

Improved Human Resources for Health Policies and their Effects on the Christian Health Association of Kenya

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ABSTRACT

Background: Human resources for health (HRH) contribute to health system strengthening, universal health coverage, and improved health outcomes. Faith-based organizations (FBOs) play an important HRH role. An intervention was undertaken to improve HRH policies and management with a focus on the human element for wider impact on institutional and workforce capacity.

Methods: Using purposive sampling of health workers in Kenya's five regions, the evaluation included semi-structured interviews, workplace observations, and in-depth interviews. We examined perceptions of workplace status, situations, and processes before and after the intervention to assess changes over time.

Results: HRH managers perceived large improvements in their offices, recruitment, promotion, availability of job descriptions and manuals, and appropriate payment of salaries. Perception scores started as low as 3.5 and reached as high as 9.4, with average differences ranging from 2.8 to 5.4 points. Health workers confirmed these changes as manifested by improvements in the proportion acknowledging increases in incentives and safety regulations (27% to 63.6% and 66.7%, respectively) between the time periods. Clients also perceived progress, such as more courteous workers (from 80% to 96%).

Conclusions: CHAK's adoption and dissemination of standard HRH policies and procedures improved its institutional capacity, HRH culture, and management practices. The positive long-term effects of such changes on the workforce and service delivery require confirmation through further research.

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INTRODUCTION

The important contribution of human resources for health (HRH) to health system strengthening [1], universal health coverage [2], and improved health outcomes [3,4] is increasingly recognized. The public sector faces continuing challenges to produce, recruit, and deploy sufficient health workers for a country's needs, particularly in remote and rural areas. Consequently, the key role of the non-governmental sector - comprising of private entities, non-governmental organizations, and faith-based organizations (FBOs) - has featured prominently in academic and online discussions of countries' health systems and global health strategies [5-8].

Among these non-governmental players, FBOs have long been instrumental in providing health care in underserved parts of the world, but have received little recognition for their efforts. Referring to the work of FBOs with HIV/AIDS, the World Health Organization (WHO) estimates that FBOs own and/or operate between 30% and 70% of health facilities in Africa [9]. Similarly, a review of FBOs' substantial role in training health workers found a high level of health system involvement by Christian health associations, which were responsible for at least a third of health facilities in nine of the ten African countries [10]. The review acknowledges the under-recognition of the FBO sector and the need to ensure that its contributions are better documented and integrated with the national health systems.

Between 2008 and 2012, two large FBOs in Kenya - the Christian Health Association of Kenya (CHAK) and the Kenya Conference of Catholic Bishops (KCCB) - implemented an intervention with the aim of improving the organizational capacity of the two institutions and their workforces. The intervention and its effects provided an excellent opportunity to evaluate and document such improvements, given FBOs' role as key actors in the health sector.

Setting

CHAK and KCCB have a large and established presence in Kenya, providing an estimated

30%–40% of the country's health care through approximately 900 health facilities. By 2006, however, both FBOs perceived dissatisfaction among their health workforce and increased attrition. An unpublished assessment by GTZ (German technical cooperation) conducted in 2007 found that the two organizations lacked a defined set of policies and procedures to appropriately manage their vast HRH networks. Some of their HRH practices were ad hoc, informal, or even inappropriate; some positions lacked contracts and job descriptions; vacation periods were not regularly scheduled or honored; performance appraisals were irregular; salary payments were uncertain; criteria for promotion were subjective; and work place safety was a low priority. New Kenyan labor laws and a national HRH strategic plan, enacted in 2007, provided an opportunity to address these gaps.

Intervention

With support from the United States Agency for International Development (USAID) funded global Capacity project, whose aim is to enhance the health workforce in developing countries, CHAK developed a comprehensive human resources management policy document in 2008 [11], which was extensively disseminated and used to guide a new set of policies and standard procedures relating to the workforce and work environment. In addition to the development of the policy document, and with further support from the Capacity Kenya and Capacity*Plus* projects, the intervention included substantial training of human resources (HR) managers, peer learning meetings and visits where successful facilities and managers shared lessons with struggling counterparts. An HR advisor accompanied the entire process, lending support and facilitating exchanges among the various actors. The learning was facilitated by the Africa Christian Health Associations Platform (ACHAP) and its HRH technical working group, which ensured the exchange of communication among members, including discussing the potential for replication in other African countries. Towards the end of the intervention, there was a general sense that the intervention had vastly accomplished its objectives, but no monitoring and evaluation systems had been setup to confirm this impression. Therefore, we designed

a post-hoc evaluation to gather information about the intervention and its results. Though both institutions benefitted from the intervention, given transitional difficulties in KCCB the evaluation was only conducted in CHAK. The research question the study aimed to answer was: did the HR policies and procedures implemented as part of the intervention produce an appreciable change in the management of the workforce, the work environment and health workers themselves, and ultimately on the association itself?

