

METHODS

Rethinking the human resource (HR) strategy in the face of systematic failures in the devolved health sector in Kenya

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This viewpoint paper is about rethinking the human resources (HR) strategy in the face of systematic failures in the devolved health sector in Kenya. The paper gives a background introduction of the health sector of Kenya as defined and established by the constitution of Kenya, explains the sharing of functions devolved in the health sector, and explains the history of devolution of the health sector. Under the identification and justification of the study, the paper highlights how specialized skills in health service provision are concentrated in urban centers and emphasizes a lack of inter-county transfer of services. The paper further explains the distribution of healthcare service provision, the current management of HR, and the statement of specific problems in Kenya; such problems include outcry from healthcare providers, which is manifested by frequent strikes across the country over issues to do with salaries, promotions, and career development. The viewpoint of the authors is that the seven building blocks of the health sector in Kenya are vital. The six building blocks can be handled by county governments while one block that deals with the management of HR of the health sector should be reformed, strengthened, and handled by the national government, hence the paper proposes the introduction of a health service commission to manage human resource components of the health sector. Finally, boost the Ministry of Health's effective control of the healthcare workforce by advancing and integrating policies relating to health systems, services, and cross-sectorial collaboration to revive primary healthcare services and attain universal health coverage.

Keywords: Devolved, health sector, human resource, Kenya, strategy, systematic failures

1. Background of the study

Kenya's 2010 Constitution guarantees health to all Kenyans. According to Article 26, everyone has the right to life; a clean and healthy environment (Article 42), and the highest attainable standard of health, including healthcare services, including reproductive health care Article 43 (1) (a); and every child has the right to essential healthcare, nutrition, and shelter Article 53 (1). (c)(1).

According to the constitution, it is the state's responsibility to implement affirmative action programs to ensure that

marginalized and minority groups have fair access to health services, water, and infrastructure [Article 56 (e)](1, 2).

The health sector was the most significant service sector devolved in Kenya during the devolution administration. The rationale for devolving the sector was to enable county governments to develop innovative models and interventions tailored to their communities' unique health needs, foster effective citizen participation, make autonomous and timely decisions regarding resource mobilization, and provide leadership on potential issues. This sector is confronted with a human resource shortage, leading to the stagnation and

even reversal of some gains in healthcare, as measured by health indices (3).

Devolution is a technique of decentralization in which authority is reorganized to distribute responsibilities between the national/central government and regional governments. Its objective is to increase public participation and advance individual liberty. Counties created by devolution are independent of direct control from the national government, and federalism is the most critical kind of devolution (4).

Devolution was prompted by the requirement for a new constitution in Kenya that ensures equity in wealth distribution throughout the nation (5). Kenya's devolution history dates back to 1963, when the colonial authority proposed the construction of regional entities based on ethnicity, though the proposal never saw the light of day (5). In the period from 1970 to 1990, the World Bank and the International Monetary Fund funded the establishment of many decentralization units as part of structural adjustment reforms that continued to promote decentralization. Since independence, Kenya has devolved certain powers at the national level. The new constitution established devolved units; in 2013, the Kenyan government confirmed a devolved governance form of authority. This new form of administration consisted of 47 new units with some autonomy from the federal government (6). After the 2012 elections in Kenya, the new regime had the opportunity to ratify and implement the Kenyan 2010 constitution; decision-making authority was given to and exercised by the newly created administrative units, i.e., the counties, each headed by an elected governor. Primary and secondary healthcare services were outsourced to counties to facilitate budget allocation, improve long-term health service delivery to the public, and bring decision-making influences nearer the local governments (7). The national government periodically disburses funding to counties, considering each county's integrated development plan.

Kenya's 2012–2013 health strategy plan mandated that each county establish a health department (8). Additionally, it established a structure for the county's health management teams, whose mission is to provide competent and consistent technical assistance to expedite the harmonization and operation of health transfer programs through the medical care facilities. Devolution distinguished between the tasks that the national government was required to accomplish and keep and those that were devolved to counties (7).

