IMPROVING LEADERSHIP, MANAGEMENT, AND GOVERNANCE OF THE HEALTH WORKFORCE IN KENYA'S DEVOLVED SYSTEM

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Mathew Thuku, Mukami Kathambara, Jennifer Kiema, Ann Malubi, Sarah Atieno, Anne Mungai, Linah Vihenda, Lulu Keeru, Lucy Njenga, Rose Indah, Annette Murunga, Dr. Janet Muriuki, Esther Kariuki, and Wycliffe Omanya

BACKGROUND

In 2014, Kenya's Ministry of Health (MOH) developed and launched a five-year strategy to define long-term interventions for addressing the constraints to human resources for health (HRH) development and management toward effective and improved health service delivery for Kenya's people. The end-term review of the Kenya Health Sector Human Resources Strategy (KHSHRS) II 2014-2018 established that Kenya has made remarkable progress in addressing HRH issues in the past decade. The total number of health workers in the sector (private and public) is estimated to have increased by 41% between 2013 and 2018, from 105,369 in 2013 to 148,322 in 2018, while the health workforce in the public sector (counties) grew by 46% (n=21,481) during the same period. The country had a total of 79,937 doctors, nurses, and clinical officers retained against a registration of 113,178 as of 2018, which translated to approximately 17 per 10,000 population, against the World Health Organization (WHO) minimum staffing threshold of 23 per 10,000 population (KHSHRS-ETR report 2019).

Kenya's devolved (county) governments recruited an additional 27,298 health workers in the past four years, increasing public health worker density from five core health workers per 10,000 population in 2013 to eight per 10,000 population in 2018, compared to a midterm target of seven (End Term Review of Kenya Health Sector HR Strategy Plan Report 2019).

The Government of Kenya devolved health service delivery to the 47 county governments in 2013, including management of the health workforce. However, devolution occurred before capacity, leadership structures, and organizational arrangements were fully in place to ensure a smooth transition, resulting in weak engagement between county and national governments. Counties experienced acute shortages and imbalanced health worker distribution with proper administrative systems largely lacking. This suboptimal transition led to recurring health worker industrial unrest, which further disrupted service delivery.

The shortages are exacerbated by inappropriate skills mix; high workload; chronic absenteeism; low staff morale; industrial unrest; inefficiencies in staff hiring, deployment, performance, and retention; and limited technical supportive supervision, mentorship, and coaching from supervisors, among other factors. To achieve universal health coverage, including HIV and reproductive, maternal, newborn, child, and adolescent health (RMNCAH)
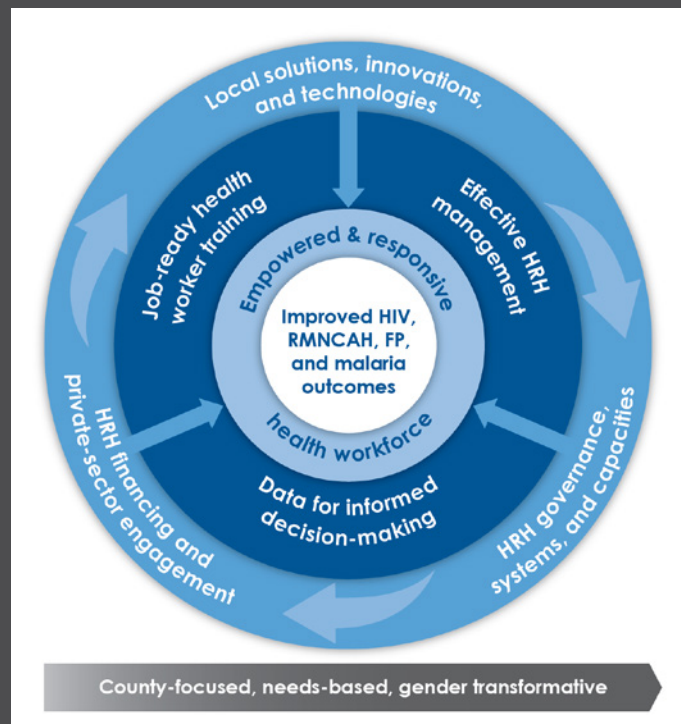
ABOUT THE HUMAN RESOURCES FOR HEALTH (HRH) KENYA MECHANISM