MATERIALS AND METHODS

Study Design

No baseline data were collected before implementation of the improved policies and procedures. Additionally, the intervention was not carried out simultaneously in all facilities. Thus, although much was known about the general conditions existing prior to the intervention, the evaluation aimed to retrospectively capture more comprehensive information on the status of systems and operations before the intervention and assess them after completion of the intervention. This necessitated the development of a mixed-method approach, combining several methods, quantitative and qualitative, ranging from interviews with involved individuals to observations at the facilities where the individuals operated. The evaluation was undertaken between December 2013 and February 2014.

Observations and Semi-structured Interviews

Semi-structured interviews were used to gather data on the perceived effects of the intervention at the health facility level. Because of the nature of the interviews, which included HR managers as well as health workers, all facilities accessed were hospitals (including some with different names, e.g., an “Eye Center” but officially categorized as hospitals by the Ministry of Health). Within each hospital, we used purposive sampling for health workers who were employed before the intervention. This resulted in visits to

all 24 CHAK functioning hospitals (out of 457 facilities, the remaining of which were primary care dispensaries (379) or health centers (54)) spanning all five regions in the country (Table 1), and interviewed 22 workers who described the health facilities and their work environment prior to the intervention and currently (post-intervention).

Similarly, 21 long-term HR officers or managers were specifically sought to provide their assessment of situations existing in their offices and functions before the intervention and to comment on changes since its implementation. The semi-structured interview assessed changes in two ways. Some respondents (primarily managers) were asked to recall specific situations (e.g., existence of safety protocols, staff manuals, computers, and offices) or perceptions (e.g., of recruitment processes) in the past and compare them to the present. Each specific scenario or perception was assigned a score from 1 to 10. Other respondents (primarily health workers) were asked yes/no questions about more factual occurrences (e.g., having had performance appraisals in the previous year) at the two time periods. The proportion answering in affirmative for each were derived and compared. These interviews were complemented by observations in each facility (e.g., office space, guidelines, signage) and by questions answerable for the current period (e.g., processes during health workers’ recruitment).

Clients (n=25) available at the facility or nearby who had been utilizing the services provided in the facilities for an extended period of time were also interviewed to explore their satisfaction with the services and views of any changes noticed before and after the period of the intervention. Such contrasts between retrospective and current assessments undoubtedly suffer from rationalization and a degree of subjectivity, as discussed later, but nonetheless were key to identifying first-hand experience, and included aspects of human resources and the work environment that had remained stagnant or underdeveloped.

During the facility visits, a review of client service records was also conducted, with the aim of recording any trends before and after the intervention. Although the intervention did not

Table 1. List of Regions and CHAK Facilities Visited (n = 24)

