

POLICY **Brief**

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Ministry of Health

Optimizing Human Resources for Quality Health Services

Insights from the Kenya Health Facility Assessment (KHFA) 2018

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Executive Statement

Human resource is an essential component of the health system, especially in the provision of basic health services. Efficient delivery of quality health services requires the availability of skilled human resources for health (HRH) in adequate numbers and rationally distributed at all levels of care.

The KHFA 2018 data reveals a situation in the country which needs to be addressed urgently, especially given that Kenya is gearing toward implementing Universal Health Care (UHC) countrywide. Nationally, the density of core health personnel is at 15.6 per 10,000. Only 6 out of 47 counties surpassed the WHO recommended target of 23/10,000. Only the distribution of clinical officers and nurses appear to have surpassed our own Norms and

Standards. Many countries have challenges in attaining the international benchmarks for core staff density but have undertaken many innovative measures to optimize their HRH component. In Kenya, devolution has come up with many challenges in the HRH sector and led to many knee-jerk decisions, leading to disparities in the quality of healthcare across the different counties. Many of the issues around HRH will be best resolved when the national government takes charge and actualizes the Kenya Human Resource Advisory Council (KHRAC) and the Kenya Health Professionals Oversight Authority (KHPOA). The World Health Organization (WHO) and other development partners such as the United States Agency for International Development (USAID) have provided elaborate and well-researched frameworks and tools that, if followed correctly and diligently, will lead to an optimized health workforce, especially in resource-constrained countries like Kenya.

Introduction

Problem Statement

The efficient delivery of quality health services requires the availability of skilled human resources for health (HRH) in adequate numbers and rationally distributed at all levels of care. Human resources is an essential component of the health system especially in the provision of basic health services. The WHO has determined a threshold of 23 per 10,000 population for core health workers (generalist medical doctors, specialist medical doctors, non-physician clinicians, nursing professionals, and midwifery professionals) as the minimum threshold needed to adequately cover the population with essential health services. Unless countries meet this threshold, they are unlikely to achieve Universal Health Coverage (UHC).

Like most countries in Africa, the shortage of healthcare workers is not unique to Kenya. Indeed, Kenya is one of the countries identified by the WHO as having a “critical shortage” of healthcare workers (MOH, 2015). This shortage is markedly worse in the rural health facilities and other “hard-to-reach areas”, which hampers the health sector’s ability to optimally utilize the existing workforce to provide quality services.

Kenya’s devolution, since 2013, has made human resources for health planning more complex and possibly even more critical. Counties now have the responsibility of employing their own health workforce and need access to timely and reliable HRH information for monitoring workforce needs. The devolution of the health sector in Kenya has faced several challenges. To date the country has witnessed several industrial actions by health workers in different counties as well as the attrition of some key health workers, especially doctors. The country has also witnessed inequitable distribution of available health workforce (at the county and at facility level), shortage of staff in essential cadres, inability to attract and retain health workers, poor remuneration and working conditions, inadequate or lack of essential tools, medical and non-medical supplies, diminishing productivity among the health workers, lack of career opportunities, lack of continuous professional education opportunities, among many other challenges. All these have had a direct impact on the quality of care.

The Kenya health sector has since realigned its policy and strategic direction in line with the Kenya 2010 constitution, Kenya Health Policy 2014-2030, and Kenya Health Sector Strategic Plan 2018-2023, so as to achieve its long- and medium-term health sector strategic goals, respectively.

The Kenya Constitution 2010 provides for the right to the highest attainable standard of health to every Kenyan and places a fundamental duty on the State to take legislative, policy and other measures, including the setting of standards, to achieve progressive realization of the rights set out under Article 43, which include the right to health.

Key Messages

- Inequity exists in healthcare worker (HCW) density by cadre, facility and county and affects general service availability. Staff skills mix at primary health facilities is not consistent with HRH staffing norms and standards, thus cannot adequately support UHC. Other countries such as Botswana and Rwanda have succeeded and Kenya should not be an exception.
- Quality of HRH has a direct impact on the quality of service. Supportive supervision can correct this but it is generally weak in terms of frequency and documentation.
- Management practices across the board affect quality of service delivery. There is need to improve the whole continuum of personnel management to reflect “real needs”, create awareness and implement the staffing norms countrywide.
- Task shifting with continuous professional education can be a solution in the short term in promoting quality services in areas with critical staff shortage levels

These constitutional provisions determine the roles and obligations of the health sector to facilitate progressive realization by all to the right to health. Schedule 4 of the constitution assigns to the county governments the function of delivering essential health services, and to the national government the functions of stewardship for health policy, capacity building, technical assistance to counties and oversight of national referral health facilities.