The HRH Kenya Mechanism is a five-year (September 27, 2016 to September 26, 2021) USAID-funded initiative led and implemented by IntraHealth International and its partners Amref Health Africa and Strathmore University Business School. The overarching goal of the Mechanism is to strengthen the health workforce to achieve improved health outcomes. The Mechanism's national-level interventions have included activities related to policy, guidelines, and regulation in support of HRH systems; faculty capacity-building and institution-strengthening at 13 public and select private and faith-based medical training colleges and universities; and support for 27 counties with high disease burden, aligned to the President's Emergency Plan for AIDS Relief (PEPFAR), RMNCAH, and President's Malaria Initiative priorities. The implementation framework has guided structured and vision-centric operations (Figure 1).

Figure 1: Implementation Framework

The Mechanism has supported USAID's efforts toward the journey to self-reliance through its interventions to strengthen HRH management systems at the national, county, and community levels. The Mechanism focused on supporting the MOH, county governments, and the Ministry of Education's Higher Education Loans Board (HELB) to improve the management and development of the health workforce under its three Sub-Purpose areas: 1) improve the quality of training and increase the number of graduating health workers; 2) improve the leadership, management, and governance of the health workforce at the county level; and 3) optimize data use for effective HRH decision-making at the national and county levels. The Mechanism built on successes and lessons learned from prior IntraHealth-led USAID projects (HRH Capacity Bridge and FUNZOKenya).

and family planning (FP) service provision, as well as the Sustainable Development Goals (SDGs), national and county governments must promote an environment that is responsive to HRH reforms and policy guidelines.

TECHNICAL APPROACH

The HRH Kenya Mechanism has supported counties to prioritize investments that strengthen HRH governance, systems, and capacities, leading to sustained improvements in the quality of, access to, and use of priority health services. Partnering with county-focused USAID-funded service delivery projects, the Mechanism has provided customized technical assistance, mentorship, and coaching to county health management teams (CHMTs) and service sites, enabling them to apply relevant HRH guidelines and tools and to access HRH data for evidence-based articulation of their HRH priorities,

which impacts service delivery. Further, it has advanced the use of HRH budgeting tools to build the capacity of CHMTs, which are responsible for HRH financial negotiations in the Government of Kenya budgeting process; institutionalized utilization of an HRH budgeting checklist; and advanced the Kenya National HRH Incentive Framework at the county level to attract and retain critical health workers.

The Mechanism has fostered the formation of enabling policy at the national level and facilitated dialogue among national and county governments, bringing its HRH expertise to strengthen health workforce management. It has provided technical assistance to help county governments be more responsive with regard to health worker attraction, recruitment, and deployment. Focusing on disease burden and health worker retention, motivation, and performance ensures that health workers are

Figure 2: Learning, Management, and Governance Implementation Framework
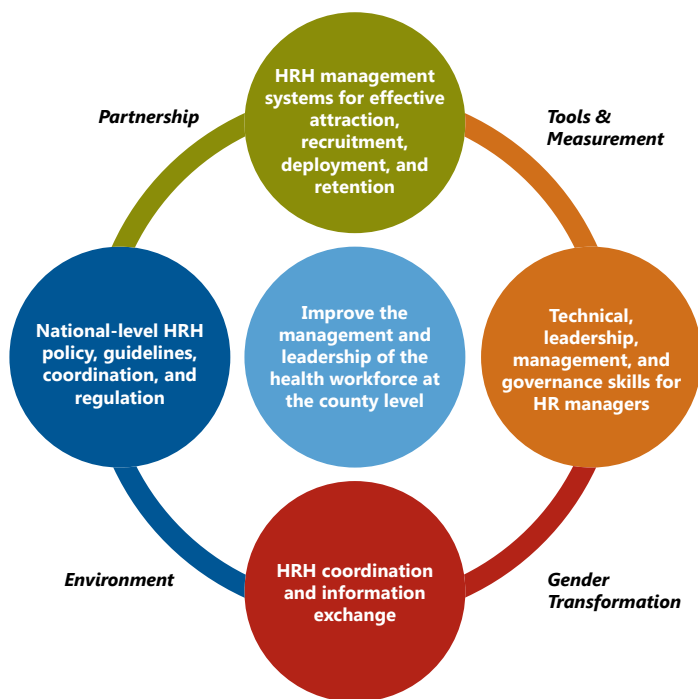
available to serve the health needs of communities, thus improving HIV and other health outcomes. Figure 2 illustrates the implementation framework.