Regions (Number of Facilities Visited)	Name of Facilities
Central and Nairobi (6)	<ol style="list-style-type: none"> 1. African Inland Church Cure International Children's Hospital (Kijabe Town, Kiambu County, Central Province). 2. African Inland Church Kijabe Hospital, Kijabe (Kijabe Town, Kiambu County, Central Province). 3. Presbyterian Church of East Africa Kikuyu Hospital (Kikuyu Town, Kiambu County, Central Province). 4. Mwangaza Uiona Tumaini Clinic, Korogocho (Nairobi County, Nairobi Province). 5. SDA Better Living Hospital, Nairobi (Nairobi County, Nairobi Province). 6. Coptic Hospital (Nairobi County, Nairobi Province).
Eastern and Central (5)	<ol style="list-style-type: none"> 1. Presbyterian Church of East Africa Chogoria Hospital (Chogoria Town, Tharaka Nithi County, Eastern Province). 2. Maua Methodist Hospital (Maua Town, Meru County, Eastern Province). 3. African Inland Church Githumu Hospital (Kangari Town, Muranga County, Central Province). 4. Presbyterian Church of East Africa Tumutumu Hospital (Giagatika Town, Nyeri County, Central Province). 5. Tei Wa Yesu Health Centre (Gai Town, Kitui County, Eastern Province).
Nyanza and Western (5)	<ol style="list-style-type: none"> 1. Anglican Church of Kenya Maseno Mission Hospital (Maseno Town, Kisumu County, Nyanza Province). 2. Mwhila Mission Hospital (Khwisero Town, Kakamega County, Western Province). 3. Friends Hospital, Kaimosi (Kaimosi Town, Vihiga County, Western Province). 4. Lugulu Friends Mission Hospital (Webuye Town, Bungoma County, Western Province). 5. Sabatia Eye Mission Hospital (Sabatia Town, Vihiga County, Western Province).
Nyanza and Western, Rift Valley (5)	<ol style="list-style-type: none"> 1. African Inland Church Litein Mission Hospital (Litein Town, Kericho County, Rift Valley Province). 2. Tenwek Hospital (Bomet Town, Bomet County, Rift Valley Province). 3. Dophil Nursing and Maternity Home (Luanda Town, Siaya County, Nyanza Province). 4. Kima Mission Hospital (Luanda Town, Vihiga County, Western Province). 5. African Inland Church Kapsowar Hospital (Kapsowar Town, Elgeyo Marakwet County, Rift Valley Province).
Rift Valley and Coast (3)	<ol style="list-style-type: none"> 1. African Inland Church Lokichoggio Health Centre (Lokichoggio Town, Turkana County, Rift Valley Province). 2. St Luke's Anglican Church of Kenya Hospital, Kaloleni (Kaloleni Town, Kilifi County, Coast Province). 3. Lighthouse for Christ Eye Centre (Mombasa Town, Mombasa County, Coast Province).

include any component of service statistics, this element of data collection was done in an attempt to draw inferences about possible ecological relationships between changes reported at the management and health worker levels and their effects on service delivery.

In-depth Interviews

To complement the semi-structured interviews and observations, several representatives of institutions involved in the development and adoption of the 2008 HR policy document and ensuing implementation participated in in-depth interviews on the situation occurring during the entire period. The interviews offered an opportunity for respondents to provide descriptions of contexts and concrete examples and anecdotes of changes that occurred after application of the new policies and procedures, including at the institutional level.

All interview forms were developed based on known index scaling [12,13], a USAID funded initiative called the HRH Effort Index [14], and the objectives of the intervention. The initial tools were pre-tested locally among five local individuals from CHAK and were slightly modified for local expressions. The tools were all applied in English. In-depth interviews were recorded and conducted by a hired consultant (social scientist). Semi-structured interviews and observations at facilities were done by seven data collectors trained for two days in Nairobi, including dry runs of interviews. Content analysis was done according to the main themes of the evaluation (policy adoption and dissemination, HRH practices, work environment, effects on managers, the workforce, clients and the institution).

Ethical Considerations

The evaluation obtained institutional review board clearance from IntraHealth International in October 2013 (IH-13002), and CHAK leadership (January 2014) provided support and permission for the interviews. Administration of all study instruments included obtaining informed consent and supplying privacy during interviews.

Statistical Analyses

Statistical analyses were carried out in SPSS version 21 (IBM, NY, USA) and graphs were drawn in Microsoft Excel.

RESULTS

Changes in HR Management

The main concerns of leaders and administrators before the intervention were exodus of workers, autocratic management, and litigation. The policy intervention was swiftly and widely adopted and implemented. Newly trained managers and those with successful initial results visited facilities that were facing challenges, and shared lessons learned through their established community of practice. As a result, some of the most visible effects of the intervention were those perceived by HR managers. Figure 1 shows changes in managers' perceived level of personal knowledge and authority as well as changes in more tangible variables such as office location, office equipment, and budgetary allocations. Differences in scores highlight the improvements that were witnessed, for example in moving from a desk in a basement with the maintenance unit to a fully equipped office close to the director's office (score of 3.3 to 7.1), or increased funding to undertake positive HR actions (score of 4.1 to 7.5). The majority of managers (as well as some HR clerks who had experienced improvements brought about by the intervention) reported pursuing further studies and taking HR courses. Many described a renewed sense of authority and greater comfort in dealing with the clinical staff, which they had found difficult to do before. Some managers had become advisers to hospital boards and even travelled to other countries to advise on HR matters. HR managers also reported that while they had always strived to maintain good relationships with the government and other partners, that aspect, too, had been enhanced through the policy intervention. An HR leader summarized these changes: "I've since noted professionalization of the HR function in many hospitals...[it] gives a sense of appreciation for...human resource management as a profession and giving emphasis for better HR practices."

