Republic of Kenya

Reversing the Trends
The Second
NATIONAL HEALTH SECTOR
Strategic Plan of Kenya

National Human Resources for Health Strategic Plan 2009–2012

Ministry of Public Health and Sanitation

Ministry of Medical Services

April 2009

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HUMAN RESOURCES FOR HEALTH
Strategic Plan 2009–2012

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National Human Resources for Health Strategic Plan – 2009–2012

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List of Abbreviations

ANC	Antenatal clinic/care
AMREF	African Medical Research Foundation
AOP	Annual operational plan
ART	Anti-retroviral therapy
CDF	Community Development Fund
CHAK	Christian Health Association of Kenya
CHEW	Community health extension worker
CHW	Community health worker
CORP	Community-owned resource person
CPD	Continuing professional development
CS	Community Strategy
DPM	Directorate of Personnel Management
ECN	Enrolled community nurse
EHP	Emergency Hiring Programme
EN	Enrolled nurse
EPI	Expanded Programme of Immunization
ERS	Economic Recovery Strategy (for Wealth and Employment Creation)
FBHS	Faith-based health services
FBO	Faith-based organization
FY	Financial year
HCW	Health care worker
HIV/AIDS	Human immuno-deficiency virus/acquired immune deficiency syndrome
HMO	Health maintenance organization
HR	Human resources
HRD	Human resources development
HRH	Human resources for health
HRIS	Human resource information system
HRM	Human resources management
HRP	Human resources planning
HTI	Health Training Institute
IPD	Inpatient department
IPPD	Integrated personnel and pay database
IST	In-service training
ITN	Insecticide treated nets
JPWF	Joint Programme of Work and Funding
JSCC	Joint SWAp Coordinating Committee
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographic and Health Survey
KEMRI	Kenya Medical Research Institute
KEMSA	Kenya Medical Supplies Agency
KEPH	Kenya Essential Package for Health
KEC-CS	Kenya Episcopal Conference - Catholic Secretariat
KHPF	Kenyan Health Policy Framework
KHSWAp	Kenyan health sector-wide approach
KMTC	Kenya Medical Training College
KNH	Kenyatta National Hospital
M&E	Monitoring and evaluation
MDG	Millennium Development Goals
MDRTB	Multi drug resistant TB
MOH	Ministry of Health
MOLG	Ministry of Local Government
MOPHS	Ministry of Public Health and Sanitation
MOMS	Ministry of Medical Services
MTEF	Medium-term expenditure framework
MTRH	Moi Teaching and Referral Hospital
NGO	Non-government organization
NHSSP	National Health Sector Strategic Plan
NHIF	National Hospital Insurance Fund
NSHIF	National Social Health Insurance Fund
OPD	Outpatient department
PAS	Performance appraisal system
PDSA	Plan, do, study, act
PE	Personnel emolument
PER	Public expenditure review
PFP	Private for-profit
PHO	Provincial Health Office
PHT	Public health technician
PMO	Provincial Medical Officer
PMTCT	Prevention of mother to child transmission (of HIV)
PNFP	Private not-for-profit
PNO	Provincial Nursing Officer
PRSP	Poverty reduction strategy paper

PS	Permanent Secretary
PSC	Personnel Service Commission
PSRP	Public Sector Reform Programme
PSRDS	Public Service Reform and Development Secretariat
RBM	Results-based management approach
RRI	Rapid results initiative
SRH	Sexual and reproductive health
SWAp	Sector-wide approach
TORs	Terms of reference
TWG	Technical working group
VHC	Village health committee
VHW	Village health worker
WHO	World Health Organization

Foreword

Providing high quality health care services for all Kenyans remains a challenge largely because of economic, social, political and other factors that have resulted in an imbalance between the demand for and supply of health services and the limited human resources for health. Inadequate numbers of skilled human resource have had a particularly negative impact on efforts to expand access and improve the quality of health services. This situation has been aggravated by the continued high prevalence of HIV/AIDS, tuberculosis and malaria, which remain the leading killer diseases in the country.

The Government of Kenya is determined to improve access to and equity of essential health care services and to ensure that the health sector plays its role in the realization of the Economic Recovery Strategy, Vision 2030, public service reforms and the Millennium Development Goals.

Kenya's health sector recognizes that human resources for health constraints are a critical ingredient – possibly the critical ingredient – hampering Kenya's health sector planning, service delivery and ultimately national health outcomes. Against this background, the sector has taken on the task of defining long-term strategies for addressing the constraints to human resource development and management so as to effectively improve health service delivery. Thus, this Human Resources for Health Strategic Plan presents, first, a situation analysis of the current human resources situation in the country, the contextual factors, and some of the influences, key issues and constraints across the sector. To address these issues, the plan proposes a series of interlinked strategies to remedy the situation and improve the quality and efficiency of service delivery.

