect that is commonly neglected.

WCI initiatives were developed and implemented to complement the Capacity Project's support to the EHP, including workplace safety, waste disposal, employee recognition, etc. The WCI is a pilot initiative to improve work climate in ten facilities in Coast, North Eastern, Western and Nyanza provinces. Initial baseline data on job satisfaction has been collected in ten intervention and ten control sites. Facilitated through the Capacity Project, teams at selected facilities have developed action plans of simple low-cost interventions that will improve the work climate. These action plans are monitored by a Capacity Project team; initial reports indicate that some facilities have been successful in implementing activities that have led to improved service delivery and an enhanced physical environment. Plans are in place to repeat the job satisfaction survey in the near future to determine any changes in job satisfaction that may be attributable to the work-climate interventions.

A mid-2006 evaluation of the roll-out of the pilot Danida/Clinton Foundation EHP initiative indicated that 120 nurses were initially deployed in January 2006 to four pre-selected districts, with follow-on expansion to approximately 500 additional nurses by August 2006. However, ongoing monitoring through MOH remains problematic and it is difficult to establish regular status updates of where the EHP hires are presently working, and any level of fluctuation against the original total hired.

The Capacity Project EHP hires are required to submit regular signed monthly timesheets, which are a pre-condition for payment. In addition, a joint MOH/Capacity Project team conducts regular supervision visits to EHP sites. Both of these initiatives are causing tension between the MOH and the Capacity Project. The MOH stance is that it sees these as a fundamental part of its core functions and therefore is seeking to harmonize and institutionalize these initiatives within its existing systems to cover all MOH employees. Letters have been sent by MOH to health facilities where Capacity Project-supported EHP hires are in post, instructing management and staff to end the practice of timesheets and assessment and evaluations with immediate effect.[14]

An unanticipated side-effect of the EHP implementation program was the high number of FBO-based applicants, many of whom were subsequently short-listed, selected and appointed—a situation that arose as a result of insufficient checks and balances, and exacerbated by higher levels of remuneration and perceptions of better

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[13] These health workers were later dismissed from service; however the EHP-related job advertisement of May 10, 2006 explicitly encouraged this group to apply for the listed vacancies, requesting that they attach documentary evidence of where they worked at that time.

[14] Sample of a formal MOH letter sighted, sent from DMOH to Kaimosi Health Centre including letter from the PNO of Western Province containing reference made to April 11, 2007, correspondence by the PS with a clear instruction not to apply timesheets and parallel assessments. Further written instruction was given that there should be no direct communication with any MOH staff and the Capacity Project, except through the MOH (DN and/or HR Department).

working conditions at MOH facilities. Some of these nurses were hired from FBOs in spite of provisional assurances from the MOH to both the Capacity Project and Clinton Foundation that it would only engage unemployed and/or economically inactive health workers. In order to get the nurses to return to their FBO facilities the MOH agreed to let them retain the salary increment that they had received on appointment by the EHP program.

According to some, MOH secondment to FBO facilities was poorly coordinated; seconded EHP-hired nurses were reportedly deployed for duty at FBO facilities without any advance notice from the MOH. There are further reports that a small number of EHP nurses were seconded by the MOH to FBO facilities but did not report for duty, and others left soon after posting, which may indicate that these nurses were not given any choice in the posting decision.

A total of 186 nurses were short-listed from 12 FBO hospitals (Table 13), amounting to approximately 10% (87) of the total number of nurses (883) in the 12 FBO facilities shown in Table 13. For example, from Githumu Hospital in Maragua District, 36% of the available nurse workforce in this facility was recruited. A consultative team (MOH/Faith-Based Health Services Technical Working Group) was established by the PS of the MOH to look into these issues and monitor the effects on FBO staffing. The resultant closure of facilities forced FBOs to seek dialogue with the Head of State to resolve the situation. Immediate action was initiated by the PS, with the publication of a media advertisement (*Daily Nation*, September 16, 2006) instructing those FBO health workers recruited by the MOH to return to their former duty posts. However, in spite of this, those health workers hired in December 2006 under the Clinton Foundation program were still re-deployed to MOH facilities.[15]

Table 13: Summary Data on MOH Nurse Recruitment from CHAK Hospitals

Hospital	District	# of Nurses Short-Listed by MOH	Total Nurses at Facility	# of Nurses Recruited	% of Total Nurses at Facility
Kapsowar	Marakwet	19	24	6	25%
Lugulu	Bungoma	14	29	9	31%
Kendu	Migori	15	47	10	21%
Maseno	Kisumu	10	31	4	13%
Kikuyu	Kiambu	31	105	22	21%
Litein	Buret	20	68	10	15%
Githumu	Maragua	5	14	5	36%
Mt. Kenya	Kirinyaga	3	11	2	18%
Kijabe	Kiambu	29	134	8	6%
Tumutumu	Nyeri	14	72	3	4%
Chogoria	Meru South	10	174	4	2%
Maua	Meru North	6	174	4	2%
Total		***176***	***883***	***87***	***10%***

Source: Adapted from CHAK Times, December 2006-January 2007, Issue 23

FBOs are attempting to follow public sector staffing standards and norms within the confines of restrictive budget limitations for recurrent expenditure (i.e., 56% to 70% of recurrent expenditure is allocated to health worker costs across various FBO providers). There are persistent concerns among FBO members that the sustainability of EHP deployed hires has not been addressed beyond the term of the current three-year contractual commitment, supported by the Capacity Project and Danida/Clinton Foundation.