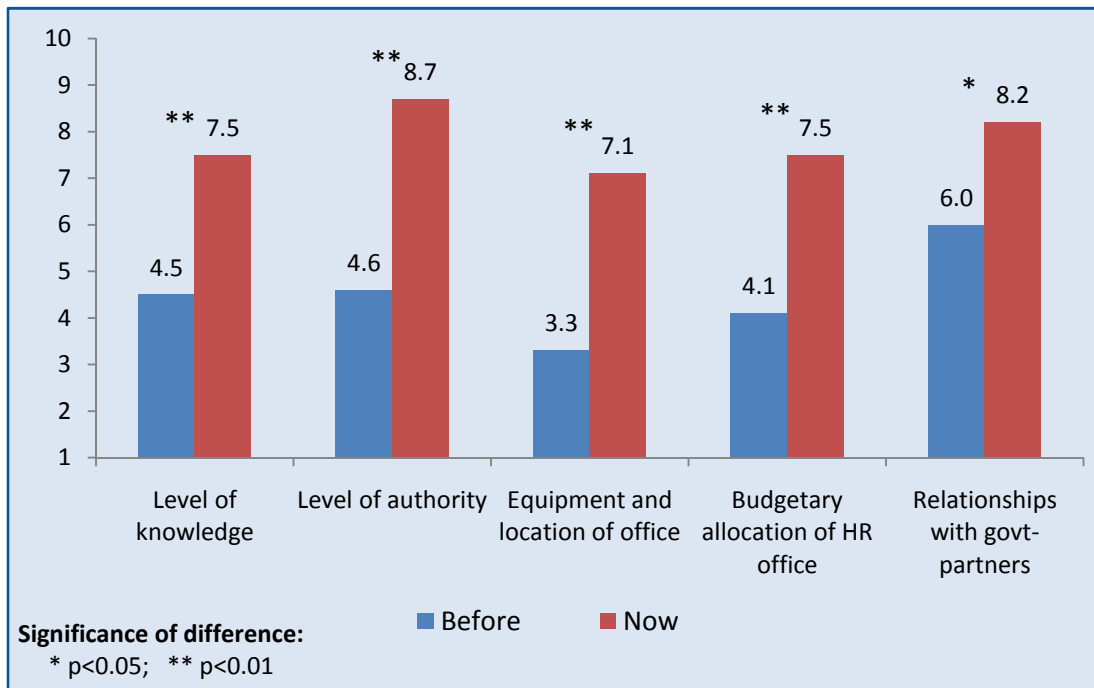


Figure 1. Managers' Perceptions of General Changes by HRH Intervention (Score)

Figure 2 shows positive trends experienced in a number of areas, including recruitment (5.3 to 9.4), promotion (4.5 to 7.3), availability of job descriptions (4.0 to 8.1), availability of HR policy manuals (3.5 to 8.9), and punctual payment of salaries and appropriate statutory payroll deductions (5.1 to 8.5). An administrator of a maternity and nursing home qualitatively described some of these changes: “We have a job description....Before we employ or after employing, we usually give [staff] the HR document, they usually go through. In terms of ethics and discipline and position, it’s all written there. We didn’t [do that before].”

Several of these changes were confirmed by health workers. For example, health workers acknowledged increased availability of HR manuals, with 73.3% currently reporting the existence of HR manuals versus 33.3% before the intervention. Reports of other changes reflected positive but less striking trends, such as having an annual performance appraisal (57.9% post-intervention versus 36.8% previously), using a job description for the appraisal (84.2% versus 57.9%), getting salary payments on time (71.4% versus 66.7%), and receiving performance-based promotions (52.6% versus 31.6%).