For instance, at the national level, the government is to be in charge of all health supply agencies in Kenya, including the National Hospital Insurance Fund, the Kenya Medical Training College, and the Kenya Drugs and Supplies Agency (7). Furthermore, the national government was responsible for the following functions: financing county health programs, overseeing and coordinating the operation of 14 national referral hospitals, managing laboratories in all public health facilities, implementing significant diseases

control programs such as leprosy, malaria, and tuberculosis, formulating health policies, and forming public-private partnerships. Additionally, the national government plans and funds all health services at the national level, the dissemination of critical medical knowledge and technical advancements, and quality assurance and standardization.

Counties were tasked with the following responsibilities (7): preventing drug abuse through campaigns and pornographic control, providing veterinary amenities except in instances where veterinary professionalism guidelines are mandatory, providing public health and sanitation amenities, managing disasters such as floods, conducting disease surveillance, responding to outbreaks, equipping hospitals with ambulances, and finally, managing health facilities and pharmacies.

2. Identification and justification of the view point

It is worth mentioning that medical facilities are not distributed equitably among Kenya's 47 counties. This situation is exacerbated; for example, inhabitants of northern Kenyan counties such as Mandera, Turkana, and Wajir travel considerable distances for two or more days to get healthcare services at the nearest facility, lowering the health indicators in these regions below the needed level in comparison to other counties across the country. In general, 50% of counties in Kenya have fewer than two health amenities per 10,000 inhabitants and fewer than 4.2 health facilities per 100 square kilometers (3). According to the WHO, Kenya suffers from a severe shortage of healthcare workers. Currently, the doctor-to-population ratio is 13:10,000; this is low compared to the WHO's minimum need of 23 healthcare professionals per 10,000 inhabitants (9).

There are considerable disparities in the number of medical care workers between counties. The ratio of medical workers to the total population in the country is significantly lower than the WHO-suggested ratio of 230 people per 1,00,000 population; it is at 169 per 1,00,000 people. However, it is superior to other East African countries like Malawi, Tanzania, and Uganda (9). Nairobi county and counties in central Kenya are better resourced and have a higher ratio than rural counties. Additionally, in some counties, an insufficient workforce has resulted in industrial unrest that has wrecked operations and provision of health services; for example, from January to August 2015, a huge number of counties (i.e., 50% of the country) experienced health worker strikes, with understaffing cited as a primary factor (3). The health industry is experiencing a brain drain, which has been exacerbated by devolving health systems, as between 30 and 40% of about 600 doctors relocate to developed countries in search of superior salaries and better working circumstances (10). According to devolution, every

county has responsibility for recruiting and hiring healthcare professionals. Kenya's health industry has seen a considerable loss of qualified health workers, primarily due to bad working conditions and insufficient remuneration. Various reports indicate that around 5,000 Kenyan professional doctors have departed, and another 3,000 have left the health field to work in other areas. As a result, just roughly 3,440 physicians care for the large populace. Devolution has been blamed for many of the health sector's present issues (11).

Thus, the viewpoint is that human resource concerns should be thoroughly scrutinized and handled to alleviate the crisis in Kenya's health sector. The six health building blocks should remain devolved in the devolution of the healthcare sector; however, only the human resource building block should be controlled by a commission (health service commission) under the national government.

3. Situational analysis, challenges, and proposed mitigation strategies

3.1. Scrutiny of the situation

According to the WHO, it is critical to have an adequate number of professional, motivated healthcare employees to achieve Universal Health Care (UHC). While examining devolution tactics in healthcare provision and the hospital's quality of service, it was discovered that human resource management had a favorable and significant influence on healthcare services in Nairobi County, Kenya (12). The government of the Philippines has devised a human resource policy for healthcare employees. The policy prioritizes human resource production, which includes continuous quality improvement of health worker education; human resource outflow and inflow to ensure that health workers have decent working conditions; and workforce distribution and efficiency, emphasizing planning for an adequate and competent health workforce and prioritizing health worker deployment. They have incorporated cross-cutting policies into the policy, including the institutionalization of human resource governance, investment in human capital, and ICT growth in human capital (13).