RESULTS

The Mechanism strengthened 27 county human resources management (HRM) systems, focusing on the urgent need for counties to develop supply-side strategies to saturate service sites with HRH, particularly in high HIV prevalence locations. The Mechanism worked with Strathmore University Business School and the Institute of Human Resource Management to build CHMTs' capacity to strengthen their HRM systems, including leadership, management, and governance (LMG) with the ultimate goal of improving the recruitment, retention, remuneration, and motivation of the public sector health workforce. Below are highlights of outcomes in HRM after the Mechanism's support.

NATIONAL HRH STRATEGY

The KHSHRS II focused on six key outcome areas: 1) an adequate and equitably distributed health workforce; 2) a conducive environment that attracts and retains health workers; 3) a responsive institutional framework that supports workforce performance management; 4) responsive human resources development (HRD) systems and practices; 5) strengthened HRD planning; and, 6) adequate financial resources mobilized to support investment in HRH. To align themselves with the national strategy, a number of counties (Mombasa,

Nyamira, Nakuru, Baringo, Bungoma, Kilifi, Turkana, Kakamega, Homa Bay, Garissa, Meru, Nyandarua, Makueni, Busia, and Nairobi) customized their own county HRH strategic plans for implementation.

As a result of implementing KHSHRS II, the number of health workers grew 46%, from 46,259 at the time of devolution to 67,740; and 45 out of 47 counties have established HRH units. The units have evolved as the center for HRH partner support, budget advocacy using the HRH budgeting checklist, maintaining and availing HRH data for decision-making, conducting county HRH maturity assessments, and sustaining HRH interventions toward counties' journey to self-reliance. The average score on KHSHRS II implementation, based on the six outcome areas, was 3.04 out of 4 points, reflecting a 76% achievement on key performance indicators. Outcome 5, strengthening HRD planning and management, had the highest score at 3.6, with 90% of the strategic initiatives planned under this outcome being implemented.

The Mechanism supported the development of the third Kenya HRH Strategic Plan, 2019–2023 to provide a framework to guide interventions, investments, and decision-making in HRH planning, management, and development at the national and county government levels for the next five years. The strategy's theory of change is anchored on three key drivers: efficiency, adaptability, and innovation. Efficiency implies a productive workforce driven by operational excellence, which will be achieved through optimal utilization of available health workers to maximize return on investment, among other factors. Adaptability connotes the adoption of high-impact HRH management models, systems, and processes that are responsive to diverse workforce needs and contexts. Innovation denotes pedagogical, systemic, and technology-driven solutions that promote the application of best HRH practices.

The Mechanism conducted LMG training for 96 health sector branch union leaders/county chapter representatives toward better engagement with county governments to avert health worker unrest and ensure continuity in health care, especially for HIV and RMNCAH/FP services. The Mechanism also conducted HRM leadership training for 130 health workers, including 61 reproductive health coordinators, to build their leadership and managerial capacity. The LMG training is a six-week competency-based training, with five days of face-to-face sessions during which participants

interact with facilitators. It is based on the common strategy training curriculum developed by the MOH in collaboration with health sector partners. The training focuses on strengthening health systems at the county level by training health managers in critical leadership and management skills to complement their technical skills. The training is focused on CHMTs and health sector trade union leaders at the national and county levels.

