

FACTORS INFLUENCING RETENTION OF ESSENTIAL HEALTHCARE PROVIDERS AT FACILITY LEVEL IN MANDERA COUNTY: A CASE STUDY OF MANDERA COUNTY REFERRAL HOSPITAL, KENYA.

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ABSTRACT

There was a serious human resource crisis in the health sector in developing countries particularly in sub-Saharan Africa. Equally, Kenya is also experiencing severe constraints of human resource for health in terms of numbers, skills and distribution. One of the biggest challenges was the retention of healthcare providers in hardship and rural areas of Kenya. The main goal of this study was to determine factors which contribute to essential healthcare providers (Doctors, Clinical Officers and Nurses) decisions to accept and stay or leave remote post of Mandera County. The specific objectives of the study included; to determine strategic policies put in place by the government in order to retain healthcare providers in the rural and remote areas of Mandera County, to assess the magnitude of healthcare providers turnover in Mandera by cadre in the last four years, to determine whether remuneration have an influence on the retention of healthcare providers in Mandera hospital and to find out whether career advancement (promotion) had a role to play in the retention of healthcare providers in Mandera district hospital. This was a descriptive cross-sectional study; the target population was all doctors, clinical officers and nurses in Mandera hospital. The study design entailed semi-structured questionnaire and was analyzed by SPSS. The study was to find out if there was strategic policy put in place by government for the staff in hard to reach districts like recruitment, deployment, training policies or any other retention strategy were in place. Socio-demographic information of the study population indicated that majority of the participants were nurses accounting for 31 of the total 45 clinical health care workers in Mandera. Further, most of the participants were males totaling to 38 out of 45 whereas females were 7. Marital status of the respondents showed that of the total 45 respondents 38 were married, 7 single, and none was divorced or widowed. When determining the highest educational qualification of the respondents, it was clear that diploma and post diploma holders formed the largest bulk of clinical health care workers accounting for 74 % of the total respondents. Majority of clinical health care workers posted to Mandera were initiated by Ministry of health while there were few staff particularly those who hailed from Mandera who requested to be posted to Mandera for

varied reasons such as to be near home and on health grounds. Those whose posting were initiated by Ministry of Health were also willing to move out of Mandera given opportunity so as to pursue academic advancement, for better social amenities and because of security reasons. The entire respondents indicated that there was lack of retention policy such as recruitment, deployment and training put in place by government for the staff working in hard to reach districts. Although the entire study subjects said they were paid hardship allowances which ranged from 600 shilling to 1200 shilling they indicated the amount was inadequate to compensate for their stay in the district. The study also revealed that there was high turnover of clinical health care workers in the district hospital in all the departments whereas replacement was not commensurate with those who left the hospital in the previous four years.

Keywords: Healthcare Providers Turnover, Remuneration, Career Advancement, Retention of Healthcare Workers

1. Introduction

It is recognized globally that human resources for health is a crucial element in the delivery of health services and the achievement of Millennium Development Goals. Recent health sector studies, as well as policies, strategies and plans, acknowledge that Human Resource for Health constraints are hampering health sector planning, service delivery and ultimately health outcomes in Kenya and world at large. Human Resource for Health inequities showed that America has 14 % world population compare to sub-Saharan Africa with 11 % of world population but Sub-Saharan Africa carries 25 % of the global disease burden and Americans taking 10 % of global disease burden. Further, America has the global health workers of 42 % compared with Sub-Saharan Africa with only global health workers of only 3%. Equally, the Americans allocate 50 % their annual expenditure to health as compared to Sub-Saharan Africa with less than 1 % annual budgetary allocation to health (WHO, 2006).