There are perceptions among FBO health workers that "pull" factors toward MOH employment include: better pay and terms and conditions; more job security and financial stability; better working environment due to higher staffing levels and reduced workloads; and opportunities for advanced training and development. The HRH situation in FBO facilities requires concerted attention and close cooperation with the MOH, GOK and

[15] From discussions with Dr. Samuel Mwenda Rukunga, general secretary, CHAK.

development partners, which has necessitated the decision by the Capacity Project to agree to support a HRH focal person on a temporary fixed-term contract, to be shared jointly between CHAK and Kenya Episcopal Conference (KEC).

The Christian Health Association of Kenya (CHAK) received an allocation of 20 doctors and 20 nurses in 2007, newly hired and deployed on secondment through MOH. However, CHAK and other FBOs have limited input to MOH decision-making on additional staffing allocations and numbers required.

Perceptions persist within the MOH and other implementing partners that EHP hires under the Capacity Project are singled out for preferential training, orientation, supervision, etc. and that these should be provided to all new hires regardless of source of support to avoid unnecessary divisions. In terms of induction, this should normally be applied, in line with public sector regulations, within three months of joining the civil service. However, the vast majority of MOH informants—many of whom have been in government service from one to ten years—declared that they are yet to receive any formal induction.

At the time of the in-country evaluation the GOK announced that civil servants would receive a 16% pay increase, backdated to July 2007. The increase is applicable to approximately 107,000 "unionizable" GOK employees in job groups A to L, at a cost of around 2.6 billion KSh. As this award was not included in the approved budget for FY 2007-2008, there are concerns about how this additional cost will be met by implementing partners for the EHP-supported hires, both in the current and subsequent financial years.

7. Recommendations and Way Forward

Building on the value-added gains from the use of a private sector recruitment agency (Deloitte), the MOH should continue to benefit from the potential cost, efficiency and time savings that have been made from outsourced recruitment. For example, the EHP has helped the MOH gain valuable expertise and systems support in terms of the development of a highly transparent and open recruitment process, supported and informed by the availability of accurate data and mechanisms to aid implementation. This should be done while at the same time retaining MOH accountability and oversight in terms of establishing clear objectives and definition of tasks. Beyond the EHP, there is potential for both the GOK and the private sectors to engage in dialogue to further establish and institutionalize best practices and standards and practices in recruitment.

Despite success in terms of increasing the actual number of available staff through the EHP, the burning issue of re-deployment of the existing HRH base is not being adequately addressed and requires additional policy support, implementation guidelines and enforcement. The skewed distribution and deployment of the existing health workforce, and resultant imbalances between rural and urban facilities, remain key challenges that the health sector in Kenya is facing. Increased focus on decentralizing recruitment and deployment will need to be coupled with imaginative strategies for attracting and retaining staff in rural areas and hard-to-reach facilities. The development, prioritization and costing of such strategies should, therefore, be a priority area of activity in the HRH Strategic Plan as well as the ongoing development of a national health sector deployment policy and plan to support implementation of the KEPH.

There is a pressing need for the Capacity Project/USAID, Clinton Foundation/Danida and other supporting partners to continue to facilitate high-level discussion and dialogue with all key stakeholders on how post-EHP absorption of all new hires within MOH and FBO facilities will actually be done. The net result of these discussions should yield a comprehensive plan for the post-contract integration of new hires, including buy-in and support at all critical levels of authority and implementation (i.e. Treasury, DPM, PSC, PSRS, MOH, DP, FBO, etc.). In terms of the adjustment to the MTEF, the Capacity Project and other supporting partners have worked closely with the MOH Planning Unit and the MPND to ensure that this is now in place. The next step is to ensure a seamless transfer of all EHP supported posts into the MOH mainstream and staffing establishment.

All EHP supporting partners should continue lobbying the MOH and GOK to help expand the EHP support program toward meeting the service delivery needs of the sector, including the FBO sub-sector. The MOH will need the ongoing support and assistance of the Capacity Project/USAID to help leverage additional resources to

address the financing gap for this, which will be established within the context of planning to acquire the numbers and types of mid-level service needed to deliver the KEPH[16].

The Capacity Project should lend its support to MOH to help establish and implement appropriate strategies to find ways around recruitment restrictions on new posts, increase the number and type of established posts and mobilize additional resources toward financing of an expanded wage bill. In particular, immediate priority must be given to discussion and agreement on existing MTEF spending allocations, which are generally pegged at around 7.5% to 8.5% of GDP in terms of the total government wage bill. Without this, any further increases in the number of available posts, and corresponding improvements in service delivery, will be limited, with resultant and persistent establishment restrictions in place and continued inability to match staffing to projected KEPH targets.

Future USAID/Capacity Project support should be provided to target MOH systemic and HRH management weaknesses. This can be done in the terms of institutionalizing best practice in the context of ongoing public sector HRM reform initiatives where possible, rather than through the development and implementation of parallel systems and processes—thus avoiding unnecessary friction between the MOH and Capacity Project like that which resulted from the stand-off over the use of timesheets and evaluation visits.

Delays in recruitment processes and time frame are due to central-level capacity limitations around the handling of public service recruitment, thus there is a need to decentralize this process as much as possible with appropriate controls, checks and balances put in place. Decentralized deployment, as demonstrated by the EHP process, can improve the equitable distribution and utilization of essential health providers against KEPH service demands and gaps. This will not only speed up the process of filling vacant posts, but will reduce the high transaction costs of centralized recruitment, as well as limit the opportunity for manipulation of the process. With the Capacity Project's support, the MOH has just completed developing a health sector Deployment Policy that will hopefully go some way toward addressing this matter in a more systematic way.