The core human resource challenges identified in the strategic plan cut across the sector. They span virtually all the critical human resources areas, including policy and institutional arrangements, human resources planning, recruitment and placement, performance management and appraisal, reward and motivation, capacity building, and employee welfare. The plan proposes broad goals to address these challenges and modernize Kenya's human resources for health as a crucial element in the delivery of health services.

While acknowledging the sector's long-standing human resource challenges, the two health ministries are committed to providing effective leadership to facilitate the implementation of this strategic plan. This commitment aims not only to accelerate the achievement of the national health targets set by the second National Health Sector Strategic Plan (NHSSP II) and the Millennium Development Goals, but also to realize Vision 2030.

We recognize that successful implementation of the strategic plan requires the concerted efforts and commitment of a wide range of stakeholders in different health subsectors and others outside the health sector. In this regard, the ministries will continue to provide stewardship in coordination of the sector and further strengthen future engagement processes. We strongly believe that it is the sum total of all our efforts – big or small – that will contribute to the reversal of the declining health status currently observed in this country and a better quality of life for Kenyans.

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Acknowledgements

This Human Resources for Health (HRH) Strategic Plan is the culmination of extensive consultation, teamwork and information gathering. The Ministry of Medical Services and the Ministry of Public Health and Sanitation sincerely acknowledge the contribution and hard work of the many individuals and organizations that contributed to the development of the plan. In particular, we wish to acknowledge the human resources for health team, which comprised representatives from the public health subsector, faith-based organizations (FBOs), non-government organizations (NGOs), training institutions, regulatory bodies, professional medical associations and various consultants. The Human Resources Management Division of the Ministry of Medical Services and the Technical Planning and Monitoring Department of the Ministry of Public Health and Sanitation spearheaded the coordination of the plan development process.

The health sector appreciates the financial and technical support given by the United States Agency for International Development (USAID) through the Capacity Project in facilitating the development of the strategic plan. The health ministries further express their appreciation to all the other individuals and institutions that contributed, and continue to contribute, towards the improvement of the health status of Kenyans and who joined us in our effort to formulate the most appropriate, feasible and cost-effective mix of strategies for improving the planning, management and development of human resources in the health sector. We are also indebted to individuals and organizations that supplied key HRH data and statistics, as these informed our understanding of the HRH situation and helped in the development of the health workforce projections and HRH strategies.

Executive Summary

High quality and accessible health services cannot be delivered without sufficient numbers of well-skilled, well-distributed and well-managed health workers. The erosion of Kenya's key health indicators – life expectancy, infant mortality and maternal mortality – during the last two decades can be traced at least in part to the deterioration of the health work force. The acute shortage, inequitable distribution and inadequate skills of health workers have contributed to this negative trend. Staff shortages are particularly acute in hard-to-reach regions.

Since it was adopted in 2005, the Second National Health Sector Strategic Plan (NHSSP II – 2005–2010) has focused on its central goal of reversing the downward trend. Yet despite increased levels of government health spending and the lifting of the civil service employment freeze, the total number of health workers in the public service continued to decline during the last five years as a result of high levels of attrition and in particular because of retirement related losses.

Moreover, the health workforce that is in place is inequitably distributed. In 2007, Nairobi, which had 8.2% of the national population, had 25.6% of the doctors employed by MOH. Between 2004 and 2008, the number of registered nurses employed by MOH fell by 17%. MOH currently has an overall vacancy rate of 29% of the approved establishment. Both Kenyatta National Hospital (KNH) and Moi Teaching and Referral Hospital (MTRH) have vacancy rates of about 20%.

Like the rest of the public sector, the ministries responsible for health face the daunting challenge of an ageing workforce arising from the many years during which there was an employment freeze. The median age of MOH staff currently stands at 42, making the recent increase in the retirement age from 55 to 60 years a boon for the health sector. If the retirement age had remained at 55 years, the ministries were going to lose 12% of their workforce within the period of this strategic plan and nearly 50% within a decade.

Retirement is not the only issue, however. Retention remains a major concern as health workers continue to leave the subsectors and the sector for a range of other reasons, from resignation – significantly including for the purpose of emigrating – desertion and termination to death. The retention problem is particularly acute in remote/hard-to-reach areas and for certain highly mobile cadres such as doctors and nurses. The commitment of the two health ministries to reduce vacancy levels and improve health worker distribution will be difficult to achieve unless the challenges of low retention, recruitment and deployment bottlenecks, and inadequate output of pre-service training institutions are urgently addressed.