WORK COUNCILS

As an outcome of the LMG trainings, the Mechanism supported 25 counties in establishing joint consultative dialogue platforms called work councils, with clear terms of reference and regular trade union engagement with health leaders. Through the work councils, issues affecting health workers, such as delayed salary payments, poor working conditions, and stalled career progression, have been resolved with responsive systems, enabling health workers to be well placed, skilled, available, and ready to deliver health services without disruption.

> "Since the formation of the work council, we are able to freely chat on WhatsApp, sit and discuss challenges faced by health workers, and jointly make resolutions to address them. We have had no strikes since the formation of the council, and we are able to treat each other as partners in improving health service delivery in the county."
>
> —*Dr. Dalmas Oyugi,*
> *County Chief Officer of Health,*
> *Migori County Government*

WORKLOAD INDICATORS OF STAFFING NEED

The Mechanism supported 19 counties in conducting workload analyses using the WHO's Workload Indicators of Staffing Need (WISN) method. The objective was to compute actual staffing requirements and gaps for the rationalization of staffing at service delivery points in HIV and RMNCAH/FP service provision. WISN assists health managers in making better and more systematic staffing decisions. The study covered 147 facilities and 47 community health units and found: 1) imbalances, shortages, and/or surpluses of health workers across cadres and levels of care; 2) a skewed distribution of HIV and RMNCAH health workers that favored level 4 and 5 health facilities; and 3) high unauthorized absenteeism, ranging from 23.4% to 26.8% of health workers by cadre

and levels of care—a major bottleneck to attaining health worker efficiency. Counties have used WISN to determine actual staffing requirements for nurses and clinical officers and have recruited additional health workers and deployed them in facilities with high workload pressure based on the WISN results, and redeployed surplus staff to areas of need. The counties are addressing workload and absenteeism challenges and are undertaking staff rationalization based on the WISN evidence.

HRH STAKEHOLDER COORDINATION FORUMS

The national HRH inter-agency coordination committee (HRH-ICC) framework was cascaded to the counties soon after devolution to address the HRH coordination gap and to provide linkage to the national level on capacity-building, policy-making, HRH regulation, and standards provision. This framework was also developed in fulfillment of Kenya's HRH commitments declared during the Third Global Forum on Human Resources for Health in Recife, Brazil in November 2013 and intended to support implementation of KHSHRS II. The national HRH-ICC thus decentralized to the counties, forming inter-county cluster HRH stakeholder coordination forums. In support of the Mechanism's aim to transform Kenya's national HRH agenda into action at the county level, the HRH coordination framework has been instrumental in: 1) expediting the development, customization, and dissemination of policies; 2) enabling national HRH officers to mentor their county counterparts; and, 3) providing collaborative platforms for multiple stakeholders to resolve HRH challenges and harmonize HR practices nationwide. Successes catalyzed through the inter-county stakeholder forums include hiring over 27,000 health workers to address shortages, expanding the national Integrated Human Resources Information System (iHRIS) to all 47 counties, developing guidelines for the sharing of specialist providers across counties, establishing professionalized HRH units in 45 counties, and promoting work councils to address health worker industrial unrest.

The HRH coordination framework serves as a sustainable model for creating a multi-stakeholder platform that fosters open dialogue and promotes consensus, commitment, and cooperation on key HRH priorities, especially in devolved health system management (Figure 3). Some of these solutions and recommendations have been successfully integrated into ongoing HRH interventions, with