Random *ad hoc* transfer of MOH staff persists, driven by highly centralized HRM systems and implementation processes. There is a need for sensitization on how HRM roles and functions can support, rather than undermine, effective KEPH service delivery at provincial, district and facility levels, with specific focus on how district-based recruitment and deployment decision-making can be further supported and strengthened.

[16] Ministry of Finance Budget Strategy Paper indicates that "…wage policy measures will allow flexibility for recruitment of medical personnel to reach optimal levels for the health sector and move toward achievement of Millennium Development Goals." (source: HRH Strategic Plan: 2007/08-2009/10)

Postscript

In several crisis countries severely affected by HIV/AIDS, especially in much of sub-Saharan Africa, popular movements to rapidly mobilize additional health workers to end the crisis in human survival continue to receive much focus and attention.

Similarly, the overarching intent of the EHP model when it was originally conceived and designed in Spring 2005 was the urgent mobilization and deployment of new workers to stabilize the existing workforce that was grossly overwhelmed by the HIV/AIDS crisis and to expand access to HIV/AIDS treatment, care and support services. In other words, the EHP innovation back then was largely viewed as a temporary "stop-gap or bypass" measure both by USAID/Kenya and health sector leaders in Kenya.

Over the years, the EHP mechanism and the implementation of its activities has evolved and actually morphed into a more coherent, flexible and viable staffing arrangement that is available to the public health sector in Kenya. This trend has generated some positive unintended consequences, including:

- The results of the WCI initiative in ten rural facilities that received EHP hires also demonstrated that mobilizing health workers in productive environments is central to any emergency action to urgently tackle any health crisis.
- Although mobilization was initially focused around combating HIV/AIDS, the new EHP hires were also deployed to many far-flung hard-to-reach sites where they provide other health services including FP/RH—and hence contributing to access and steadily building health systems.
- Contracting out, as an alternative and cost-effective concept of service delivery—not just for hiring staff but for other services like cleaning, facility maintenance, laundry, security and food services in hospitals—has now become a widely accepted intervention within MOH cycles in Kenya. Although contracting out can be a double-edged sword, especially if quality and other standards of contract management are not agreed upon and rigorously enforced, its overall merits are well documented.
- The EHP mechanism or its various derivatives are currently being used by other development partners and programs including DANIDA, GTZ, UNICEF and the Malaria Program to bring additional contract health workers into the system. A senior MOH Kenya official recently mentioned to me that they have close to 3,000 contract health workers (10% of the total health workforce) who work in government facilities across the country and are supported by different funding agencies or programs.
- During the post-election violence that gripped Kenya early in 2008, the EHP model was utilized to recruit and deploy 39 nurses (within a span of five days) to provide emergency health services in nine temporary camps holding thousands of internally displaced persons. The flexibility of the mechanism and its ability to respond to different and sometimes unforeseen needs of the health system has been lauded by health sector leaders in the country. Additionally, during a recent USAID/APHIA II Partners' quarterly meeting in Nairobi in April 2008, it was reported that some APHIA II programs in the provinces were also recruiting health workers, including counselors, to expand the reach of their program activities—and the director of medical services of the MOH who chairs all such meetings instructed that the EHP model should be used to avoid fragmentation. He cautioned that we need to follow an existing scheme that is working well already. Obviously, he was right because the dangers of fragmentation are especially high in low-income countries like Kenya that are dependent on external resources—and that are increasingly segmented into disease-specific efforts.

Sustainability

When the EHP was started, sustainability was not on the table at all. But as the work got underway—and

through effective action, learning processes and expanding our knowledge base—sustainability has been infused into the EHP conversation and implementation. The following concrete steps have been taken to ensure that the EHP hires are mainstreamed and absorbed into the regular workforce staffing and establishment following the expiration of their current three-year contracts:

1. A complete and parallel HRM filing system with payroll data (both electronic and individual paper files in fireproof cabinets) for all the EHP hires has been established at the HR Unit in the central MOH. This system will serve to ensure a seamless transition from the current Capacity Project-managed HRM system to one managed and supported by the MOH. This system provides basic workforce information and data to ensure that all EHP workers are counted (accounted for) and any trends and changes over time can be tracked easily—and that there are no data related gaps as the transition takes place.
2. A provisional transition plan has been discussed with the MOH. This includes generating and sharing a list of all EHP hires whose contracts are due to expire at least six months in advance so that they can plan and set in motion appropriate arrangements for their absorption as required by civil service rules and regulations—the most important of these being issuing each of them with indents and personnel numbers by the Public Service Commission.
3. The salaries for the EHP and other contract workers supported by other development partners have been built into the current Medium Term Expenditure Framework (MTEF) for the health sector. However, the MTEF process is complicated, and because it has a unique government expenditure projections cycle, there is often the danger that certain projected budget lines can be dropped, sometimes inadvertently. The MOH chief economist is helping to coordinate closely with the MTEF budget staff in the Ministry of Planning and National Development (MPND) to ensure that this important expenditure item is not lost or left out in all future MTEF projections. Similarly, the Capacity Project has one senior staff member seconded to the MPND who has excellent relations with senior staff there, so he too is keeping an eye.

—Ummuro Adano, Senior HR Management Systems Advisor, The Capacity Project (MSH)

June 2008

Annex A: Scope of Work

Consultancy to conduct a mid-term evaluation of the Capacity Project's Emergency Hiring Plan in Kenya
September 2007

Scope of Work

Context and Background

Like most countries in sub-Saharan Africa, Kenya has suffered from shortages of skilled health workers and managers. Over the years the situation has become a crisis largely because of the crippling effects of HIV/AIDS. Staff attrition rates are on the rise due to HIV infection, illness and death, as well as out migration of staff.