While it is true that people produce their own health, the effectiveness of health services depends upon health workers and support systems. Put otherwise, money and medicines apart, health achievements depend on the frontline health workers who connect people and communities to services and technologies. Health systems cannot operate without the people to run them. In other words, health personnel are the people “who make health happen”. Africa’s health labor force crisis goes much deeper than the shortage and migration of health professionals. Uncertain health systems are further strained by the HIV/AIDS pandemic which is claiming the lives of already overburdened health personnel and resulting in more and more people in need of treatment, care and support. In spite of a projected continuing shortfall of tens of thousands of

health professionals, training institutions are not stepping up production of trained and qualified health personnel. Thus, there have been a myriad of challenges in the areas of staff training, deployment, motivation and retention; in the inequitable spatial distribution of health workers resulting in severe urban-rural imbalances; in poor monetary and non-financial incentives; in generally difficult working conditions and the lack of technical competence. A chronic under investment in human resources for health underpins the problem (Samuel, 2007).

Despite health and poverty eradication being high on the international agenda with significant achievements in some countries, progress remains extremely slow throughout Africa. This is primarily due to weak health systems characterized by severe shortages and low capacity and motivation of health workers at all levels across the continent. The skilled health worker crisis is mainly acute in rural and hard to reach areas, where eighty per cent (80%) of the population in Africa lives. The consequential low capacity at the peripheral level of the health system is a crucial barrier to good health. AMREF believes that developing capable, motivated and supported healthcare workers at all levels of the health system is important in ensuring the delivery of accessible and effective health care across Africa. In many parts of Africa, the skills of health care professionals do not match the actual health needs. Task shifting – giving more responsibility to lower cadres of health workers and ensuring sufficient training and support is vital, particularly in post-conflict countries with extreme shortages of health workers such as South Sudan and Mozambique. In countries where formal health workers are too few, Community Health Worker (CHW) has an important role to play in providing services to the poorest and most vulnerable communities. AMREF has learnt important lessons about the impact on health that CHW can have; about how to train, support and motivate CHW and about the importance of ensuring effective referral systems and links with formal health care workers (Sarah, 2007).

The major challenge facing developed and developing countries is inequalities and imbalance of health care workers densities in urban compared with rural areas. For example, in Bangladesh, thirty per cent (30%) of nurses are located in four metropolitan districts where only 15% of the population lives. In South Africa rural areas are inhabited by forty six per cent (46%) of the total population, but only twelve per cent (12%) of doctors and nineteen per cent (19%) of nurses are working there. Rural and urban areas in South Africa face a critical shortage of health workers,

as these health workers prefer to work in areas with better opportunities for income generation and professional development and better living and working conditions. In Kenya, sixty four per cent (64%) of psychiatrists are located in the capital, Nairobi, which accounts for only 7.5% of the population; and in 2002 in Mali, 265 nurses were posted in Bamako or in regional hospitals, while only 164 were working at the peripheral level. As a result, only twenty four per cent (24%) deliveries were attended by a skilled professional. In USA 9% of registered physicians practice in rural areas, whereas 20% of the population live in rural areas. In France there are also large inequalities in the density of general practitioners, with well-off areas of the south of France and Paris being much more endowed than the centre or north. While rural Canada covered ninety nine point eight per cent (99.8%) of the nation's territory, and accounted for 24% of the Canadian population in 2006, this only represents 9.3% of the physician labor force. Often times, shortages in rural areas in developed countries causes a pull factor for health workers from developing countries, with severe consequences for the latter (WHO, 2009).

1.1 Objectives the Study

- i. To assess the magnitude of essential healthcare providers turnover in Mandera by profession in the last four years.
- ii. To find out whether remuneration have an influence on the retention of essential healthcare providers in Mandera
- iii. To determine the role of career advancement on the retention of essential healthcare providers
- iv. To assess the strategic policies put in place by the government in order to retain essential health care workers in the rural and remote areas of Mandera.

1.2 Research question

- i. What is the magnitude of essential healthcare providers turn over in Mandera district hospital?
- ii. Does the remuneration have influence on essential healthcare providers' retention in Mandera district hospital?
- iii. Does career advancement have influence on essential healthcare providers' retention in Mandera district hospital?

- iv. What are the policies or strategies put in place by the government to retain essential healthcare providers in hard to reach districts?