Figure 3: The Inter-County Cluster HRH Stakeholder Coordination Framework
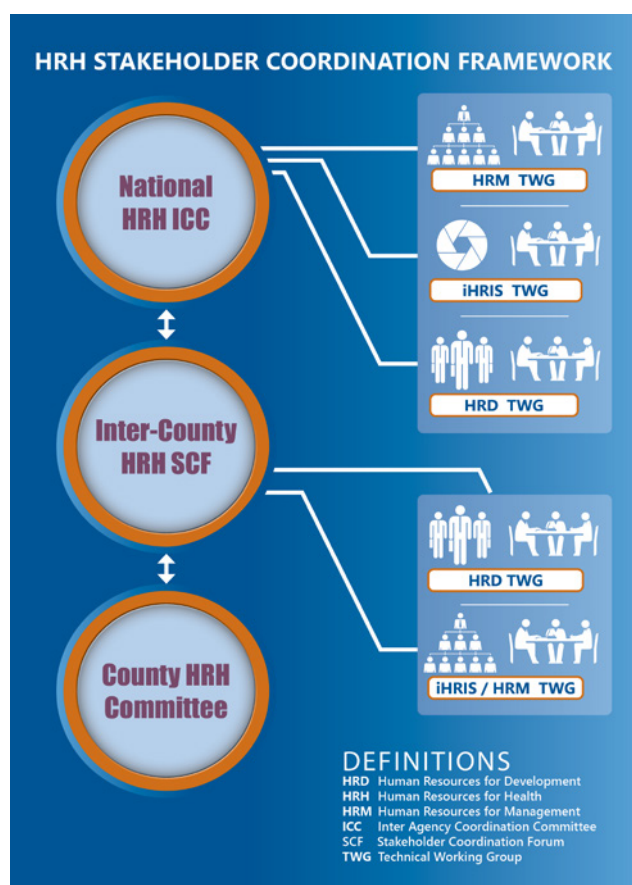
commendable results. This endeavor needs to be sustained to significantly impact the health care service delivery systems in Kenya.

INCREASED COUNTY HRH BUDGETARY ALLOCATIONS

The newly created HRH units participated in the budgeting process and in HRH budget advocacy using both the HRH budgeting tool and checklist. Table 1 shows outcomes from three focus counties with regard to budgetary allocations.

IMPROVED PLANNING AND FORECASTING

The Mechanism supported staff audits to facilitate HRH planning and forecasting, as well as to determine bottlenecks that hinder effective and efficient service delivery. In Siaya County, the audit established HRH staffing gaps and an overreliance on donor-supported contract workers (55% of health workers being county workers and 45% being partner contract health workers); this overreliance was particularly pronounced in the provision of HIV services. Advocacy using the budgeting tool and checklist was conducted at the staff audit findings dissemination meeting. The county budgeted for KES 142,382,996 and recruited 78 health workers, of whom 77% are key staff, to provide HIV services and work toward universal health coverage. Homa Bay County addressed identified gaps in health worker distribution and harmonized its payroll, including removing exited staff. Kiambu County improved its nursing health worker projections using iHRIS. Nairobi County, jointly with the USAID Afya Jijini project, used audit findings to develop a proposal for recruitment that was approved by the county secretary; 230 health workers were thus earmarked for recruitment. Mombasa County undertook a budget analysis of 262 health workers who had left the service between 2013 and 2018 and realized that the unutilized budget amounted to KES 323 million. The county hired 286 health workers using the identified budget savings.

IMPROVED ENABLING ENVIRONMENT FOR HRH

Fifteen counties adopted the Public Service Commission guidelines to develop and implement staff performance appraisal tools to improve staff performance management and health worker productivity and to set annual performance targets. Five counties developed job descriptions—with defined health worker roles, reporting lines, and performance management measures—for county

Table 1: Budget allocation outcomes from three focus counties

County	Budget allocation		% Increase in budget allocation	Allocation for
Year	FY2017/18	FY2018/19		
Nairobi	295,576,472	339,959,400	15%	Promotion, Recruitment, Performance Management
Mombasa	509,139,973	559,044,415	9.8%	Promotion, Attrition, Retirement
Siaya	56,396,717	142,382,996	152%	Recruitment of Additional 78 Health Workers

Photo 1: Completed Migori staff job descriptions and staff performance appraisal system guidelines and tools for the various counties
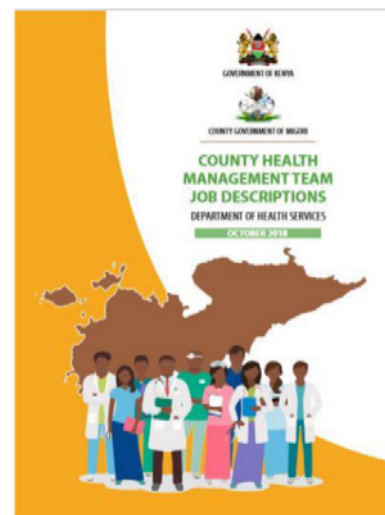
department of health employees. These efforts are critical to strengthening commitment to purpose, harmonization of the work environment, and codes of ethics. In addition, counties adopted best practices for effective health worker attraction, recruitment, deployment, and retention, including incentive guidelines (2), staff job descriptions (6), and staff performance appraisals (14).

