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Human Resources for Health Issues in Kenya

Constraints and opportunities from a recent baseline survey

Introduction

The Human Resources for Health (HRH) Advocacy project funded by the European Union through World Vision Austria is implemented by World Vision Kenya (WVK), Health NGOs Network (HENNET) and African Medical and Research Foundation (AMREF) in Kenya. World Vision Kenya (WVK) is the local managing partner for the project.

The Project was initiated to support budding effort by both Kenya government and development partners to address critical HRH constraints facing the health sector. It seeks to strengthen the voice and clout of civil society organizations (CSOs) to advocate for additional health workers as a critical contribution to revamp primary health, and to ensure effective community based demand side accountability from primary health delivery institutions.

In order to set the stage for evidence based advocacy, the project launched a series of rapid studies and assessments to unearth the baseline situation of different dimensions of HRH in Kenya. This paper summarizes the outcome of a rapid baseline survey and reveals critical gaps in the policy framework for HRH as well as resource constraint that must be addressed through additional budgets and better articulation of health workforce issues beyond personnel emoluments. The study shows the need for civil society organizations to join hands with development partners, Faith based organizations to advocate and support implementation of specific measures to address well documented HRH challenges.

Purpose of the baseline

The purpose of project baseline survey was to assess the baseline status of HRH policies and practices, community health strategy implementation and the overall health sector advocacy by stakeholders. The survey objectives, which are built around the project objectives and the four key result areas were: i) To establish the general level of knowledge on current HRH policy environment and practices among the government, partners and other civil society organizations; ii) To conduct an inventory of the type and number of health workforce in Kenya and their distribution relative to the population; iii) To identify the various health ministry/sector processes related to HRH and the community strategy, their time lines and outcomes; iv) To assess the level of HRH related advocacy among key stakeholders such as implementing partners, CSOs and other NSAs; v) To determine the extent of implementation of the community health strategy in Turkana North, Yatta, Mwala, Kitui West (Mutonguni), Machakos and Nairobi East districts and in Kenya generally; vi) To identify any community based monitoring or social audit processes targeting improvement in health service delivery and/or other services in the six project districts; and vii) Recommend ways of remedying various situations to achieve project goal.

Methodology

The baseline survey employed methodological triangulation to ensure that there are multiple sources of evidence for validity and reliability. The approach comprised of participatory methodologies and included literature review of key documents reviewed including the Kenya Vision 2030, The Second National Health Sector Strategic Plan of Kenya (NHSSP II) 2005 –2010, the first National HRH Strategic Plan, 2009 – 2012; HRH ICC Terms of Reference; relevant health and HRH websites including MOMS, MOPHS, WHO, Kenya Open Data, and the HRH Global Resource Centre. Key informant interviews and a focused group discussions. The survey drew upon three major approaches for gathering information namely record reviews, qualitative data collection and site visits.

HRH Constraint – A scarcely documented subject

The findings of this survey indicate varied levels of understanding of HRH policies and practices. At the MOPHS and MOMS central levels there is fairly good knowledge of HRH policy environment and practices and the challenges to addressing critical health workforce constraints related to shortage, mal-distribution and their overall performance o

The HRH Strategic Plan

The government working with stakeholders developed the first National Human Resources for Health Strategic Plan 2009 – 2012, which offered a coherent HRH vision and framework to health workforce challenges a comprehensive manner. The Strategy articulates a basis for health workforce projections and identification of HR gaps in a more structured manner, beyond mere vacancies. This is the first strategy that covers the entire gamut of HRH issues from HR planning and strategy, to training, workforce management, partnership strengthening, and resource mobilization and retention issues. It prioritizes problems related to staff shortages and mal-distribution, retention challenges, weak human resource management systems, weak leadership and management capacity, weaknesses in pre-service and in-service training, poor sectoral coordination of the HRH agenda, and low compensation and benefits package. Overtime, these issues have resulted in decline in number of health workers and the attendant compromise on quality of health care.

However, there are limited innovative ideas to improve availability of staff. The HRD and HRM teams appear to be non-proactive in addressing structural issues that affect availability, distribution and quality delivery. Challenges of HRH at level 1 appear not to be central to the HRM and HRD departments. At the decentralized levels, there is inadequate appreciation of HRH policies and practices. Overwhelming attention is at two fronts; recruitment of additional staff and training.