Changes in Working Conditions

As a result of the new policies, CHAK put several performance support mechanisms in place. Managers reported improved supportive supervision (4.3 to 8.2), in-service training plans for staff (4.2 to 7.8), and the use of HR information systems to aid decision-making (2.8 to 6.1). In response to yes/no questions, health workers mostly corroborated these reported improvements in working conditions (Figure 3), citing, for example, supervisors having reviewed administrative procedures or health workers having received incentives in the previous two years. Additional improvements reported by health workers included having safety regulations, the equipment needed to do their job, and daily access to the Internet. Observations conducted in facilities found an enabling environment for workers such as a staff manual (76%), guidelines/protocols (95%), a safety manual/guidebook (59%), safety signs (71%), appropriate washrooms (91%), and a break room/recreation area (96%).

The Client Perspective

Examples cited by clients included facilities opening on time and not having to wait for health workers to get ready (68% versus 88%), health

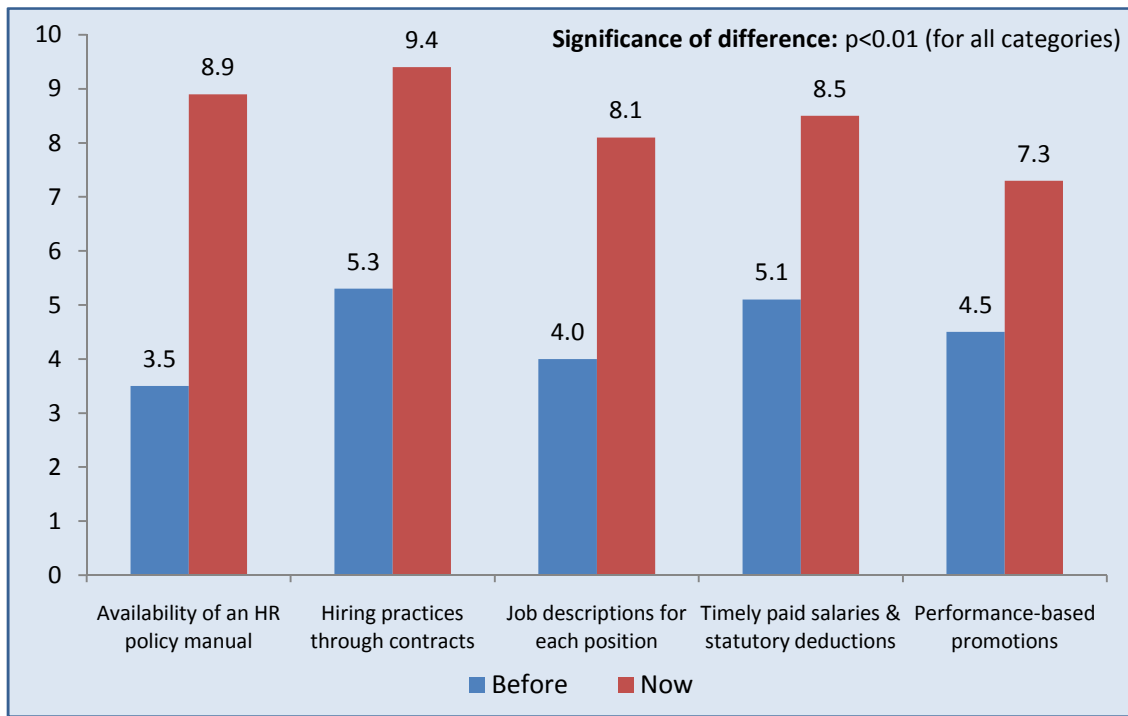


Figure 2. Managers' Perceptions of Changes to Lifespan Practices by HRH Intervention (Score)