LITERATURE REVIEW

2.1 HERZBERG'S TWO FACTOR THEORY

Working condition is major determinant of job satisfaction, According to Herzberg's motivational theory; factors that make people dissatisfied at work are dissimilar from those motivating them to do a good job. Dissatisfiers relate to working environments rather than the task itself: low salary, poor career prospects and training opportunities, unsatisfactory access to equipments and support mechanisms, and disappointing human interactions with colleagues and managers all contribute to a sense of dissatisfaction. As oppose to these extrinsic motivational factors, intrinsic motivation relates to the real content of work, feelings of achievement, self esteem and self confidence; they add to job satisfaction and stimulate performance (Uta, 2008).

According to Herzberg, restricting dissatisfiers motivates a worker to stay, but not to perform better. In line with this assumption, some authors argue that avoiding dissatisfiers is more significant to promote retention than building particularly high levels of job satisfaction. Others however dispute this view, especially for professionals, and suggest that turnover results more from low intrinsic job satisfaction than from experiencing difficult working environments. Many middle-and low-income countries today suffer severe staff shortages and/or misdistribution of health personnel which has been aggravated more recently by the disintegration of health system in low-income countries and by the global policy environment. Low wages, poor working environments, lack of supervision, lack of equipments and infrastructure as well as HIV /AIDS, all contribute to the departure of health care personnel from remote areas (Uta, 2008).

2.2 MASLOW'S HIERARCHY OF NEEDS AND MOTIVATION

Maslow's hierarchy can be used to clarify the kind of information people seek at different stages of development. For example, people at the lowest stage seek coping information so as to meet their basic needs. Information which is not directly linked to helping a person meet his or her needs in a very short time span is simply left unattended. Persons at the safety stage need helping information. They look for how they can be safe and secure. Informative information is sought by persons in quest for their belongingness needs. Many at times this can be seen in books or other materials on relationship development. Empowering information is wanted by individuals at the esteem stage. They are searching for information on how their egos can be developed. Finally, individuals in the growth stages of cognitive, aesthetic, and self-actualization seek enriching information. While Norwood does not specifically address the stage of transcendence, I believe it is safe to say that persons at this stage would sort information on how to connect to something beyond themselves or to how others could be edified (Norwood, 1999).

2.3 EMPIRICAL REVIEW

There was an unequal distribution of skilled public health workers across selected institutions in Georgia, with lack of professionals in rural district centers and overstaffing in urban centers. Survey respondents disagreed or were unsure that skilled public health workers possess sufficient skills and knowledge necessary for delivery of public health programs. The survey shed additional light on the findings that there is no clear vision and plans on human resource development. Limited budget, poor planning, and lack of knowledge of the local government were mentioned as main reasons for inadequate staffing. The study participants were concerned with lack of good training institutions and training programs, lack of adequate legislation for Human Resource issues, and lack of necessary resources for Human Resource development from the government (Mamuka, 2008).

Aggressive external recruitment drives, particularly targeting nurses, were of great concern as they were a contributing factor for the increasing trends in nurse migration. The main factors influencing the migration of SHP were consistent with those found in other studies elsewhere in the world. These included low remuneration; poor working conditions, such as inflexible working hours, shortages of supplies and equipment and a poor working environment especially in rural and remote areas where health needs are least well served; limited continuing educational opportunities for professional development and career advancement; having trained and obtained a higher qualification abroad; the desire for better income and family well-being, including children's education and remittances; the aggressive recruitment drives by external agencies; and the presence of relatives and friends abroad. While the decision to migrate or to leave the public health sector and seek employment elsewhere was primarily a personal decision, the study also revealed that structural and societal issues affected the migration of SHP. Some examples included the globalized labour markets in health care, small-scale economies, fiscal policies leading to downsizing of an already inadequate labor force, bureaucratic and governance weaknesses, limited capacity in labor force planning and management (the lack of comprehensive and reliable information and database of health personnel, particularly on the distribution of the health labor force, attritions and migration flows), and political and civil instability (WHO, 2005).