In Indonesia, a study on the decentralization of public healthcare services discovered that devolution was not working as intended due to poor local apparatus competencies to comprehend and implement the programs' ethics and practices on the ground; poor financial resources; and lack of enough support to carry out the programs (14). A study conducted in Sudan revealed that the devolution of health services had resulted in a degradation of health services, especially availability, price, and quality. The younger, inexperienced professionals prescribed the medications, and the more expensive medications were not covered by insurance. Additionally, it was noted that HR

management was centralized, job security deteriorated, and the quality of training decreased following devolution (15). To determine the level at which healthcare human resource challenges influence healthcare providers in the devolved system of government in Bungoma County, Kenya (16). The findings indicated that healthcare workers had a favorable and statistically significant relationship with healthcare provisions ($r = 0.406$, $p = 0.013$). Hence, the state of health services in Bungoma County is extremely concerning, principally the hospital strike, which has had a disastrous effect on residents' health and resulted in the collapse of key healthcare, notably for expectant mothers and infants (16).

Numerous obstacles hinder the development of Kenya's health employees, including significant shortages of critical cadres, uneven pay among cadres, low and terrible working conditions, and a want of health employees. Radiologists, nurses, physicians, clinical officers, nutritionists, laboratory technologists, and health records officers are critical cadres facing acute shortages. The WHO recommends a minimum of 2.3 nurses, midwives, and physicians per 1,000 people, but Kenya, a country with a population of 44 million people (2014), has a ratio of 0.1 physicians and 1.2 nurses and midwives per 1,000 people. In light of the national deficit, the uneven distribution of healthcare employees exacerbates injustices. Rural and remote locations face the most significant shortages of healthcare workers. As of 2012, a county like Mandera (one of the hardship areas in the larger northern Kenya) had 0.9 public servant nurses per 10,000 residents, whereas the county of Kwale (a rural county in the Kenyan coastal area) had 3.7 public sector nurses per 10,000 residents (17). Kisumu County (which hosts Kisumu city) has 7.3 public servants nurses for every 10,000 residents (17). Highlighted distribution disparities are the most pronounced in arid and semi-arid regions in Kenya. Whereas health worker issues influence service delivery across the country, coverage of health services in counties dominantly in arid and semi-arid areas like Isiolo, Garissa, Wajir, Mandera, Lamu, Marsabit, Tana River, Turkana, West Pokot, and Samburu is noticeably worse, with the lowest health worker-to-population ratio in the country. Although the counties in the ASAL areas account for around 35% of Kenya's population, they account for only 2% of nurses, 2% of physicians, and 5% of clinical officers (18). Though these ASAL areas have unique and predominantly characterized by rural geography, nomadic lifestyles, low population density, insufficient infrastructure, inadequate telecommunications amenities, and insecurity, the ASAL region is harmed by several issues that limit access to excellent service provisions and contribute to poor health outcomes. These conditions also act as a deterrent to recruiting and retaining future and current healthcare personnel.

Human resource management issues such as staff transfers, wage payments, and conditions of service continue to be a source of concern. These questions emphasize persistent tensions between three principals: MOH civil officials,

political leaders in the counties, and healthcare employees, all of whom wish to maintain or grow their control over the devolved healthcare system. County governments are seeking jurisdiction over the hiring, firing, and setting of health professionals' criteria to increase their power and autonomy over control. To protect healthcare employees as provided for and envisaged in public service health delivery and performance, health professionals have petitioned the national government to establish a Health Services Commission with a mandate to allocate health employees to the counties in order to protect their conditions of service (19).

3.2. Human resource challenges in the health sector in Kenya

Significant problems confronting Kenya's devolved health sector (20) in terms of human resource strategy include the following:

- Strikes by healthcare workers.
- Human resources: inter-county transfers and staff rationalization are a concern.
- There is a dearth of enticing packages in the counties that can attract specialists.
- The county's ties with the national government are poor, especially with delay in releasing funds and solving issues related to industrial unrest by health workers.
- The allocation to the health department in the counties is below 15%, as per 2001 Abuja's declaration (20).
- Concerns about job security among healthcare personnel.