The impact of the HRH challenges facing Kenya's health sector is compounded by the rising disease burden fuelled by malaria, HIV and TB. The number of new TB cases, for example, continues to rise and in 2007 stood at 117,000. Moreover, the 1.2 million Kenyans living with HIV/AIDS will continue to need care into the foreseeable future. Currently, there are significant gaps in access to preventive and curative HIV services. Scaling up existing and additional HIV services such as male circumcision will further increase the demand for both the number and the skills of health workers. Access to HIV services remains suboptimal despite significant improvements in the last few years.

On a positive note, there has been a demonstrated reduction in malaria associated morbidity and mortality driven primarily by increased use of insecticide treated nets (ITNs) and improved access to effective antimalaria

The National HRH Strategic Plan intends to support the NHSSP II goal of reducing health inequities and reversing the decline in key health indicators by providing a framework to guide and direct interventions, investments and decision making in the planning, management and development of human resources for health.

drugs. The Government has also given approval and made provision for the recruitment of an additional 1,500 health workers annually. Another positive development has been the recruitment of over 3,000 health workers on contract terms with the assistance of Kenya's development partners. The Government has committed to absorb these workers when their contracts expire.

Several HRH studies and assessments conducted over the years have raised serious concerns about human resources planning and management in the health sector. The sector has not had an effective coordination mechanism to ensure that different players and subsectors work in a concerted manner in the planning, development and management of the health workforce. HR systems and practices remain weak and as a result many health workers are poorly managed. An effective human resources information system (HRIS) is lacking. There are also challenges in both pre-service and in-service health training: In-service training is poorly coordinated and is often not informed by identified needs. For a number of cadres, the output of pre-service institutions is below the levels required to meet identified staff gaps in the short and medium term.

This strategic plan articulates a number of outcome areas, strategic objectives, strategies, indicators and timelines to address the identified challenges and to achieve the set objectives. Workforce projections support the recommendation that the health sector in Kenya recruit an additional 24,000 workers by the end of 2012 as part of a longer-term goal of addressing the critical health worker shortage in earnest. Of this number, 18,000 workers will be recruited by the two ministries of health.

These are recruitment levels Kenya has not experienced before and meeting these recommendations will require significant mobilization of resources by the Government, the private sector and Kenya's development partners. Increased Government funding to move closer to the Abuja Declaration target (of 15% of total government expenditure) would make resources available to recruit more staff, increase the capacity of pre-service training institutions, and improve the salary and benefits package of the health workforce. It is recognized that even after this massive recruitment, significant staffing gaps will remain. Scaling up recruitment above these levels will call for an increase in the enrolment and output of pre-service health training institutions. It is expected that the impact of increased capacity of pre-service will not be realized with the period covered by this strategic plan.

The strategic plan presents a framework for achieving its outcomes, with corresponding benchmarks and indicators of progress. The plan includes an itemized budget and recommends the establishment of a HRH leadership group to guide the implementation, monitoring and evaluation of the proposed strategies.

Anticipated Outcomes

Five broad outcome areas are targeted for this strategic plan, ranging from equitable distribution and retention of health workers to better institutional and management systems. Proposed outcome areas and the strategic objectives that will guide our progress are itemized below and illustrated in the following chart. Projected costs are summarized in Table 1.

Outcome 1: Appropriate and equitably distributed health workers in post

- Strategic objective 1.1: Strengthen recruitment and deployment
- Strategic objective 1.2: Scale up recruitment and deployment
- Strategic objective 1.3: Identify and train level I health workers required to implement the Community Strategy

Outcome 2: Improved attraction and retention of health workers

- Strategic objective 2.1: Improve attractiveness of health sector jobs
- Strategic objective 2.2**:** Develop an attractive package for hard-to-reach areas

Outcome 3: Improved institutional and health workers performance

- Strategic objective 3.1: Improve leadership and management
- Strategic objective 3.2: Institute a results-based management system
- Strategic objective 3.3: Improve health care workers' safety, health and wellness

Outcome 4: Strengthened human resources development (HRD) systems and practices

- Strategic objective 4.1: Establish a supportive policy framework
- Strategic objective 4.2: Increase the capacity and output of pre-service institutions for key cadres
- Strategic objective 4.3: Institute competence based training

Outcome 5: Strengthened HR planning and management

- Strategic objective 5.1: Strengthen and decentralize HR planning and management
- Strategic objective 5.2: Strengthen HR systems and practices
- Strategic objective 5.3: Strengthen the human resources information system (HRIS)
- Strategic objective 5.4: Strengthen collaboration and partnership
- Strategic objective 5.5: Institute task-shifting