A study of health systems challenges in Nigeria showed that, with the many challenges facing the health system in Nigeria, is acute shortage of competent health care providers. As a result of poor infrastructure and inadequate compensation packages, a significant number of physicians, nurses and other medical professionals are lured away to developed countries in search of rewarding and lucrative positions. In fact, some of these countries have recognized recruiting agencies and examination protocols targeting the best and brightest medical brains in Nigeria, forcing the government to require that these agencies register with the Federal Ministry of Health and function within an established framework. Nigeria is a major health workforce exporting nation, accounting for 347 (recently revised upward to 432) out of a total of 2000 nurses that emigrated out of Africa between April 2000 and March 2001. This numbers appears to be underreported as it fails to take into account the vast number of nurses who move abroad under different pretexts. The efflux has resulted to severe shortages in local health facilities and drastically impacted access (Uneke, 2008).

The major challenge facing developed and developing countries is inequalities and imbalance of health care workers densities in urban compared with rural areas. For example, in Bangladesh, thirty per cent (30%) of nurses are located in four metropolitan districts where only 15% of the population lives. In South Africa rural areas are inhabited by forty six per cent (46%) of the total population, but only twelve per cent (12%) of doctors and nineteen per cent (19%) of nurses are working there. Rural and urban areas in South Africa face a critical shortage of health workers, as these health workers prefer to work in areas with better opportunities for income generation and professional development and better living and working conditions (WHO, 2009).

Shortages in the health labor force represent a major challenge for health policy-makers. There are various approaches to defining shortages. From an economic perspective, a shortage occurs when the quantity of a given skill supplied by the labor force and the quantity demanded by employers deviate at the existing market conditions. Non-economic definitions are generally normative, i.e. there is a shortage of labor relative to defined norms. In the case of skilled health personnel, these definitions are based either on a value judgment— for instance, how much care people should get – or on a professional determination – such as deciding what is the correct number of physicians for the general population. On the basis of those criteria, staff shortages are reported in most countries of the world, although the severity varies. The shortage seems most severe in Africa. For instance, serious staff shortages in all health professions categories are reported in Zimbabwe, including 2,000 vacancies for nurses. In Asia, Vietnam experienced a 57% decline in the number of nurses between 1986 and 1996. Shortages appear to have been accentuated by the migration of health personnel (Pascal, 2005).

The low number of health workers across Africa is a significant bottleneck to the provision of health care. This is most apparent in remote, hard to reach parts of the continent. The geographical imbalance of health workers within countries and the lack of appropriate skills, training and support for existing workers are at the crux of the health worker crisis in Africa. In many countries the skills of limited and expensive professionals such as doctors are not well matched to local health needs. In almost all sub-Saharan countries there are far higher concentrations of workers situated in urban areas than in rural areas. In Uganda about 70% of medical doctors and 40% of nurses are based in urban areas, serving only 12% of the population, meaning that many rural facilities are served by untrained or less skilled workers. There is no escaping the fact that the absolute numbers of skilled workers needs to increase. However, addressing the appropriate skills mix for African countries and ways to train, motivate and retain lower to middle-cadres of workers, including CHW, should be an immediate priority. This briefing therefore focuses on the importance of training and deploying health workers where they are needed most, at community level, and the ways in which proven models can be scaled up to address the health worker crisis (Sarah, 2007).

A review conducted by the Africa Region of the World Bank in collaboration with the African Regional Office of the World Health Organization at a consultative summit in 2002 in Addis-Ababa in some low income countries found that in the previous few years increasing attention has been paid to the development of health policies. But side by side with the supposed benefits of policy, many analysts share the opinion that a major weakness of health policies is their failure to create room for issues of human resources. The lack of explicit policies for Human Resource Health development has created, in most countries, imbalances that threaten the capacity of health care systems to attain their objectives. The labor force in the health sector has

specific features that cannot be ignored. Health institutions are faced with external pressures that cannot be effectively met without appropriate adjustments to the labor force. The development of the labor force thus appears to be a crucial part of the health policy development process. Putting employees problems on the political agenda and developing clear Human Resource Health policies is a way to clarify goals and priorities in this area, to rally all sectors concerned around these goals, and to promote a more comprehensive and systematic approach to Human Resource Management. In the long run, this opens the prospect of developing health care systems that is more responsive to the expectations and needs of populations (Gilles & Dubois, 2003).