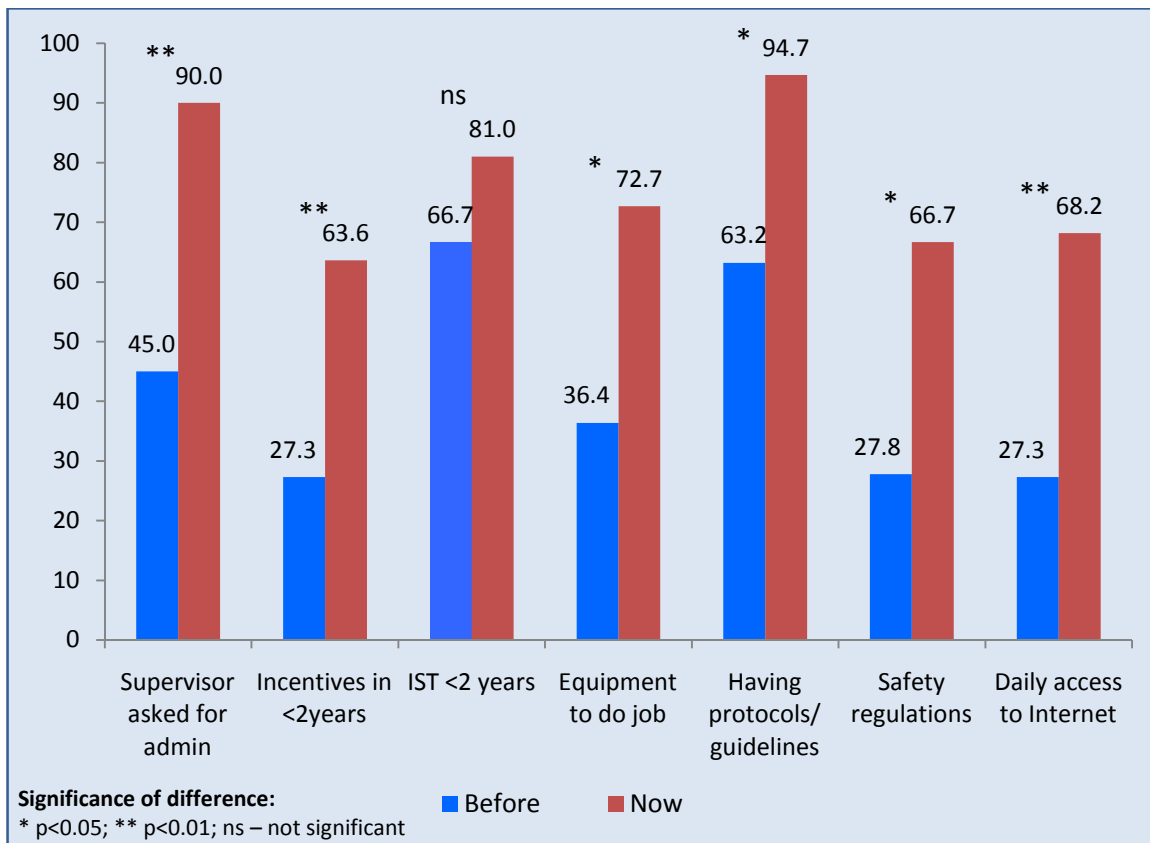


Figure 3. Health Workers' Perceptions of Changes in Working Conditions (Proportion)

workers being in place when clients arrived (64% versus 88%), seeing health workers look “happier and more rested” (84% versus 100%), and perceiving health workers as more likely to remain in the facility until all patients were attended to (77% versus 100%). Interestingly, positive changes were reported in aspects such as facilities being open for extended hours, health workers treating clients more courteously and agreeably, and health workers appearing more knowledgeable in general and about what they were doing (e.g., consulting with books or a computer to do their jobs) (Figure 4).

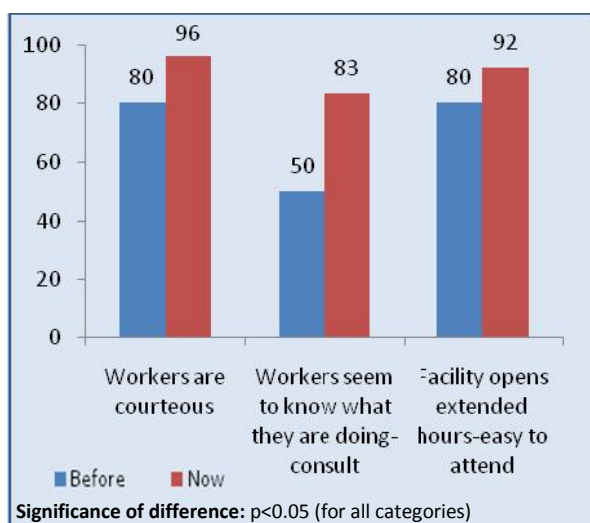


Figure 4. Clients' Perceptions of Changes in Workers and Facilities (Proportion)

In an exchange with the interviewer (I), a client (R) expressed these changes as follows:

I: Can you say the staff of this hospital are happy or do they work when unhappy?

R: They are very happy [and] also welcome you.

I: Before, in the past six years, how was the staff?

R: There were those who were harsh but now they are gone.”