Despite the shortage of health workers in the public and private sectors, many recent graduates of health training institutions cannot find employment due to budget constraints and restrictions on personnel recruitment. Some cadres of trained health workers are underutilized because they cannot get jobs in their areas of professional training that maximizes their full potential and create opportunities for professional growth. Limitations on human capacity development are the most severe constraint to achieving both ART targets and Kenya's long term health objectives including the Millennium Development Goals.

To address these human resources for health needs, Kenya MOH, with technical assistance and financial support from the Capacity Project, designed and implemented an Emergency Hiring Plan, quickly recruiting, hiring and training 830 workers and deploying them in high-need areas. A prospective evaluation (referred to as EWM) is ongoing to track the effects of the program over the course of the three years of operation. However, for countries considering this strategy to increase HRH, a detailed description of the process to implement such a plan would be useful, together with a summary of findings to date and stakeholders' impressions of the plan and its impact.

Purpose

To identify useful lessons from the Emergency Hiring Plan in Kenya to provide information for other countries to decide on and undertake a similar plan.

Objectives, data sources and/or data types

Objective	Illustrative Data Sources
1. To provide a detailed description of the process instituted to recruit, hire, train and deploy the 830 Emergency Hires.	**Key informants:** • HR director, MOH • One or 2 PMOs eg NE Province(?by phone) • Capacity Project/Kenya staff representatives • Small sample of new hires (?) • Representatives from the Public Service Commission, and Personnel Management • MoF about getting the longer-term funding incorporated into the MTEF **Document review:** • Work plan and budget • Job descriptions • Job announcements and postings • Training materials • Deployment plan • Related Capacity Project/Kenya documents (e.g., Progress Reports, Voices)

Objective	Illustrative Data Sources
2. To determine the extent to which the Plan's short-term objectives of transparently recruiting, hiring, training and deploying 830 health care providers in high need areas were met.	**Key informants:** • PS • DMS • HR director, MOH • Capacity Project/Kenya staff • Public Services Commission • Department of Personnel Management (Cabinet Office – not to be confused with MOH) • Trainers • Lead development partner on health (or HRH, if there is one) **Document review:** • Deployment plan • Job descriptions • Job announcements • Training materials • Capacity Case Studies • If possible obtain a time series of staffing returns – either from two selected provinces, or at national level **HRIS:** • # of new staff by cadre, by facility type, by gender and by region • EWM data on staff morale, job satisfaction • EWM data on perceived staff preparedness, satisfaction with recruitment, hiring, training and deployment
3. To summarize lessons learned to date on what works and doesn't work in creating an emergency response to HR shortages.	**Key informants:** • HR director, MOH • One or 2 PMOs e.g. NE Province (?by phone) • Capacity Project/Kenya staff (director, • CHAK representatives • Public Services Commission • Personnel Management • Trainers • Lead development partner on health (or HRH, if there is one) **Document review:** • Case studies from Capacity Project
4. To determine and document the impact of the EHP on the wider labor market, with a special emphasis on its impact on faith-based organizations and on FBO staff availability.	**Key informants:** • HR director, MOH • Capacity Project/Kenya staff (director, • CHAK representatives • CHAK facility representatives • Catholic secretariat **Document review:** • Case studies from Capacity Project • CHAK Times, Issue No. 23, December 2006-January 2007 **HRIS:** • # of new hires last working in FBO facility

Objective	Illustrative Data Sources
	• # of new hires deployed to FBO facility • Staff morale, job satisfaction FBO, public sector
5. To identify any positive short-term collateral effects on the public sector (e.g., changes to the public sector hiring process, raising awareness of governance issues related to hiring) and any unintended negative short-term consequences (exposing inefficiencies, creating low morale among other health workers)	**Key informants:** • PS • HR director, MOH • Capacity Project/Kenya staff (director, • Public Services Commission • Personnel Management • Trainers (?) • Public Sector Reform Project **Document review:** • Capacity Case Studies **HRIS:** • EWM data on staff morale
6. To identify any long-term effects on the country's HRH work (e.g., pointing the MOH in the direction of core HRH issues that need to be addressed.)	**Key informants:** • PS • HR director, MOH • Capacity Project/Kenya staff (director, • Public Services Commission • Personnel Management • Trainers (?) • Public Sector Reform Project

Data Collection Strategy

- Document Review (Existing country and project documents)
- Interviews with key informants
- Human Resources Information System

Stakeholders

The health sector in Kenya has a very diverse range of stakeholders. The following government agencies, training institutions, professional associations, nongovernmental and faith based bodies, and private sector players need to be aligned and engaged so that they direct their collective efforts and support this process from the outset:

- Primary Stakeholders/Customers
    - USAID Mission: Kenya (Dr Bedan Gichanga, Janet Paz-Castillo)
    - MOH (Permanent Secretary, Director of Medical Services), National AIDS Council, NASCOP
- Other key government agencies
    - Directorate of Personnel Management
    - Public Service Commission
- Providing data
    - MOH: Planning Unit & Office of Senior Principal Personnel Officer
    - Deloitte and Touche, EMG (Victoria Francis in US, John Kairie in Nairobi)
    - Christian Health Association of Kenya (Dr Mwenda)
    - Catholic Secretariat (Health Coordinator)
- Contributing Stakeholders
    - Capacity Project, Nairobi
    - IMA, Nairobi
    - MSH, Nairobi (Dr Michael Thuo, Ida Grum)
    - JHPIEGO, Nairobi (Pamela Lynam)
    - Other interested donors and groups (??)
    - Other ongoing initiatives (Clinton Foundation?)