Human resources for health in Mozambique pose a major challenge for various reasons. Mozambique is a poor developing country; its epidemiological profile is dominated by communicable diseases, especially malaria, tuberculosis, cholera and HIV/AIDS among the population in general; acute respiratory infections, diarrhoeal diseases, malnutrition, anaemia and measles among the infant population; and high infant mortality and maternal mortality. Average prevalence of HIV/AIDS is 16.2%. Despite efforts by the government to improve the health status of the population, much remains to be done to increase accessibility to health services, improve the quality of services and provide drugs. The main source of human resources supply to the national health system (NHS) is recruitment of the graduates of Ministry of Health training institutions. However, staff placement in health services is still characterized by imbalance in staff distribution among the different regions and provinces and between urban areas and rural areas where 80 % of them live characterized by imbalance in staff distribution (Samuel, 2007).

According to the study carried out in South Africa one strategy to maximize the effectiveness of the program in increasing the supply of health workforce to rural areas is to choose candidates based on characteristics observed to be associated with a low chance of defaulting on the service obligation and a high chance of remaining in a rural area after completion of the obligation. There is evidence from both developing countries and developed countries that medical graduates from rural background are more likely to choose rural practice than their peers from urban areas. For example, a 2003 study in South Africa found that ten (10) years after graduating from medical school, doctors of rural origin were 3.5 times more likely than doctors of urban origin to practice in rural areas (Till & David, 2009).

METHODS

This was a cross-sectional descriptive study design involving healthcare providers in Mandera district hospital. The Study population was 45 respondents, all healthcare providers which included Doctors, Clinical Officers and all Nurses in Mandera county referral hospital. This was a census survey. The researcher used questionnaire to collect data from healthcare providers at their work station. It was administered by Principal Researcher (PR) and research assistant (RA). Content analysis method was used to analyze data. The responses from the questionnaires were sorted, coded and input into Microsoft excel and statistical package for social sciences (SPSS) was used for analysis and generating frequencies and descriptive statistics which were used to derive the study conclusions.

RESULTS

4.1 Data Presentation and Interpretation

This section presents data and the associated interpretations as guided by the respective study objectives.

4.2 On the question of the designation

Table 4.1: Respondents Designation

Category	frequency	Percent
Doctors	5	11
Clinical officers	9	20
Nurses	31	69
Total	45	100

The respondents were represented mainly by the nurses with 69% , the clinical officers were 20% and the doctors were 11%.

4.3 On the question of the posting

The respondents were asked if their posting were mainly initiated by the government or was by individual request.

Table 4.2: Respondents request for Posting

Category	frequency	Percent
Own request	13	31.11
Ministry posting	31	68.89
Total	45	100

The posting was either own request or ministry initiated. Majority (68.89%) of the respondent were posted to Mandera by the ministry while 31.11% were posted following their own individual request.

4.4 On the question of the individual posting

The researcher wanted to know the reason why respondent had requested the government to post them to Mandera district hospital.

Table 4.3: Respondents individual posting

Category	frequency	Percent
Near family	5	57
My home district	9	36
Health ground	0	0
Other reason		7
Total	45	100

However, 30% of the respondent had initiated the posting to mandera due to proximity of their families (57%) near their home district (36%) and on health ground (0%) and other reason (7%).

4.5 On the question if given an opportunity whether they would like to move out of Mandera to another station

Table 4.4: if given an opportunity whether they would like to move out of Mandera to another station

Category	frequency	Percent
Academic advancement	13	52
Better social amenities	6	24
Security problem	4	16
Other reason	2	8
Total	25	100

Majority of the respondent (100%) when asked if they were given an opportunity to move out of Mandera to another station would do so. However, only 28% percentage of the respondent would move out of their station given that opportunity. The respondent who were posted by the Ministry in Mandera said that given the reason to move out to other station was manly academic advancement (52%), better social amenities (24%) and 16% said on security ground 8% said they would move out due to other reason.

