The Kenya Emergency Hiring Plan: Results from a Rapid Workforce Expansion Strategy

Linda Fogarty, Jhpiego, and Ummuro Adano, Management Sciences for Health

Introduction

A worldwide shortage of health workers is challenging governments, donors and nongovernmental organizations to find solutions to meet growing health care demands. The Capacity Project-supported Emergency Hiring Plan (EHP) is one such solution, designed to quickly hire and train large numbers of qualified health workers and deploy them where they are most needed. The approach has attracted substantial attention from donors, nongovernmental organizations and national-level human resources for health (HRH) planners as a promising mechanism to rapidly expand the health workforce to increase service access.

Through the process of negotiating with the Government of Kenya (GOK) to implement a solution to the health worker crisis, the EHP opened a window of opportunity for HRH strengthening and provided an influential model for good governance.

The EHP Context

When the Capacity Project started working in Kenya in 2005, the GOK had committed to ambitious Millennium Development, President's Emergency Plan for AIDS Relief (PEPFAR) and National Health Services Strategic Plan goals that were not achievable without more health workers to implement an array of government and donor-funded projects. As the burden of HIV care in facilities grew, Kenya also had a surplus of unemployed health workers because worker training and development had outpaced recent hiring goals. The conditions were right to hire and deploy more health workers.

However, the conditions for change were not enough on their own. In working with many ministries of health we frequently hear, "This is what the policy says…we have always done it this way." Often an elaborate set of assumptions are in place but not necessarily visible to those outside the organization. To understand and navigate such an organizational culture and still present an alternative approach to overcome a persistent challenge requires "strategic patience"— waiting for mutually appropriate opportunities to inch forward on common ground while holding firm on critical program features.

Identifying the need was easy. A detailed HRH mapping exercise had revealed that although staffing norms were being met in high population density settings, staffing in rural areas was entirely inadequate (James and Muchiri, 2006). With this information the Ministry of Health identified staffing gaps across facilities and districts for five cadres— registered clinical officers, registered nurses, enrolled nurses, lab technologists and pharmacy technologists—totaling 7,773 individuals. The GOK requested that the Capacity Project and other partners quickly hire and deploy health workers across the country. The hard part would be agreeing on an approach.

The EHP in Action

Capacity Project staff worked with the Ministry of Health, the Directorate of Personnel Management in the Office of the President, the Ministry of Finance and African Medical and Research Foundation (AMREF) to design an acceptable recruitment and hiring process that outsourced hiring and employment management to a local private-sector organization (Deloitte and Touche, Kenya).

The features of the approach—transparent hiring, standardized interviewing, criteria-based selection—were straightforward. Yet some stakeholders were reluctant to change the system and feared political reprisals. Some of the initial meetings were tense, and characterized by frequent breakdowns. We soon realized that the application of authority, power and influence over human resources in terms of who trains, recruits and deploys is not just a management concern; it is profoundly political and touches on critical aspects of governance. This was not just a workforce mobilization project to strengthen services in the health sector—it was becoming a governance project. Steadfast negotiations over eight months, involving three permanent secretaries and, at times, high-level interlocutors from both sides, slowly led to a mutually acceptable approach culminating in its initial implementation and 393 providers graduating in seven sites in August 2006. What was considered impossible even six months prior had begun to encroach, albeit in a small way, into the language and practice of the Ministry of Health.

Key EHP Features

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

(Adano, 2008; Marsden and Chirchir, 2008)

Common EHP Misconceptions

The EHP is not:

- *A quick fix that takes the burden off the Ministry of Health*
- *An off-the-shelf model, complete with instructions and guidelines that can be easily replicated*
- *An easy process to plan and implement*
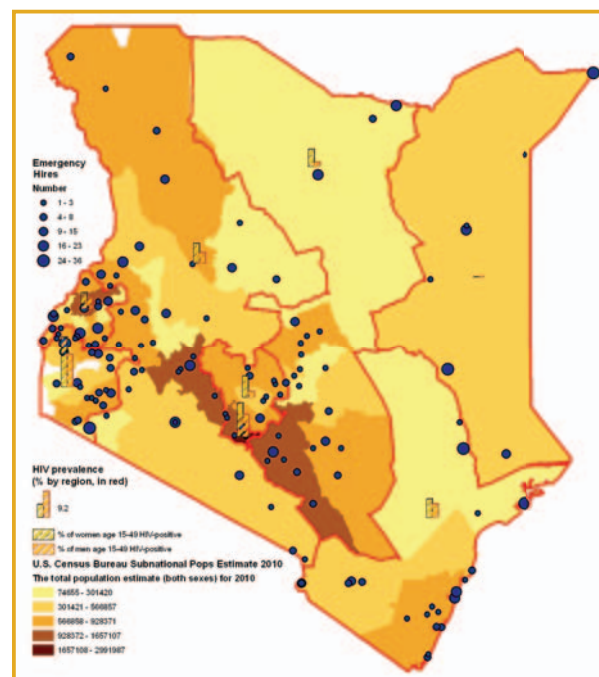- *A replacement for existing hiring arrangements.*

New hires attended a standard public service induction that provided information about the employment contract, job description and compensation (in line with the Ministry of Health's standards, terms and conditions of service) and received two weeks of training in integrated HIV care, treatment and support. Facility managers attended a two-day site preparation workshop introducing the purpose and process of the EHP. Once the health workers took up their posts, Deloitte and Touche managed their payroll and benefits, and the Project worked with the Ministry to provide regular supportive supervision visits.

Posts Filled Quickly and Transparently
The EHP reduced the time for recruitment from approximately one year (and sometimes as much as 18 months) to less than three months. In approximately six months, the EHP recruited, hired, trained and deployed 830 new workers. A total of 6,568 applicants from all provinces in Kenya responded to the several newspaper advertisements and announcements, and 4,456 applicants (68%) were short-listed. Ninety percent of short-listed applicants (4,022) were interviewed in ten areas across the country, and 912 new hires (830 plus replacements) were chosen to fill the identified posts. The process yielded a diverse pool of health care providers: male and female, both single and married and with a wide range in age (see Table 1).

The Project filled 100% of the total 830 high-priority posts over three hiring phases, placing workers in 193 facilities in 63 districts in all seven provinces, and hiring replacements to fill vacated posts (see Figure 1).

Figure 1. EHP Workers and Population Density

Ninety-four percent of the new hires were still employed in October 2008. Facilities retained health workers at a high rate, most likely because they were well prepared for their jobs and paid on time (unlike two-thirds of their colleagues). The EHP strategy to recruit locally and post according to preferences appeared helpful in keeping workers in their posts. For example, in the remote Turkana District, one new hire said, "What I do is a calling to serve my people, and this requires dedication."

A Fair and Valued Process
New hires expressed surprise with the openness, transparency and fairness of the recruitment and hiring process. Some applicants reported that the questions asked in previous interviews were irrelevant; they were pleased that these sets of questions were appropriate and that the make-up of the interviewing panel was balanced. Others stated that in the past, because they lacked certain political ties, they had been unable to secure a post even though they were qualified. New hires agreed that good HR management practices (such as providing written job descriptions and presenting salary and benefits information in the contracts) were followed. Further, they reported feeling well prepared for their jobs, and confident in their skills and ability to perform job tasks.

New hires reported that their jobs were interesting and challenging, and that they

Table 1. New Hire Demographic and Hiring Information

Variables	Province or Cadre	Sample (N=912)
% men		36
% married		55
Average age (and range)		29 (19–46)
% providing care to both child and older dependent		49
% new hires posted per province	Central	8
	Coast	11
	Eastern	12
	Nairobi	5
	North Eastern	8
	Nyanza	18
	Rift Valley	20
	Western	17
% in each cadre	enrolled community nurse	56
	registered nurse	18
	clinical officer	11
	laboratory technologist	10
	pharmacy technologist	4
% posted to province considered "home"		61
% never before received HIV training		57

were making an important contribution to the community. Very few were considering leaving the health care field. However, much like their coworkers, new hires felt salaries were inadequate and found support staff insufficient and the quality of services generally low. This may explain why at the final data collection nearly half reported considering switching jobs, though not careers.

EHP implementers were concerned about possible tensions between the new hires and coworkers, but an evaluation found no evidence of resentment or differential treatment, perhaps because of the alignment of salaries and benefits (Fogarty et al., 2009). Both peers and facility managers thought the new hires decreased the overall workload and improved service access. Facility service statistics confirmed this perception.