3.3. Suggestions for mitigation

- The critical need to bolster health sector human resource reforms, including establishing a health service commission to manage human resource components.
- Reinforce the Ministry of Health's considered oversight of health personnel by advancing and coordinating policies connected to healthcare services, systems, and cross-sectorial collaboration in order to revitalize healthcare and accomplish universal health coverage.
- At the national, county, and local levels, develop health workforce leaders with specialized human resource policy and management skills.
- Identify mechanisms for improving the health workforce's skills and professionalism.
- Establish processes for implementing an effective human resource management model, emphasizing on the promotion of the healthcare career law

and institutionalizing human resource management policies that affect service quality, productivity, and universal coverage, like performance management policies, incentives, recruitment, and hiring.

- Assist in measuring and monitoring health sector human resource goals and conducting research into the areas where the nation has made the greatest progress.

4. Reforms and proposed mitigation strategies implications

- Strengthen and reform human resource management in the health sector, including establishing a health service commission to oversee human resource components.
- Developing the Ministry of Health's Human Resources department with a new strategic role on the availability of human resources policies, procedures, and manuals at the national, county, and local grass root levels that establishes a cross-sectorial harmonization team.
- At the national, county, and local levels, current numbers should be trained in human resource policy, planning, and management.
- It is necessary to map the stakeholders involved in human resource training and to undertake a situational analysis of human resource training.
- Introducing Healthcare Career policies; establishing teams to develop the Healthcare Career bylaws; mapping human resource management procedures; and the existence of HR procedural manuals.
- Implementation of a health sector monitoring system at the national, county, and local levels to achieve human resource objectives.

5. Conclusions and recommendations

5.1. Conclusion

The government of Kenya is committed to enhancing the health and well-being of its citizens by focusing on the provision of healthcare and universal health coverage. The initiative's central objective is to strengthen the health workforce and management systems necessary to foster effective and efficient performance and the provision of better quality services. The government should be eager to declare its future human resource commitments by recognizing the critical nature of human resource systems, strengthening them, and having a strong foundation of HR personnel in the face of the many systematic challenges faced as a result of devolution in this country.

The national government is on track to meet its obligations by the projected completion dates due to a clear focus on processes, policies actions, and necessary stakeholders. To capitalize on the momentum gained, the government immediately began carrying out its stated commitments. A critical component of Kenya meeting its human resource commitments is developing a results structure that describes progress and outcomes based on indicators connected with completion periods or by leveraging existing human resource frameworks. Kenya may benefit from benchmarking from the successful experience of developed countries that have devolved healthcare in connecting their human resource commitments to the existing framework and utilizing that structure to necessitate and enable their progress toward the HR commitments.

5.2. Recommendations

- The establishment of the Health Workers Service Commission with the mandate to manage health workforce functions and centralize management of health workers.
- Strengthen ties with partners in order to assist state intervention to fund projects to improve the delivery of services, health personnel availability at the household level, and underlying health reforms.
- Embrace a tri-collaborative approach to delivering health interventions in order to achieve the highest potential health results among the public service (beyond health), private and non-governmental agencies, and faith-based groups at the national and county thresholds in the future.
- Enhancement of affordable private partners' investment in the provision of healthcare with counties ready to necessitate with the provision of ICT solutions, infrastructures, and financing of HR development for example through revolving education fund and related initiatives.
- Ensure the registration exercise for the Capacity Assessment and Rationalization of the Public Service (CARPS). CARPS and Quick Report releases make headcount and biometric data for each staff member ready for implementation.
- Improve efficiency and effectiveness in HR processes like recruiting and managing records by minimizing recruitment U-turn time and increasing utilization of ICT for cost-effectiveness.