Activities
The following activities are illustrative of tasks to be undertaken by the two consultants:

1. Complete a desk audit of all available documents. Become familiar with the HRIS data on new hires and analyze the data to understand the EHP's scope and impact (1 week).
2. Complete visit to Nairobi. Hold key informant interviews with all appropriate stakeholders (2 weeks).
3. Develop a report addressing all objectives above (1 week).

Agenda/Schedule

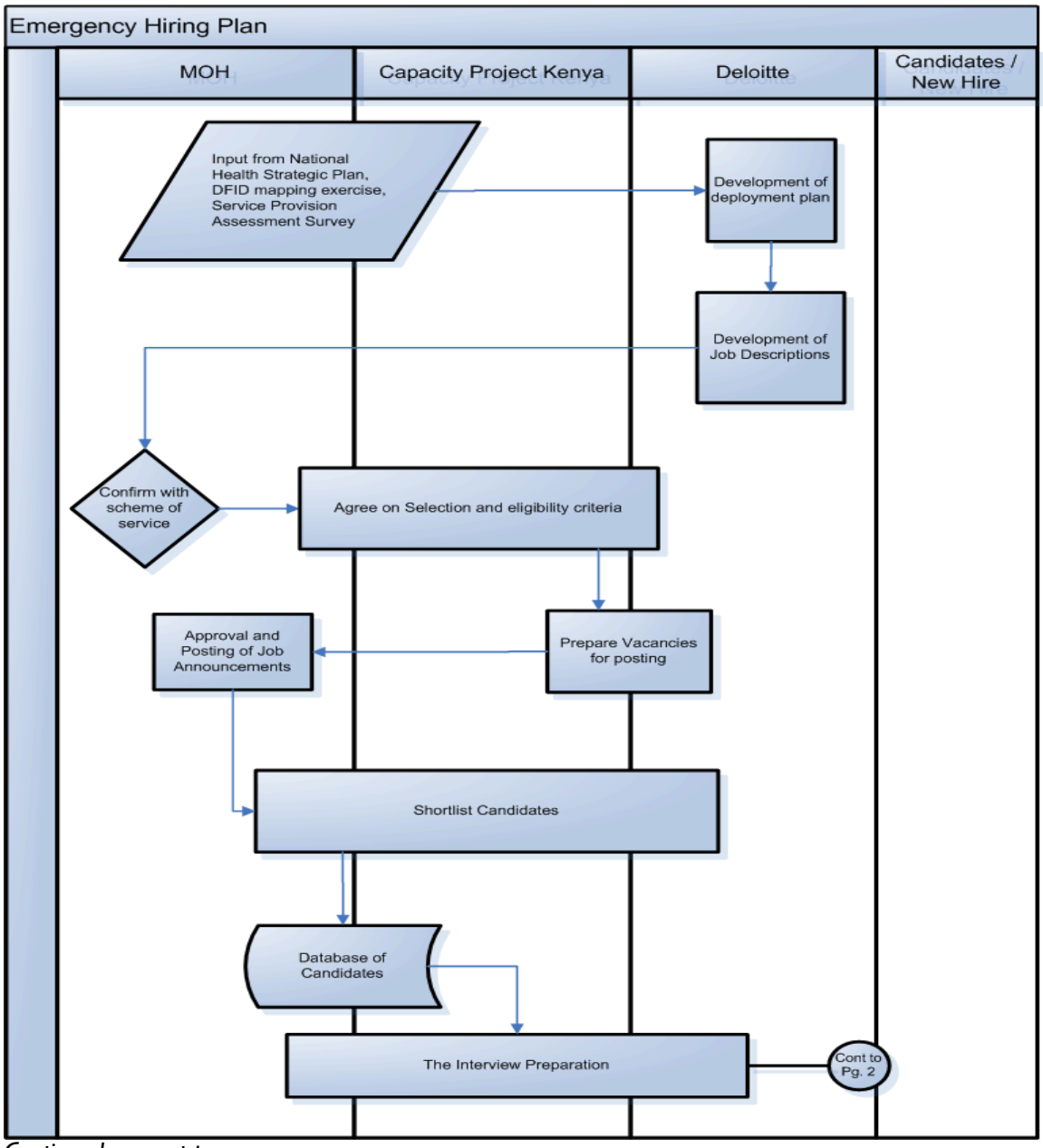
- Country visit in September, October
- Complete report in October, November.

Deliverables

1. **A short trip report** that provides a synthesized summary of all existing information and meets the objectives stated above.
2. **Debriefing presentation** with similar content
3. **Assessment report** (within 4 weeks of first visit)

Reporting
At the end of the initial visit the consultants will arrange a pre-departure debriefing session with USAID, MOH, and other primary stakeholders to present preliminary key findings and recommendations.
Both hard copy and electronic versions of all reports will later be submitted to the Capacity Project, USAID and Ministry of Health.