4.6 On the question of how many members of staff left their department for other stations in the last four years.

The respondents were asked how many members of staff left their department to another stations in the last four years. The respondent as follow;

Table 4.5: how many members of staff left your department for other stations in the last four years?

Category	frequency	Percent
between 0-5	5	11
between 6-10	19	42
between 11- 15	17	38
more than 15	4	9
Total	45	100

The respondent said that 6 - 10 of their colleague representing 42% left their department to another station 11 -15 of their colleague 38% left, 0-5 of their colleague left (11%) and more than 15 representing 9% left for another station in the last four year.

4.7 On the question of how many members of staff that left their department were replaced, whether their department was adequately staffed and the staff requirement in their department

The respondents were asked how many members of staff left their department for other station were replaced.

Table 4.6: how many members of staff left their department for other stations in the last four years?

Category	frequency	Percent
None	36	80
1	3	6
2	3	6
3	1	2
4	1	2
5	1	2
Total	45	100

A mean of 3.45 were replaced mainly the doctor. However, the clinical officer mean 1.38 who left were replaced and the nurses were 1.08 mean of replacement. However, majority (80%) of the respondent said none were replaced and between 1 and 2 staff replaced only 6 percent each said were replaced and 3-5 of all respondent only 2% were placed. On the question of how many members of staff left their department all the respondent had the opinion that their departments were inadequately staffed. On the question of staff requirement nurses respondent said between

40-45 nurses of different specialist. Clinical officer required 20-30 and doctor required at least 6 in Mandera District.

4.13 On the question of what makes you like Mandera

The respondents were asked what makes you like Mandera.

Table 4.7: What makes you like Mandera

Category	frequency	Percent
Appreciation & support by seniors	4	8
Community respect and appreciate my work	15	33
Good work relation	1	2
Mandera is my home	19	42
I love the community here	3	6
Other	3	6
Total	45	100

The respondent said that appreciation & support by seniors (8%), Community respect and appreciate my work (33%), good work relation (2%) Mandera is my home 42%), I love the community here (6%) Other reason (6%).

The respondents were asked how the government compensates them for being in hardship district. Majority (67%) of the respondent said they receive hardship allowance, other respondent said they receive better salary compared with those working in urban areas (15%) academic advancement (3%) and other respondent said (15%) none of the reason.

4.8 on the question of how government compensate them for being in hard to reach district, how much are you paid per month in form of hardship allowance and if they find it adequate the amount paid as hardship allowance

The respondents were asked how the government compensates them by being in the hard to working environment if the amount was sufficient and how much they were paid.

Table 4.8: how government compensate them for being in hard to reach district

Category	frequency	Percent
Hardship allowance	31	69
Better salary compared with those working in urban areas	7	16

Academic advancement	1	2
Other	6	13
Total	45	100

Majority (69%) of the respondent said the government compensates them through hardship allowance 16% said the government compensates them through better salary compared with those working in urban areas; 2% said that government compensate them through academic advancement and 13% think government do not compensate them in any way. The respondents were also asked how much they were paid per month in form of hardship allowance. The entire group of nurses, doctor and clinical officers who are married receive equal amount of ksh 1200 while the single officers receive ksh 600. However, all the respondent doctors, nurses and clinical officer said the amount was not enough.

4.9 - on the question what they would like most to see happen to encourage them to continue working in Mandera

Table 4.9: how should the government compensate them for being in hard to reach district

Category	frequency	Percent
Improved pay package/remuneration	45	100
Career advancement	45	100
Good working conditions with adequate equipment/materials	45	100
Good infrastructure	1	2
Support supervision	1	2
Ensured security	5	11
Total	45	100

The respondents were asked what would encourage them continuing working in Mandera. The majority (100%) said improved pay package/remuneration, career advancement and good working conditions with adequate equipment/materials. Good infrastructure and support supervision were not a major issue (2%). However, some respondents also said ensure security (11%).

4.10- on the question of whether there is a policy on recruitment, deployment and training put in place by the government for health workers in remote/rural areas

This section of questionnaire dealt with specific objective number four which assesses the existence of policies put in place by the government in order to retain healthcare providers in the remote rural and rural areas of Mandera.