Existing staff in middle level facilities are generally overloaded with work. At the district level, the situation is equally bad, with a handful of individuals acting as heads of several departments in the newly created districts with skeleton staff. With this environment, there is very limited knowledge of the HRH policies and desired practices. At the community levels the different contexts there seem to dictate the HRH practices that obtain on the ground. While some community unit members in some parts of the country appreciate the structure and staffing of CU components, the same is not the case in all areas.

Regarding staff availability and distribution, there is general shortage and inequitable distribution of health workforce. There is weak application of HRH Norms and Standards regarding staffing of the health facilities. At the community level there is no structured mechanism to address HRH issues. That notwithstanding, the outlook is not necessarily gloomy; HRH issues in are receiving increased attention. There has been an increase in the number of HRH related initiatives in the health sector, with the development of the HRH Strategic Plan 2009 – 2012 being a remarkable milestone towards concretizing and enhancing the success of the HR initiatives. Scaled up recruitment of key health staff, improvement of work climate initiatives, review of the status of health training institutions including the review of the curriculum to meet emerging sector requirements and refurbishment of infrastructure among many others are the major positive initiatives that are being realized. Further, the formation of the HRH ICC has been a major step towards ensuring sustained advocacy to address issues such as development of a responsive health policy framework in line with the new constitution, development of policy on recruitment and training, and recruitment of additional health workers.

At another front, progress is being made in implementing the community strategy and improving the desire and ability of community members to advocate for their own health needs, and of strengthening links between communities and health facilities. Through their various activities targeting community prevention programs, hard-to-reach populations, and networking between communities and clinical services, the interventions are reaching people with prevention and abstinence information. Community Health Dialogue Days is taking place, while health facilities in the six districts are being linked to communities and community structures. Referral systems in health facilities are being established. Perhaps most importantly, the link between the community strategy and strengthening health facilities has meant that community members who advocate for their health needs are now met with increased service capacity and availability in the health facilities attached to their communities.

On community based monitoring or social audit processes, Community Based health Information System (CB-HIS) activities are being implemented in selected districts. The CBHIS focuses on strengthening the capacity of CHW to collect data, analyze the same, and use the information to improve management of their health. When a community defines its own priorities, ownership is created along with a commitment to address identified needs. The result has been that information on health-related and MDG indicators is being captured using CBHIS. Village registers have become a major source of information enabling the community health committees, management committees, the DHMTs, and local CSOs to plan for and implement health care interventions, including prevention and health promotion.

Recommendations

In order to improve HRH status, there is need for a complete mapping of health workers to aid in planning. Plans are already underway through an initiative championed by capacity Kenya to map health workers and this should be hastened. The mapping exercise will present a better picture of health care workers involved in active health service provision, especially given that a significant portion of the professional health care workers have moved into management positions, both within the government and in

none state agencies. Currently, available data are fluid and characterized by temporariness due to the high movement of health care workers within the sector. The mapping will also help in magnifying shortages in provinces/counties.
Going forward, there is need for a practical strategy for attracting and retaining health workers in hard to reach areas; advocacy for legislation to establish a Health Workers Service Commission; establishment of a scheme of service for all MOH staff, harmonization of staff development and training and a shift in approach for the management of health facilities.

At the community level, there is need for uniform interpretation and implementation of community strategy provisions. If differences must be there based on contexts, then advocacy should focus on revising the Community Strategy guidelines. There is need for a practical framework for facilitating the work of CHWs and CHEWs, and for motivating the former. Further, there is need to increase the number of CHWs and CHEWs per district. This may require advocacy for adjusting of rules regarding employment through decentralized funds and other special initiatives. There is also need to harmonize the operations of CHCs, especially in regard to their terms of reference and relationship with CHWs. Advocacy should also focus on improving government budgeting for community strategy interventions. Still related to the community strategy, stakeholders should be mobilized through advocacy to clearly define a functioning community unit and actualize the same; currently there is a disjuncture between what is in the guidelines and what is obtaining on the ground
sustainability by engaging in income generating activities and exploring other ways of sourcing for funding.

About the HRH Advocacy Project

The Human Resources for Health (HRH) Advocacy project was funded by the European Union through World Vision Austria, and implemented by World Vision Kenya (WVK), the Kenya Health NGOs Network (HENNET) and African Medical and Research Foundation (AMREF) in Kenya. The Project seeks to enhance access to primary healthcare countrywide through advocacy for increased human resources for health (HRH) and effective community level demand side accountability from primary health delivery institutions.

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