Strategic Plan Highlights

Specific Objectives of the HRH Strategic Plan

- Provide a coherent HRH vision and framework
- Estimate health workforce requirements within the plan period
- Identify health workforce gaps and identify strategies for addressing these gaps
- Propose strategies for strengthening pre-service and in-service training
- Support improvements in the management of the health workforce
- Support strengthening of HRH partnerships
- Support resource mobilization to strengthen HRH

Outcome Areas and Strategic Objectives

Outcome 1: Appropriate and equitably distributed HCWs in post

SO1.1: Strengthen recruitment and deployment

SO1.2: Scale up recruitment and deployment

SO 1.3: Identify and train staff to implement the Community Strategy (24,000 additional health sector workers recruited)

Outcome 2: Improved attraction and retention of HCWs

SO 2.1: Improve attractiveness of health sector jobs

SO 2.2: Develop an attractive package for hard-to-reach areas

Outcome 3: Improved institutional and health worker performance

SO 3.1: Improve leadership and management

SO 3.2: Institute a results-based management system

SO 3.3: Improve health care workers' safety, health and wellness

Outcome 4: Strengthened human resources development systems and practices

SO 4.1: Establish a supportive policy framework

SO 4.2: Increase the capacity and output of pre-service institutions for key cadres

SO 4.3: Institute competence-based training

Outcome 5: Strengthened HR planning and management

SO 5.1: Strengthen and decentralize HR planning and management

SO 5.2: Strengthen HR systems and practices

SO 5.3: Strengthen the human resources Information system (HRIS)

SO 5.4: Strengthen collaboration and partnership

SO 5.5: Institute task-shifting

Table 1 Summary of Strategic Plan Costs

Outcome	Annual budget projections			
	FY 2009/10 Ksh 000 (US$)	**FY 2010/11 Ksh 000 (US$)**	**FY 2011/12 Ksh 000 (US$)**	**Total Ksh 000 (US$)**
1: Appropriate numbers and types of health workers in post and equitably distributed	4,890,300 (65,204,000)	10,698,650 (142,648,667)	15,220,428 (202,939,040)	30,809,378 (410,791,707)
2: Improved retention of health workers at all levels	21,200 (282,667)	12,900 (172,000)	1,000 (13,333)	35,100 (468,000)
3: Improved institutional and health worker performance	219,500 (2,926,667)	271,600 (3,621,333)	297,350 (3,964,667)	788,450 (10,512,667)
4: Strengthened human resource development systems and practices	10,100 (134,667)	44,810 (597,467)	6,050 (80,667)	60,960 (812,800)
5: Strengthened human resource planning, and management and leadership at all levels	84,150 (1,122,000)	87,550 (1,167,333)	76,250 (1,016,667)	247,950 (3,306,000)
Grand total	**5,225,250 (69,670,000)**	**11,115,510 (148,206,800)**	**15,601,078 (208,014,373)**	**31,941,838 (425,891,173)**

1. Introduction

One of the worrying trends in Kenya's health sector over the last ten years has been the failure to improve key national health indicators, including infant mortality, maternal mortality and total fertility rates, among others. The Second National Health Sector Strategic Plan[1] (NHSSP II) has as its central goal the reversal of this downward trend.

On the other hand, there has been a steady increase in the level of Government funding for health programmes. Government health expenditure rose from Ksh13.3 billion in 2002 to Ksh27.4 billion in 2007. As a proportion of total government expenditure, however, the 7.6% (2007) devoted to health remains significantly below the Abuja Declaration target of 15%. Significant progress has been made on service delivery, particularly on the stabilization of the HIV/AIDS epidemic, and the scaling up of ART access.

[1] Ministry of Health, 2005, *Reversing the Trends – The Second National Health Sector Strategic Plan of Kenya: NHSSP II – 2005–2010.*

It is further noted that the employment freeze affecting the public sector has also been lifted and this has led to significant recruitment of key health cadres, especially nurses, by the Government and a number of development partners such as USAID (Emergency Hiring Programme – EHP) and the Clinton Foundation. Poverty levels remain worryingly high, but there is evidence pointing to a gradual reduction in the proportion of Kenyans living below the poverty line.

1.1 Key Statistics

As a signatory to the Millennium Declaration, Kenya has structured many of its health and development programmes around the Millennium Development Goals (MDGs). Table 1.1 summarizes major socio-economic and health indicators according to the four MDGs that are directly relevant to the health sector, along with other country data and indicators.