The Kenya Health Policy 2014-2030 outlines the government's commitment and policy in ensuring that the country attains the highest possible standards of health, proportionate to the needs of the population, through supporting the provision of equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans. The health workforce is one of the seven policy orientations specified in the Kenya Health Policy and which specifically intends to ensure that there is adequate and equitable distribution of human resources for health.

The Kenya Health Sector Strategic Plan (KHSSP) 2018-2023 lists the health workforce as a key health investment. It is also guided by the human resources for health (HRH) norms and standards document, which defines the minimum required number of health workforce by cadre, facility level and catchment population. Overall, the staffing level is measured against the norms and standards to assess the gaps in the recruitment and retention of health workers.

The objectives of the Medium-Term Plan III 2018-2022 in accelerating the attainment of UHC through efficiency, availability, equity in access to healthcare services can only be achieved through enhancing HRH capacity for health service provision and improving availability of specialized medical services, which again, depends on the capacity of HRH to deliver.

The Ministry of Health through the Health Act 2017 proposed the establishment of the Kenya Human Resource Advisory Council (KHRAC) and the Kenya Health Professionals Oversight Authority (KHPOA) to maintain a duplicate register of all health professionals working within the national and county health system; promote and regulate inter-professional liaison between statutory regulatory bodies; coordinate joint inspections with all regulatory bodies; receive and facilitate the resolution of complaints from patients, aggrieved parties and regulatory bodies; monitor the execution of respective mandates and functions of regulatory bodies recognized under an Act of Parliament; arbitrate disputes between statutory regulatory bodies, including conflict or dispute resolution amongst Boards and Councils; and ensure the necessary standards for health professionals are not compromised by the regulatory bodies. If fully operationalized, the KHPOA will address some of the health worker challenges in a holistic and systematic manner.

Additionally, in an effort to address the perennial industrial action in the health sector, professional unions including the Kenya Medical Practitioners, Pharmacists & Dentists' Union (KMPDU), the Kenya Clinicians Union, Nursing Union has signed various MOUs and agreements with the national and county governments in the interest of promoting sound industrial relations, the economic well-being of the workers and the employer, and overall improvement of healthcare service delivery in the public sector. This, however, has not solved all the problems of health workers since the counties are still constrained to meet all the obligations in the signed agreements, and furthermore, the flow of funds from the national government has generally not been smooth.

This policy brief discusses issues of availability and distribution of healthcare workers and provides policy directions on how the existing staff establishment (in both public and private facilities) can be best optimized in order to provide quality health services as envisioned in the Kenya Health Policy and various policy documents. With the move towards UHC this need becomes even more pertinent.

Methodology

This policy brief uses findings from the Kenya Harmonized Health Facility Assessment (KHFA) 2018/19, together with evidence from the review of key sector policy documents to inform the situational analysis and elucidate further experiences from other HRH related studies and assessments in-country. The reviews also help align the policies with the laid out global strategies in mobilizing and rationalizing the health workforce so as to efficiently and effectively achieve quality health service delivery.

The KHHFA assessment entailed a comprehensive study of availability and readiness of health facilities in Kenya to provide services using a modular approach. The modules applied included: availability, readiness, management and finance, quality of care and community health systems. The survey population targeted 2,980 facilities in all the 47 counties with representation across counties, ownership levels and facility types.

In regards to the health workforce, the KHFA 2018 assessed staff availability in relation to specific services offered in a facility and readiness of services which links the available staff to the availability of infrastructure or equipment to enable the staff to provide the services required.

In addition, it also addressed issues of availability of other HRH related matters such as continuous professional development, performance appraisal, health worker license verification.

Other areas include programs and incentives put in place to mobilize staff during emergencies, staff engagement in the monitoring and application of infection prevention and control strategies.

In the management support systems module, licensing and credential validation, routine system for evaluating staff, performance recognition and reward, continuous professional/medical development for nursing and medical/clinical staff, training management, and infection prevention and control were assessed. In the readiness module, KHFA assessed the aspect of mobilization of staff during emergencies.

Overall, issues of staff were mentioned in all the modules in relation to the capacity of staff to provide quality health services in the specific service delivery areas.