Annex B: Capacity Project EHP Process Flow Chart



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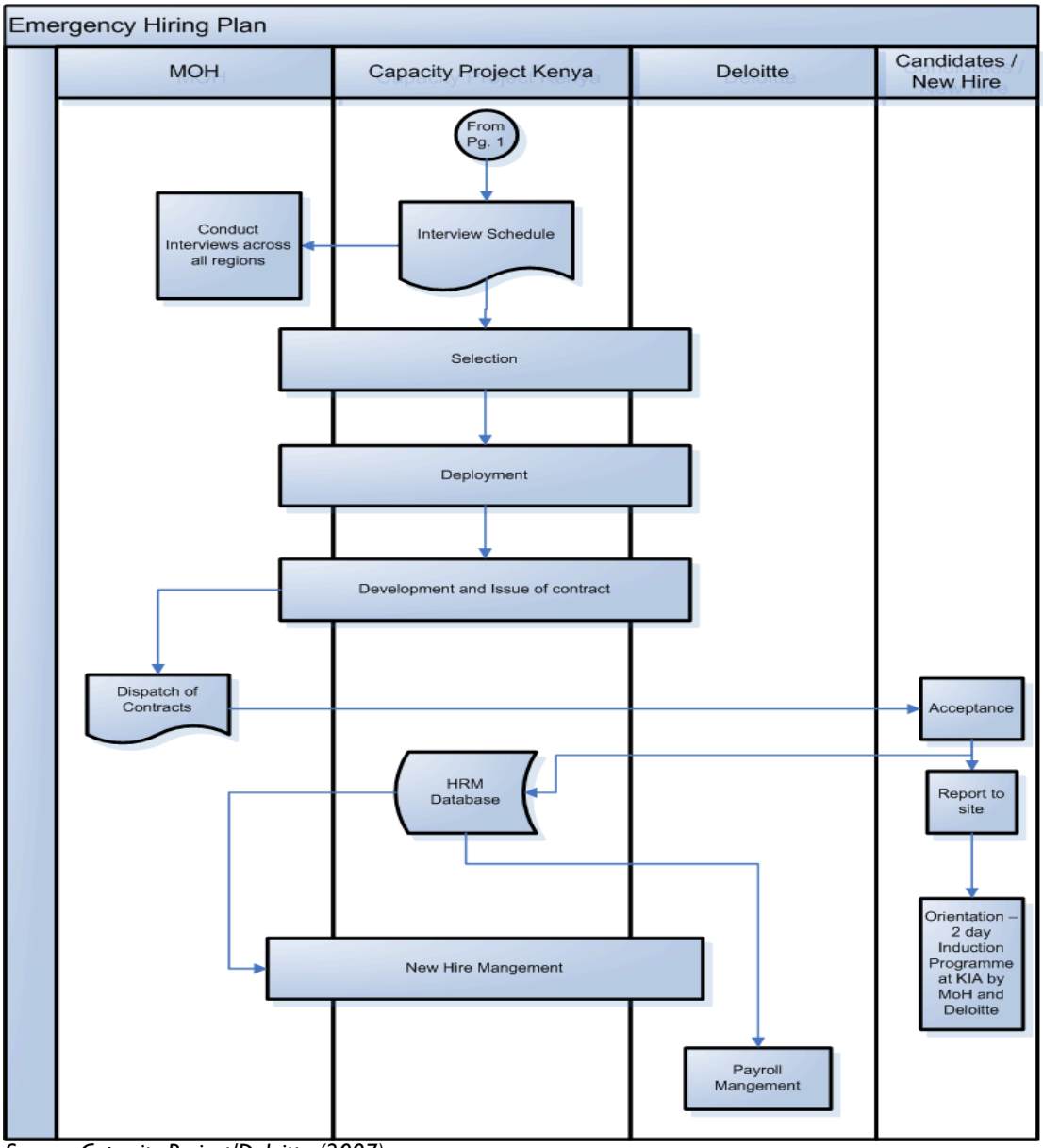

Source: Capacity Project/Deloitte (2007)

Annex C: List of Informants

	Organization	Name	Designation
1.	Apex Communications	Mr. Lawrence Gikaru	Managing Director
2.	Capacity Project/Kenya	Mr. Kimani Mungai	Kenya Programme Director
3.	Capacity Project/Kenya	Ms. Catherine Namanda	Senior Programme Officer
4.	Capacity Project/ Kenya	Mr. Charles Mito	Knowledge Management Manager
5.	Capacity Project/Kenya	Ms. Jane Mmaye-Kibisu	HR Functions Manager
6.	Christian Health Association of Kenya	Dr. Samuel Mwenda	Secretary General
7.	Danida	Ms. Rhoda Njuguna	Programme Officer: Health & HIV
8.	Deloitte, Management Consulting	Ms. Isabel Ngugi	Associate Director
9.	Deloitte, Management Consulting	Mr. Kimani Njoroge	Director
10.	Deloitte, Management Consulting	Mr. Pius Musyoki	Consultant
11.	Deloitte, Management Consulting	Mr. Charles Oduor	Principal Consultant
12.	Deloitte, Management Consulting	Mr. Francis Thairu	Consultant
13.	Friends Mission Hospital, Kaimosi	Ms. Christine Minayo	Nurse
14.	Friends Mission Hospital, Kaimosi	Dr. Solomon Kamau	Doctor
15.	Friends Mission Hospital, Kaimosi	Ms. Irene Gulavi	Nursing Officer in Charge
16.	Kenya Episcopal Conference	Dr. Margaret Ogolla	Head: Medical Services
17.	Kenya Institute of Administration	Mr. MOHammed Nura	Training Manager
18.	Kenya Institute of Administration	Dr. Margaret Kobia	Director
19.	Kenya Medical Training Centre, Kisumu	Ms. Juliana Misore	Training Manager
20.	Ministry of Planning & National Development	Mr. Stephen Wainaina	Planning Secretary
21.	MOH: Isinya Health Centre, Kajaido	Ms. June Chelangat	Nursing Officer in Charge
22.	MOH: Division of Reproductive Health	Dr. Josphine Kibaru	Head: RH Division
23.	MOH: Division of Reproductive Health	Dr. Nancy Kidulla	Technical Advisor
24.	MOH: Division of e-health and CPD	Dr. Esther Ogara	Head: e-health & CPD
25.	MOH: Human Resource Management Department	Ms. Anne Rono	Deputy Director
26.	MOH: Human Resource Management Department	Ms. Rael Rotich	Chief HRM Officer/HRMIS
27.	MOH: Isinya Health Centre, Kajiado	Mr. Fred Avoga	Clinical Officer in Charge
28.	MOH: Isinya Health Centre, Kajiado	Ms. Eunice Gitonga	Nurse
29.	MOH: Nyando District Hospital	Mr. James Ocharo	Nursing Officer in Charge
30.	MOH: Nyando District Hospital, Nyanza	Ms. Janet Belle	Nurse
31.	MOH, NASCOP	Dr. Ibrahim MOHammed	Head: NASCOP
32.	MOH: NASCOP/Capacity	Dr. Shobha Vakil	Technical Advisor, ART Programme
33.	Public Service Commission	Mr. Peter Macharia	Senior Assistant Director: HRM
34.	Public Service Commission	Ms. Caroline Kagete	HRM Officer
35.	USAID: Kenya	Ms. Melahi Corcurera Pons	Senior Health Sector Program Manager
36.	World Health Organization	Dr. Humphrey Karamagi	Health Economics & Systems Advisor