ESTABLISHING COUNTY HRH MATURATION

To determine the uptake of HRH interventions by counties, the Mechanism developed an HRH maturation tool that rates the counties' HRH systems status. The tools measure four stages of maturation—initiation, development, expanding or consolidation, and sustaining. Action plans are drawn to support progression to the next stage. Once the sustaining stage has been attained the county is ready to transition from direct project support. HRH maturation is based on the following HRM and HRD components and subcomponents: 1) HR capacity; 2) HR strategy; 3) HRH policy and practice; 4) performance management; 5) HRM data; 6) staff training and development; and 7) gender mainstreaming in HRM.

As of the Mechanism's midterm evaluation in September 2019, overall maturation had grown by 0.5 points, from 2.6 at baseline to 3.1, out of a maximum of 4 points. The HRH components with the highest maturation scores were HRM data at 3.3, HR policy at 3.1, and performance management at 3.0. The increased scores are attributed to the Mechanism's and service delivery partners' extensive interventions in customizing and implementing policy guidelines at the county level; training in HR data for decision-making; updating

and adopting iHRIS for use by the counties; and advocating for staff performance appraisal system implementation. The lowest score was registered under staff training at 2.6, followed by gender mainstreaming and HR strategy at 2.8 points each.

Regarding maturation status, the most improved counties from baseline were Mombasa, which went from 2.3 to 3.7; Kisii, from 2.1 to 3.4; and Kisumu, from 2.3 to 3.5 (Figure 4). The counties with the lowest scores were Meru and Uasin Gishu, both at 2.1. Their low performance is attributed to very low scores on HR capacity, HR strategy, and staff training and development.

HRH UNITS

The Mechanism revised the MOH's generic concept note for staffing the HRH units, proposing three HR staff members for each county HRH unit, to facilitate the implementation of all HRM, HRD, and HRH data analytics at the county health departments. Counties adopted and customized the concept note for their own use. Forty-five counties have placed 189 HR officers in HRH units, and 50 HR managers trained in mentorship have mentored 77 HR officers.

Nairobi County has developed a gender implementing matrix to monitor the implementation progress of the Mechanism-supported gender policy guidelines. A sample gender analysis for the leadership team indicated that while top leadership (County Executive Committee members and the Chief Officer of Health) is 100% male, overall, the rest of the leadership team is well balanced in terms of gender (Figure 5). These results indicate the progressive mainstreaming of gender in leadership.

CHALLENGES

- Limited funding strained the scale of interventions that could be implemented simultaneously. This funding deficit affects sustainability efforts, as most interventions are donor-funded.

- The USAID suspension order on the national MOH and affiliated institutions significantly affected policy-related interventions, as policymaking is a national-level function.

- Frequent changes of top leadership among health department and HRH officers affected smooth implementation of HR interventions at county levels.