Table 4.10: whether there is a policy on recruitment, deployment and training put in place by the government for health workers in remote/rural areas

Category	frequency	Percent
Yes	5	11
No	40	89
Total	45	100

The respondents were asked whether there is a policy on recruitment, deployment and training put in place by the government for health workers in remote/rural areas. All the nurses and clinical officer said that there is no policy (89%). However, the medical doctors said there are policies for recruitment (11%).

5. DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary of Findings

The summary of findings is presented on table 5.1 below with highlight of the key findings of the study under each objective.

Table 5.1: Summary of Findings

Objective	Mean	Findings	Remarks
To assess the magnitude of essential healthcare providers turnover in Mandera by profession in the last four years.	2.91	There is high turnover of Employee in this area especially due to harsh economic and working condition.	It is normally good to look at healthcare providers benefit
To find out whether remuneration has an influence on the retention of essential healthcare providers in Mandera.	4.44	The study found that employee remuneration was crucial in the decisions of retention of health workers	Apart from the normal salary, adequate hardship allowance should be used for compensation for health worker working in rural and remote area.
To assess the strategic policies put in place by the government in order to retain	4.80	The respondents are in agreement that proper policies should be put in place if the government would want to	

Objective	Mean	Findings	Remarks
essential health care workers in the rural and remote areas of Mandera		retain the services of health worker.	
career advancement on the retention of essential healthcare providers	3.20	There is need also for government to consider transferring the worker to other station for career advancement	Currently some worker stay for more than 10 year before being transferred.

5.2 Discussions

The healthcare workforce has been identified as the key to effective health services delivery. However, skilled personnel shortages is the most commonly reported staff-related problem in health care, especially in resource-constrained countries. Among the many challenges facing Kenya’s health system is an acute shortage of competent healthcare providers. As a result of inadequate infrastructure locally and poor compensation packages, significant number of physicians, nurses and other health professionals migrated to developed countries in search of fulfilling and lucrative positions.

Our review of primary data analysis suggests that there are negative impacts on workloads, especially at peripheral facilities in rural districts, which may impact on health service provision and the referral chain. Increased workloads caused by understaffing result in stress, burn out and demotivation, which are the factors that ‘push’ remaining health workers to leave. This creates a vicious cycle and it is this cycle that needs to be broken.

The rural workforce is ageing and the turnover of nurses, doctor and clinical officers in rural areas is high. In addition, rural health services are experiencing recruitment and retention difficulties; very little is known about the recruitment and retention of new graduates nurses, doctor and clinical officers in rural health areas and the potential long-term investment they could offer to rural health services.

Other factors influencing retention briefly mentioned by the respondents include financial incentives, career development and management issues – all important factors affecting staff motivation. Recognition is also highly influential in health worker motivation. A study on health worker motivation in Africa showed health workers are strongly motivated by their professional conscience and professional ethos. Motivation is also described as willingness to exert and maintain an effort towards attaining organizational goals. The work environment, support, supervision and recognition, appreciation by superiors and the community have all been mentioned as motivating factors.

The issue of doctors, nurses and clinical officer being unwilling and unable to serve in rural areas is a major one. While hard data is lacking, many primary health centers in rural areas lack doctors. Retaining doctors in rural areas remains a major challenge. The respondent indicate that doctors are more likely to remain in rural areas if they can stay with their families. The lack of appropriate housing, food, other facilities and inadequate schooling options for children could also be reasons preventing families from moving to rural areas. One possible solution is a general improvement of the facilities in rural areas; another is providing ‘special’ facilities for doctors, health workers and their families.

We found that most respondents intended to move to other stations where education is available for furthering their education and career advancement predominantly to work in better institutions and get the experience of a different place in the long term. Although the rural lifestyle in general was unattractive to medical workforce, the respondents from rural areas/small towns, and whose family were in those rural area were more likely to work in rural areas/small towns and to settle in Mandera than clinical officer, nurses and doctors from urban and from professional families.