Results & Conclusions

Findings from the Kenya Harmonized Health Facility Assessment (KHFA) clearly shows that there are still gaps in numbers and staff skills mix as per the HRH norms and standards at all levels, thus the urgency to prioritize urgent but well-thought out interventions towards achieving optimal staff levels. Some of the key results are summarized as follows:

- Disparities exist in health care worker (HCW) density by county and cadre in general service availability. This was statistically proven through inequity analysis using the Lorenz curve. The main source of the inequity was due to health workforce distribution across the counties as shown by the two indicators of concentration coefficient = 0.02624, and Gini coefficient = 0.26976.
- Nationally, the density of core health personnel is at 15.6 per 10,000. Only 6 out of 47 counties surpassed the WHO recommended target of 23/10,000: Tharaka-Nithi (33.8), Nyeri (31), Uasin Gishu (28.2), Nairobi (26.3), Kajiado (24.6) and Lamu (24.6). Mandera was the most disadvantaged county at 5.2/10,000. According to the WHO National Health Workforce Accounts (NHWA) Data Portal, Kenya is comparable to Rwanda's 14.29 and Uganda's 15.81 but poorly to South Africa's 26.15, Ghana's 46.91 and Botswana's 67.87.

- By specific cadre, however, only the distribution of clinical officers and nurses appear to have surpassed our own Norms and Standards as shown in the table below:

Cadre	KHFA	Norms & Standards	Uganda	Rwanda	South Africa	Ghana	Botswana
Medical Officers	0.6	3.7	1.68	1.34	9.05	1.36	5.27
Clinical Officers	3	3.7					
Nurses	10	8.7	12.38	10.85	13.08	42.0	54.03
Laboratory technicians	2	1.3					

- Detailed scrutiny of the NHTA data reveals some discrepancies in the proportion of females taking up nursing duties in the selected countries for comparison. Botswana has the lowest proportion of female nurses (29.1%) and Rwanda has the highest at 96.5%. In the Kenyan KHFA, data on HRH stock was not disaggregated by gender. The female gender is an important determinant of women’s health service utilization patterns, especially in reproductive health matters.

	Kenya	Uganda	Rwanda	South Africa	Ghana	Botswana
% Female Nurses	75.9%	79.3%	96.5%*	90.9%	77.4%	29.1%
% Female MOs	n/a	n/a	19.1%	57.8%	37.3%	34.0%
% Nurses in public facilities	66.3%	93.8%	69.6%	75%	55.8%	93.7%

- In terms of distribution by county, data from the KHFA shows that there tends to be a higher density of medical officers in counties with low populations, such as Isiolo (1.99) and West Pokot (1.37), Lamu. Nairobi and Kiambu had 1.27 are exceptional due to their proximity and the fact that most of the major facilities are located in the said counties.
- HRH inequities has been shown to be a key cause of disparities in quality of care provided. From the results of the Lorenz curve analysis, it is noted that quality of care was the second highest source of inequity, specifically support for quality of care (Concentration coefficient = 0.02431, Gini coefficient = 0.21451).
- There exist wide inter-county variations in levels of supportive supervision (50% absolute gap). 71% of health facilities received at least one supportive supervision visit within the past 3 months. Supportive supervision is important since it has a direct link to service quality and healthcare worker performance (Purity, et. al 2017).
- Ghana had also faced a similar situation to Kenya and in response, developed the HRH Strategic Plan 2007-2011 which identified key HRH concerns and laid out a framework for interventions that led to the achievement of appropriately skilled, motivated and equitably distributed workforce (Asamai, et. al. 2020).

Recommendations

Based on the findings from the KHFA 2018, the learnings from the experience of other countries, and also the available literature on HRH, it is worth noting that Kenya is able to improve service delivery within the available resources if healthcare worker optimization is done. In the toolkit for Optimizing Health Worker Performance and Productivity to Achieve the 95-95-95, USAID through the HRH2030 consortium identifies the key issues affecting HIV service delivery, which are applicable in most of the other service areas on healthcare in Kenya. First is performance, which refers to the quality (of work, technical skills, care delivered, and impact of work on health outcomes) and if is optimal, the services provided will be reflective of training and ability, regardless of where they are located in Kenya. Second is productivity which refers to the cost of service per capita over a given period, influenced by “work assignment, management practices, modes of remuneration, health worker engagement, work organization, the regulation of the division of labor, and the availability of other labor and nonlabor resources”.

Lastly is efficiency, which is the “ability to effectively use the allocated resources, including time, energy, and materials and supplies, to perform a task without waste; to maximize the use of existing resources; or to do more with less.” The document provides a detailed 5-step process for achieving this:

Step 1:

Review performance to reveal the service delivery gaps.

Step 2:

Identify the possible HCW problems that may influence the service gaps - usually known and include skills and competency gaps e.g. poor engagement, poor allocation of staff and tasks, and inefficient work processes).