Annex D: Background References and Documentation

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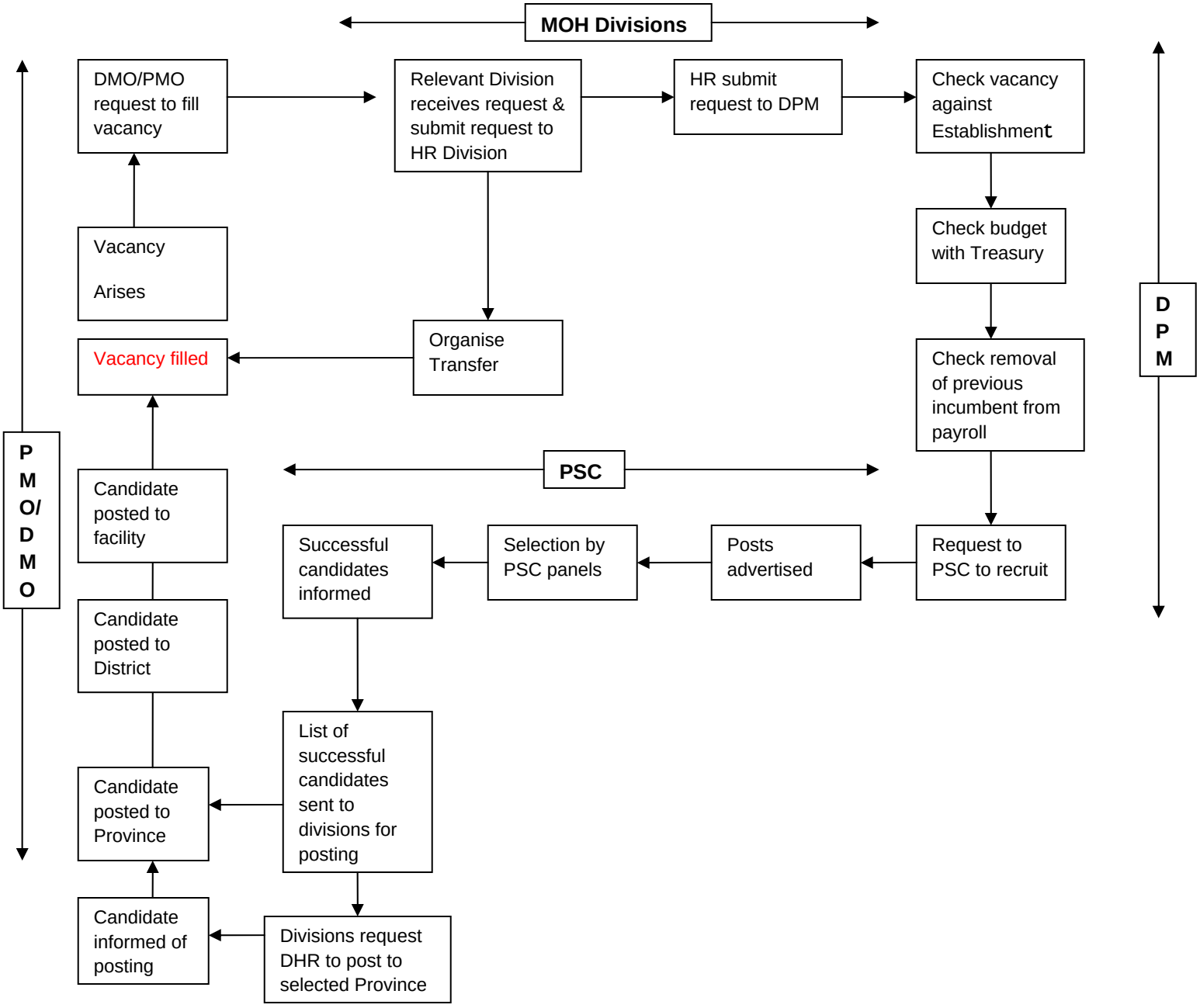
Annex E: Process of Filling a Vacancy



Source: MOH, 2007

Annex F: Monitoring and Evaluation Framework

Capacity Project M&E Framework and Performance Monitoring Plan (PMP)