Author contributions

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References

1. Const2010. *Kenyalaw*. (2022). Available online at: <http://www.kenyalaw.org/lex/actview.xql?actid=Const2010> (accessed May 3, 2022)
2. Kipchumba M. *Devolution and the health system in Kenya*. (2012). Available online at: https://www.healthpolicyproject.com/ns/docs/Kenya_Kipchumba_Presentation.pdf (accessed May 2, 2022)
3. Land Portal. Council for the development of social science research in africa. *Afri Dev*. (2017) 1:55–77.
4. Unit. (2022) Available online at: <https://nmbu.brage.unit.no/nmbu-xmlui/bitstream/handle/11250/2612581/Job%20Kubai%20Ntongai%20Master%20Thesis%202019.pdf?sequence=1&isAllowed=y> (accessed May 2, 2022)
5. Khaunya M, Wawire B, Chepng'eno V. Devolved governance in kenya; is it a false start in democratic decentralization for development. *Dev Int J Econ*. (2015) 4:23–43.
6. Mwabu G, Kibua T. *Decentralization and devolution in kenya: new approaches*. Kenya: Nairobi University Press (2008).
7. Kenyalaw. (2022). Available online at: <http://kenyalaw.org/kl/fileadmin/pdfdownloads/bills/2015/HealthBill2015.pdf> (accessed May 2, 2022)
8. Dhsprogram.com. (2022). Available online at: <https://dhsprogram.com/pubs/pdf/fr308/fr308> (accessed May 2, 2022)
9. World Health Organization. (2022). Available online at: <https://apps.who.int/iris/bitstream/handle/10665/250330/9789241511407-eng.pdf> (accessed May 2, 2022)
10. Standard Team. *Blame game as Kenya's health crisis hurts*. (2015). Available online at: <https://www.standardmedia.co.ke/health/article/2000174647/blame-game-as-kenyas-health-crisis-hurts?pageNo=2%2C%20accessed%2014%20September%202015> (accessed May 2, 2022)
11. Linda J. Devolution, shifting center-periphery relationships and conflict in northern Kenya. *Polit Geogr*. (2018) 63:135–47.
12. Sylvia A, Ragui D. Devolution strategies in healthcare provision and quality of services in hospitals: the case of mbagathi hospital, nairobi county. *J Strat Manage*. (2018) 3:57. doi: 10.47672/jsm.355
13. Tangcalagan K, Bool DP. *Universal health care in the philippines through the lens of workforce 2030: an omnibus review of human resources for health policies*. Manila: USAID Human Resources for Health 2030 Philippines (2019).
14. Trimurni F, Mansor N. Decentralization of public healthcare services in the province of sumatera utara. Indonesia. *Int J Public Health Sci*. (2020) 9:364. doi: 10.11591/ijphs.v9i4.20508
15. Salah B, Mohamed N, Sony A. *Devolution Of Health services a study of the implementation of decentralization in khartoum locality, sudan*. (2016). Available online at: <https://www.duo.uio.no/bitstream/handle/10852/53261/1/V10-A4-fixed-Final-devolution-thesis.pdf> (accessed May 2, 2022)
16. Kipruto A, Letting N. Factors influencing provision of health care in a devolved system of government, bungoma county, Kenya. *Global J Health Sci*. (2017) 2:13–38.

17. Wakaba M, Mbindyo P, Ochieng J, Kiriinya R, Todd J, Waudo A, et al. The public sector nursing workforce in Kenya: a county-level analysis. *Hum Resour Health*. (2014) 12:6. doi: 10.1186/1478-4491-12-6
18. Muriuki J, International I. *Kenya makes progress toward HRH commitments in a devolved health system*. (2015). Available online at: <https://www.intrahealth.org/sites/ihweb/files/resource-other-attachments/hrhcommitmentskenyacastudy.pdf> (accessed May 2, 2022)
19. Healthpolicyproject.com. (2022). Available online at: https://www.healthpolicyproject.com/pubs/292_KenyaConditionalGrantsreportFINAL.pdf (accessed May 2, 2022)
20. UHC. *A framework for action*. (2022). Available online at: <https://documents1.worldbank.org/curated/en/735071472096342073/pdf/108008-v1-REVISED-PUBLIC-Main-report-TICAD-UHC-Framework-FINAL.pdf> (accessed May 3, 2022)