Step 3:

Understanding the underlying causes of workforce problems using a set of tools, including scorecards, surveys, root-cause analysis, performance evaluation, among others.

Step 4:

Based on results of Step 3, this step involves designing appropriate workforce interventions;

- competency-based in-service training
- mentoring
- supportive supervision
- developing appropriate job aides/standard operating procedures
- nonfinancial incentives such as staff recognition, workload balancing, performance appraisal, and team building
- improved communication (both within facility and with community)
- improved work environment (including provision of continuous supplies)
- task shifting and task sharing (counselling, tracing, clerical)
- worker scheduling based on time-based client flow (including on-call staff)
- updating and displaying job descriptions
- use of differentiated service delivery models, especially for clients on longitudinal follow-up (including non-communicable diseases in special outpatient clinics)

Step 5:

This very important step is to develop a responsive plan for monitoring the interventions and providing regular feedback.

The toolkit should be integrated as a key facility-management performance activity whose results will be monitored regularly. Support from the national level is crucial. Data on most of the issues identified in the toolkit above are available in the KHFA 2018 as discussed earlier and will need to be monitored regularly in the subsequent surveys.

Other long-term considerations for staff optimization include the political goodwill to reorganize the health workforce, including redistribution across the counties.

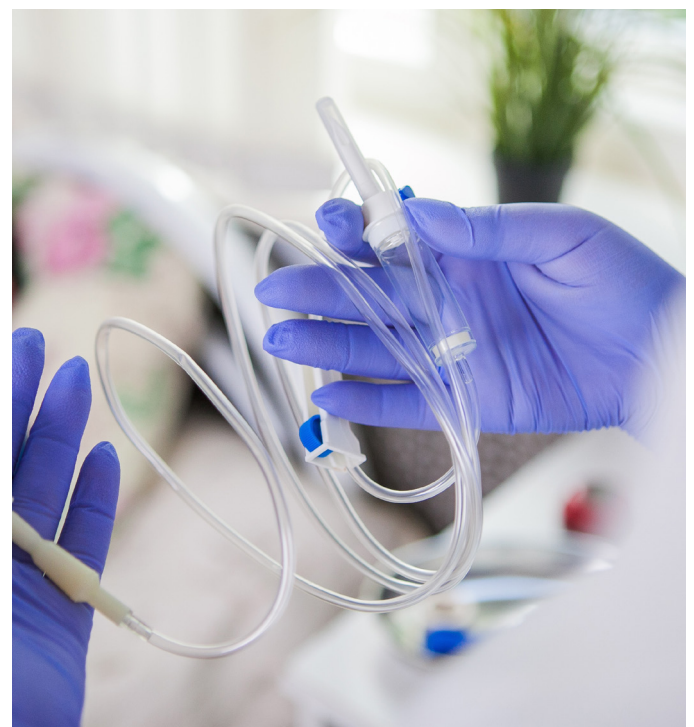


Counties should recruit an appropriate number of CHVs, CHEWs and CHC members in compliance with the Kenya quality model of health (KQMH). Consider incorporation of CHVs into the formal healthcare workforce and create awareness at the community level to use the CHV as the first point of contact before visiting the health facilities. Several HRH benchmarks are in use (WHO, KEPH, HRH Norms & Standards) in Kenya and each has different measures that makes it difficult to compare. All facilities (GoK and non-GoK) must implement the HRH Norms and Standards at the minimum. The standards should also be reviewed regularly at national level to reflect current needs. National guidelines on supportive supervision should be in place and enforcement of staff returns must be made mandatory for both public and nonpublic facilities in order to help in improving health workforce information and generation of evidence for decision making.

Education and training should be scaled up. All health training institutions must provide quality pre-service training and in-service that considers current realities and challenges. From the KHFA data we note that some major facilities are not able to use equipment such as CT scanners due to lack of qualified personnel, thus directly impacting on service availability and quality. The institutions must also provide pertinent activity data for monitoring progress.

The health sector regulatory boards and councils must provide assurance on the qualifications and competence of staff, and this includes guidance on task shifting and/or task sharing and harmonization of salaries and benefits.

Health workforce dialogue and partnership must be strengthened with the advocacy bodies. Management practices affect quality improvement thus these should also be improved. Awareness of the guidelines of KQMH and motivation of the staff implementing the guidelines have a significant influence on quality of health services. These recommendations are in line with the WHO Roadmap for scaling up the human resources for Health for improved health service delivery in the African region 2012–2025 that aims to achieve optimization of the utilization, retention and performance of the active health workforce.





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