Additional Changes at the Institutional Level

At the institutional level, the CHAK secretariat realized the importance of supporting its

workforce (to the extent that it added “Recognition of human resource and investment in their development, motivation and teamwork” among its organizational values after the intervention). Institutional leaders participating in the qualitative interviews reported less litigation and improved retention and productivity. Their newly found pride as supporters of their workforce was coupled with an improved relationship with the government (bridging “separations” that had existed before) that led to the signing of a memorandum of understanding (MOU) allowing the government to second more health workers to FBO facilities (especially in remote areas), use their large hospitals for internships, and include them in the government-led trainings. These agreements with the government extended the service delivery capacity of CHAK facilities and freed up resources towards other goals. The impact of the intervention also elicited interest from other African Christian health associations, such as in Malawi, Ghana, and Lesotho, who have since invited CHAK to share its experiences and are replicating facets of the intervention.

DISCUSSION

The evaluation of the effects of adoption and dissemination of standard policies and procedures for the management of human resources for health in FBO facilities confirmed important changes at different levels: institutional, individual (managers and health workers) and, to some extent, at the service delivery level. In particular, CHAK reported huge gains in its organizational pride, human resources orientation and relationship with the government. From the individual standpoint, personnel administrators built a new managerial capacity, who spoke highly of the “professionalization” of the HR function. Although the intervention was not aimed directly at health workers, they, too, experienced positive effects through improved and fairer procedures including payroll, performance support, and improvements in the work environment.

The WHO describes a lifespan approach to the health workforce that focuses on all stages from recruitment to workforce exit [3]. A direct consequence of the enhanced HR functions

introduced by the intervention was the improvement of some of these HR lifespan practices. For example, managers ensured positions had job descriptions and recruitment included advertisement and a proper selection process, while standardizing payroll systems. The difficulty of measuring client perspectives on service delivery, especially for preventive and promotional services such as family planning, has long been recognized. Although client perceptions should be a key consideration in assessing quality of services, clients may be “unable to make meaningful evaluations of some aspects of service quality” either because they are not able to assess technical competence or because of “courtesy bias” [15]. Consequently, measures of client satisfaction in different settings typically register high rates, such as in Ethiopia (94%), Sri Lanka (81%), and even Iran (61%) [16-19]. In our study, clients interviewed perceived positive trends over the period investigated.

The results confirm earlier findings about the importance of financial and workplace incentives to health workers, even when working in religious or humanitarian institutions having better equipment and more supplies than in the public sector [20,21]. However, the evaluation also confirmed that, through training, support and communication, it is feasible to create a new “layer” of empowered and confident HR managers and leaders, who through improved attitudes and better organization of the workplace are potentially able to influence worker satisfaction and retention [22], and even improve health outcomes [23]. Although service delivery data collected for this evaluation found inconsistent recording and fluctuations (data not shown) that did not allow for any firm conclusions, individual interviews with clients signalled positive receptivity and trends on services.

This evaluation had some limitations, which include potential biases associated with sample selectivity of the health workers (e.g., having worked for longer in the facilities assessed) and the small numbers sampled. Nonetheless, the objectives of the evaluation required a purposive sampling strategy. Additionally, because of lack of baseline data, the retrospective and primarily qualitative nature of the inquiry was unavoidable and probably accounted for biases from recall

(an intervention that occurred years ago), justification and subjectivity. Given the comprehensive adoption of policies in all sites it was also not possible to include control areas, which makes it difficult to draw conclusions about the net effects of the intervention. However, from the consistently positive direction of results presented through comparison of data from managers, health workers, and even clients, plus observations and other study material (most of which are not presented here for reasons of space constraints), we can conclude that the effects observed and reported on for this intervention were real and would not have occurred had situations continued on a natural trend.

CONCLUSIONS

The adoption and ample dissemination of new, standard HRH policies and procedures in the Christian Health Association of Kenya contributed to appreciable improvements in its HRH culture and internal management, and the management of health workers and the work environment, likely affecting service delivery in a positive manner. The positive long-term effects of such organizational changes require confirmation through further assessment.

AUTHORS' CONTRIBUTIONS

ALF conceived and designed the study and instruments, and co-analyzed and wrote the manuscript. DM participated in the design, coordination, and write-up of the manuscript. PMM led data collection, co-analyzed, and wrote an early draft of the manuscript. AY contributed to an early draft of the manuscript. All authors have read and approved the final manuscript.

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CONFLICT OF INTEREST

Authors have declared that no competing interests exist.

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