Increased Service Access
The new hires had an immediate impact. Lopiding Sub-District Hospital in remote Turkana District, for example, was able to remain open because of 14 new hires posted there. One client said that before the new health workers, "we had to queue too long for services, and at the end of the day most of us were referred to another hospital because Lopiding could no longer perform certain activities." Another said that "attitudes of the staff are now positive and patients are treated faster."

Thirty-six weeks of data collected from the ten sample facilities suggest that the addition of the new hires increased service access across a variety of services. Voluntary counseling and testing (VCT) and prevention of mother-to-child transmission (PMTCT) services increased from less than three days per week to five. The average number of services provided increased for 11 of the 12 HIV services monitored, including VCT, PMTCT and new antiretroviral therapy patients. Additionally, child health, general medical/surgical and prenatal services became available more days per week, and facilities served more child health and general medical/surgical patients. Family planning services became available more days per week; however, the data do not clearly show an increase in the number of family planning services provided.

EHP Becomes GOK Tool
Unlike in Namibia where a similar hiring mechanism was initiated and championed by the government, in Kenya the Capacity Project catalyzed and provided the mechanism, and the GOK agreed to its implementation only after long negotiations (Frelick and Mameja, 2006). Although launching the EHP required steadfast negotiating and patience, ultimately the GOK embraced the approach wholeheartedly. The GOK even adopted the EHP approach a second time, during postelection violence

in early 2008 when camps for displaced Kenyans urgently needed nurses to provide care. Subsequently, other organizations within Kenya (e.g., Clinton Foundation and the Global Fund to Fight AIDS, Tuberculosis and Malaria) adopted the EHP approach, and variations are being used in Uganda and Tanzania. Although the plan originated as a stop-gap measure to quickly infuse a large number of workers into the workforce to provide desperately-needed HIV care, the GOK plans to hire all EHP workers as permanent public-sector employees and to use this mechanism to hire 4,000 additional health workers on contracts.

Beyond Workforce Mobilization
The EHP had unexpected influence on the GOK's HR systems. Because of the plan the Ministry of Health began a review of current processes and policies, and is considering adopting the more transparent hiring and deployment approaches used in the EHP. Through this small project, Kenyan institutions and committed individuals rallied to take on some real distortions in the system, bringing greater equity, openness, merit and social justice.

Approaches such as the EHP are often necessary because longer-term HRH initiatives either failed or did not exist. Therefore, one of the most important effects of the EHP has been to raise the profile of HRH in Kenya and generate action to address long-term HRH challenges. The EHP also served to embed the concept of contract hiring for health workers into the HR public policy thinking and dialogue. Additionally, the processes used to implement the EHP became troubleshooting tools that helped the Ministry and the Project explicate problem areas, which in turn could be programmed for medium- to long-term HRH interventions.

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

In Educating the Reflective Practitioner, Donald Schoen wrote, "The practitioner must choose. Shall he remain on the high ground where he can solve relatively unimportant problems according to prevailing standards of rigor, or shall he descend to the swamp of important problems and non-rigorous inquiry?" (1987). With the EHP in Kenya, we were in the "swamp" tackling unaddressed, endemic distortions

within a hiring and deployment system that had compromised merit and due process in the eyes of the health workers and was failing to accomplish the HRH-related goals of the health sector in terms of increasing access. But this or any similar "swamp" cannot be drained in a day, week, month or even in years. It takes courage, patience and a strong partnership to roll up your sleeves and walk in. And once it's drained, there are no guarantees that it will not fill up again. We cannot remain on the high ground and pretend that we are saving lives by using standard tools, conducting system audits or commissioning more studies that confirm what we already knew.

The EHP model did not use a single tool or enact a process that required rigorous inquiry—it had a clear goal and a simple methodology. International development is crying out for a different approach, mindset and a *simple* paradigm shift characterized by programs such as the EHP that are context specific, genuinely innovative and challenge the status quo. Furthermore, these programs use and strengthen the capacity of local institutions and individuals to effect change and achieve results, and inspire both professionals and ordinary citizens to realize their aspirations for equitable public systems and good governance in the conduct of public affairs.

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Additional Resources

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