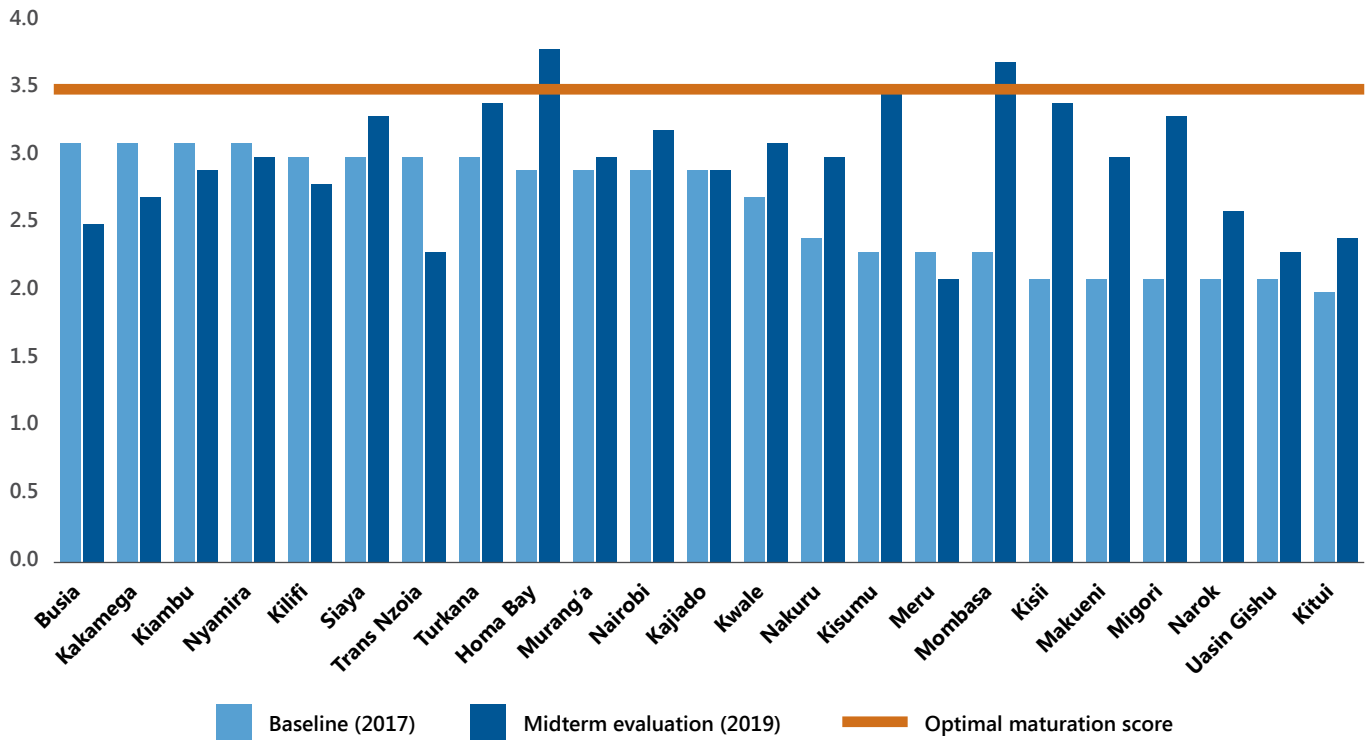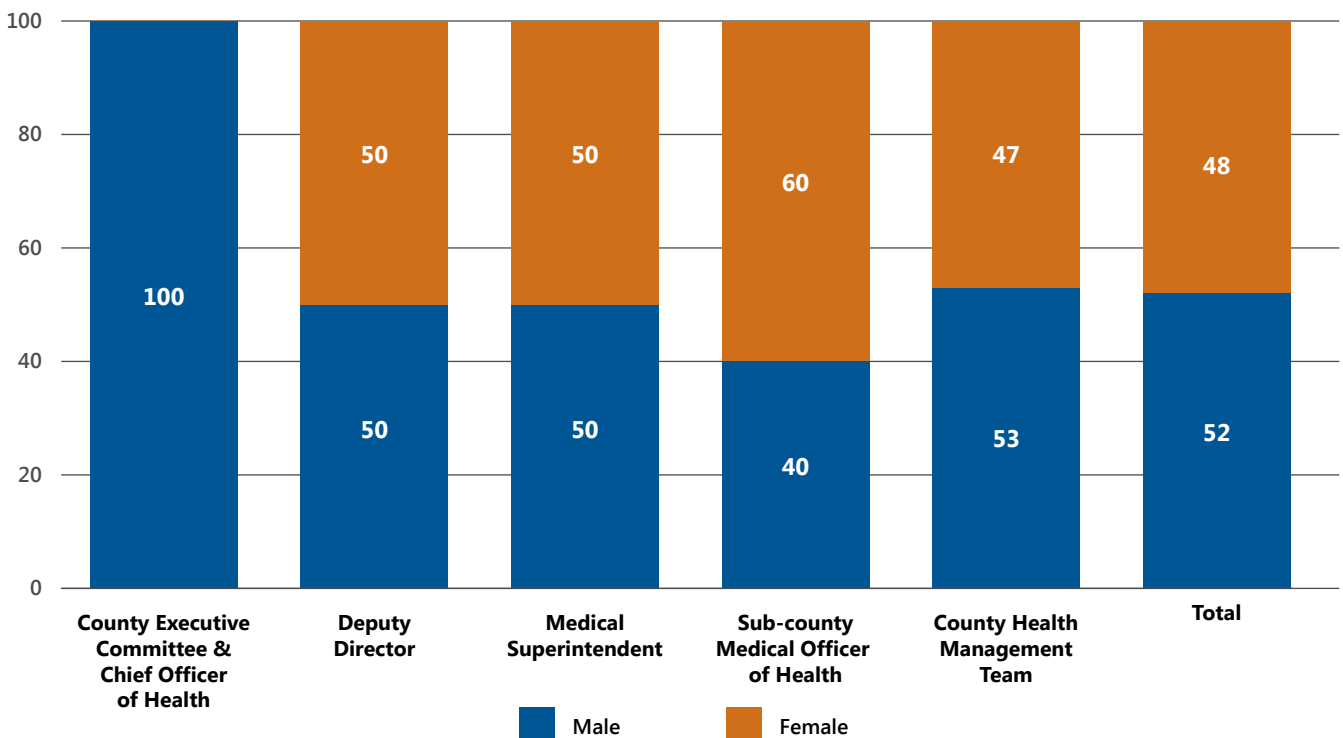**Figure 4: Summary of county maturation scores based on midterm evaluation (2019)**