5.3 Conclusions

The study findings revealed that working conditions, career development opportunities, and appropriate infrastructural issues are core factors affecting an individual’s motivation to work in rural areas, regardless of the health worker’s geographic origin. This calls for an urgent and comprehensive review, and accommodation of issues related to staff motivation if the MDGs are

to be realized. This would entail developing a comprehensive rural health work force improvement strategy which incorporates a coordinated inter-sectoral approach involving partnership among stakeholders in rural health development.

It takes decades to build a qualified health workforce. Multidisciplinary health teams – including clinicians, nurses, MLWs and community health workers – together with public health leaders and workers with a population based approach to healthcare, are required. It is essential however, to review teaching methods and materials to ensure that they are current and relevant. Urgent attention to training approaches for mid-level and community health workers is needed. Innovative approaches to teaching in industrialized and developing countries must be considered, with state-of-the-art teaching materials and continuing education through the creative use of information and communications technology.

Losses to investments made are noted when personnel levels are too low to efficiently use other resource investments in services and when supervision and mentoring by qualified personnel is inadequate to complement formal and in-service training. Systematic measurement and reporting of workloads is needed to increase staff ratios in areas where workloads are too high for service quality or for efficient use of other resources.

The issue of salaries/wages and allowance should be critically looked into. Realistic remuneration packages should be offered to health care workers, comparable to those of other professionals and sufficient to meet accommodation, transport, utilities and opportunities for education.

To improve levels of worker retention, incentives need to be offered that address these pull factors. Despite the wide range of potential sources of data, statistical evidence on the migration of doctors and nurses is lacking. The ‘prerequisite for an effective deployment of staff is an information system that enables management and nurses to review patterns of activity and variation in workload, so that they can use informed judgment to make decisions on day to day staffing levels’ (Bachan and Calman 2005). It’s clear that what is needed for this to occur is a

database of evidence on the movement of health workers and its link to health service performance.

The government's first priority should be to invest in comprehensive human resource management information systems that will provide sound data for policy formulation and decision-making. In line with recent studies (Forcier et al, 2004; Stilwell et al, 2003; Martineau et al, 2002; Ntuli, 2003), we recommend that a system on health worker migration be developed to include parameters that will link macroeconomic indicators (GDP, employment, economic and political security), while also monitoring and supporting bilateral agreements and policy decisions with specific sectoral relevance to health worker migration, i.e.: Migration of health workers in Kenya: the characteristics and state of the health workforce in relation to the institutional and structural characteristics and demands of the health sector; the levels and distributional outputs of and deployments from medical education and training; employment and compensation structures in the health worker labour market across different providers; and the volume and compositional structure of the health worker migration streams, emigration rates and destination countries, with periodic assessment of determinants of decisions to emigrate, social and economic ties of emigrant health workers with their homelands and determinants of return decisions.

5.4 Recommendations

All countries can accelerate health gains by investing in and managing their health workforce more strategically. Diverse national circumstances mean that solutions must be crafted to unique country challenges. Successful strategies should be country-based and country-led, focusing on the frontline in communities, and backed by appropriate international reinforcement. Therefore we recommend the following;

1. The government to put in places a master plan strategy in retaining health care workers in hard to reach districts which includes policies in recruitment, deployment, training and retention of staff in remote/rural areas.

2. Reforms in medical education are crucial which stipulates a special allocation of student admission quota to candidates from rural areas into public universities and other tertiary institutions of Health Sciences both at pre-service and in-service training.
3. Better pay package in form of improved remuneration and other allowances like hardship which has been low for many years. Also improve terms and conditions of doctors and specialist in order to attract them to work in remote and hardship areas retain those who were already there.
4. Improve general health systems of the region by posting adequate human resource with required skills and qualification, allocation of adequate financial resources and improve health general infrastructures of the hard to reach districts.
5. After academic advancement, the government to come up with a mechanism of bonding those health workers posted to, hard to reach districts such that they work in those health facilities for a certain period of time before they are posted out elsewhere or join private practice and/or move out for greener pasture.

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