PROJECT OBJECTIVES	MONITORING (Inputs, Processes, Outputs)	EVALUATION (Effect/Impact Indicators)		
	Indicators and Activities/Methods	**Indicator**	**Methods/ Instruments**	**Application (By whom, and when)**
Goal: Increase the capacity of the public health sector in Kenya (Ministry of Health) to rapidly mobilize additional qualified health workers and also strengthen long term HRH planning and management to expand access to HIV/AIDS services, meet PEPFAR targets and deliver quality health programs in priority posts in selected geographic regions.				
Objective 1: Develop and implement a fast-track hiring and deployment model that will mobilize 830 additional health workers and deploy them primarily in the public sector to urgently tackle the HIV/AIDS crisis.	**Inputs:** Staff, TA provided. salaries offered, training curricula. **Process:** Priority post identification process (descriptive narrative, Deloitte). Milestone completion of outputs as outlined in the Objectives and Activities matrix, baseline dates TBD. (Deloitte, IntraHealth) Recruitment and selection process (descriptive narrative, Deloitte) Number of applications received: 6,568 average time from receipt of application to deployment: 3.5 months **Outputs:** • Number of new hires selected 4,456 • Number of new hires interviewed 4022 • Number of new hires deployed 849 (disaggregated by cadre and gender (project records/Deloitte): • Number of new hires lost (e.g., rejected offer, resigned, died) 58 • Number of replacements 19	Number/% of new workers deployed who remain in post and providing services annually. *Links to PEPFAR indicator* 2006: 624 (100%) 2007: 791 (93%) Staff satisfaction at priority posts, disaggregated by emergency/regular staff, cadre, and gender CI #3: Workforce is realigned to better meet priority health objectives. CI #8.2 Evidence-based programs are being implemented to reduce turnover of high priority cadres	Project records/payroll, supervision records Staff satisfaction survey	Deloitte Records to be gathered monthly, reported quarterly. Training & Development Manager, RKM Manager. Baselines for regular staff to be established as sites are selected, but before deployment; follow up one year later, with additional intervals to be determined IntraHealth, Project Coordinator

PROJECT OBJECTIVES	MONITORING (Inputs, Processes, Outputs)	EVALUATION (Effect/Impact Indicators)		
	Indicators and Activities/Methods	**Indicator**	**Methods/ Instruments**	**Application (By whom, and when)**
Objective 2: Strengthen the existing systems and capacity for training and development of health workers both in the short and long term.	**Inputs:** Trainers, Curricula, trainees **Process:** Training needs assessment Milestone completion of outputs as outlined in the Objectives and Activities matrix, baseline dates TBD. (JHPIEGO, IntraHealth) TIMS database updates **Outputs:** Number of workers trained in 2 week HIV crash course, disaggregated by cadre and gender. *Link to PEPFAR Indicator* 2006: 741 2007: 78 Number of workers trained in 1 week FP update course, disaggregated by cadre and gender.	• % of trainees able to perform HIV care to standards at the conclusion of the 2 week crash course. (pre/post test) 819 (100%) • % of trainees able to perform FP to standard at the conclusion of the 1 week update course. (pre/post test) • % of new hires expressing confidence in ability to provide HIV services adequately • Staff satisfaction at priority posts, disaggregated by emergency/regular staff, cadre, and gender • CI #6.2 Professional council/association for a specific cadre has developed the structure and business acumen to be sustainable • # FP visits in high priority facilities • # FP methods distributed by type (long-term, permanent, barrier, natural, other) in high priority facilities	Training reports Payroll Data	IntraHealth; Training & Development Manager, RKM Manager; pre-post training. IntraHealth, Project Coordinator

PROJECT OBJECTIVES	MONITORING (Inputs, Processes, Outputs)	EVALUATION (Effect/Impact Indicators)		
	Indicators and Activities/Methods	**Indicator**	**Methods/ Instruments**	**Application (By whom, and when)**
Goal: Increase the capacity of the public health sector in Kenya (Ministry of Health) to rapidly mobilize additional qualified health workers and also strengthen long term HRH planning and management to expand access to HIV/AIDS services, meet PEPFAR targets and deliver quality health programs in priority posts in selected geographic regions.				
Objective 3: Design and implement a simple work climate improvement initiative in five additional sites to improve staff job satisfaction and aid retention as well.	**Inputs:** Staff time, supervision time, travel/communication costs **Process:** Supervision & Performance improvement models TBD **Outputs:** Supervision records Performance records	• Client satisfaction at priority posts • Staff satisfaction at priority posts, disaggregated by emergency/regular staff, cadre, and gender (also under Objective 1) • Number of clients served in HIV/AIDS comprehensive care sites in priority posts • Number of HIV patients receiving care at priority posts • Number of HIV patients receiving ART at priority posts • Number of new VCT conducted at priority posts • Number of new cases of HIV identified at priority posts • Capacity PMP indicator #14, improved performance management and support systems; #15, new supervision models piloted.	Client satisfaction survey, selected sites. Staff satisfaction survey, selected sites Facility service records	Training & QA Advisor Baselines established as sites are selected, but before deployment; follow up one year later, with additional intervals to be determined IntraHealth, Project Coordinator

PROJECT OBJECTIVES	MONITORING (Inputs, Processes, Outputs)	EVALUATION (Effect/Impact Indicators)		
	Indicators and Activities/Methods	**Indicator**	**Methods/ Instruments**	**Application (By whom, and when)**
Goal: Increase the capacity of the public health sector in Kenya (Ministry of Health) to rapidly mobilize additional qualified health workers and also strengthen long term HRH planning and management to expand access to HIV/AIDS services, meet PEPFAR targets and deliver quality health programs in priority posts in selected geographic regions.				
Objective 4: Select and implement a range of complementary interventions to strengthen Human Resources for Health policies, systems and practices in the Ministry of Health in order to provide an overall framework for comprehensive workforce planning, development and support.	**Inputs:** TA Provided, desk review **Process:** **Outputs:** Analytical document	TBD, Possibly Capacity PMP Indicator #3,and 4 Workforce is realigned to better meet priority health objectives; improved workforce performance support system		IntraHealth, TA providers

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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