Figure 5: Nairobi county leadership team, disaggregated by gender

LESSONS LEARNED AND RECOMMENDATIONS

- The inter-county stakeholder forums, with members co-opted from other departments (e.g., the county public service board, public service management, information and communication technology) on an as-needed basis, have played a critical role in resolving HRH issues, thus improving the working relationship between county departments and strengthening HRH.

- Sustained collaboration with service delivery partners in areas such as training facility in-charges and health managers with HRM responsibilities, supporting county HRH/iHRIS technical working groups, and coordinating HRH through inter-county stakeholder coordination forums, is instrumental in building county health systems, including strong HRH systems, and attaining UNAIDS' 90-90-90 targets, among other health and development goals.

- The counties' partial or full financing of the HRH stakeholder forums provides a means of progressing toward their self-sustainability. The forums need to be fully financed by the counties and incorporated into annual budgets.

- Regular communication and dialogue forums between counties and health worker union leaders, as demonstrated in Uasin Gishu, Nyamira, Migori, Turkana, and Mombasa counties, provide opportunities to identify and address emerging challenges in a timely manner, thereby averting industrial unrest and strikes.

CONCLUSION

Kenya's national and county governments have demonstrated their commitment to making key HRH reforms and policy guidelines in line with devolution. The HRH Kenya Mechanism has fostered and led the formation of enabling HRH management policies and guidelines at the national level and has facilitated their adoption, dissemination, and use by county governments.

Through technical assistance, county governments are more responsive with regard to health worker attraction, recruitment, deployment, retention, motivation, and performance, which helps ensure the continuity of service delivery. Counties are now better prepared to prioritize investments that strengthen HRH governance and systems, leading to sustained improvements in the quality of, access to, and use of priority health services, as initially envisioned during the Mechanism's start-up. Success stories, best practices, and challenges have been documented and can be accessed as learning materials for both current and future HRH programming. The counties should continue and scale-up HRH management best practices to ensure quality health service delivery.

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CONTACT

Dr. Janet Muriuki
Country Director, Kenya
Program Lead, HRH Kenya Mechanism
jmuriuki@intrahealth.org

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