Table 1.1: Key national economic, social and health indicators

MDG number and description	Indicator description	National level	Source and year
MDG 1 Eradicate extreme poverty and hunger	Average GDP growth rate, 2003–2007	5.4	Economic Survey 2008
	GDP per capita (US$)	780	Economic Survey 2008
	Proportion of population living below the poverty line	46%	KIHBS, 2005/06
	% of children under 5 who are underweight (2006)	20.9	MOMS, 2008
MDG 4 Reduce infant mortality	Infant mortality rate (per 1000 live births)	60	KIHBS, 2005/06
	Under-5 mortality rate (For 1000 live births)	92	KIHBS, 2005/06
	% of fully immunized children	66	KIHBS, 2005/06
MDG 5 Improve maternal health	Maternal mortality ratio (per 100,000 live births): 1993–2003	414	KDHS, 2003
	% of births assisted by a skilled health attendant	48	MOH, 2008
	% of births delivered in a health facility	39.1	KIHBS, 2005/06

Continued

Table 1.1: continued

MDG number and description	Indicator description	National level	Source and year
MDG 6 Combat HIV/AIDS, malaria and other diseases	Adult HIV prevalence (women)	8.7	KAIS, 2007
	Adult HIV prevalence (men)	5.6	KAIS, 2007
	Number of people living with HIV/AIDS	1.4 Million	KAIS, 2007
	Number of people on ART (2008)	222,000	NASCOP, 2009
	% of eligible people living with HIV/AIDS on ART	50	NASCOP, 2009
	TB cases registered in 2007	117,000	MOMS, 2008
	% of outpatient attendance due to malaria	30-50	DOMC, 2008
	% of hospital admissions due to malaria	20	DOMC, 2008
Others not directly linked to MDGs	Kenya population (2009 projection)	35.7 million	KNBS
	Total fertility rate	4.9	KDHS, 2003
	Life expectancy at birth (male) - 2006	54.3	MOMS, 2008
	Life expectancy at birth (female) - 2006	59.1	MOMS, 2008
	Inter censal population growth rate %	2.9	MOMS, 2008
	Health expenditure (public sector) as % of total government expenditure, 2006/07	7.6	MOMS, 2008
	Number of nurses per 100,000 population	128	KNBS
	Number of doctors per 100,000 population	18	KNBS

Key: ART = Anti-retroviral therapy; DOMC = *Kenya Malaria Fact Sheet*, Division of Malaria Control; KDHS = Kenya Demographic and Health Survey ; KIHBS = Kenya Integrated Household Budget Survey, 2005/06; KNBS = Kenya National Bureau of Statistics; MOMS = Ministry of Medical Services, *Facts and Figures;*

1.2 Disease Burden

Kenya's epidemiological profile has not changed significantly during the last decade, even as the population growth has continued at around 3% and poverty levels approach 50% (refer to Table 1.1). The disease burden has significant HRH implications in terms of the need for more and better skilled health workers.

As shown in Figure 1.1, for example, malaria remains the number one cause of adult and childhood mortality and morbidity. There is, however, evidence that increased use of insecticide treated nets (ITNs) and increased availability of new combination antimalaria drugs has led to a dramatic reduction in malaria morbidity and mortality (Malaria Indicator Survey, 2007). In 2007, the Ministry of Health announced that malaria deaths among children had fallen by 44%.

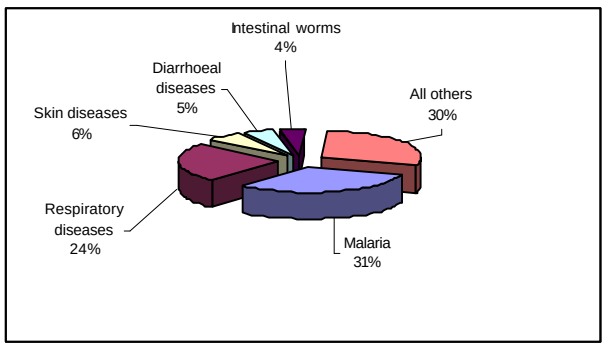
Despite showing clear signs of stabilization, HIV/AIDS remains a major contributor to the national disease burden. With adult prevalence estimated at 7.4% (KAIS 2007) and an estimated 1.4 million adults and children infected, HIV/AIDS remains a critical health issue. New HIV infections have fallen significantly in the last few years, but remain alarmingly high at 70,000 infections per year (KAIS 2007). Although there are significant regional variation, HIV/AIDS is a problem in all provinces as shown in Figure 1.2.

The management and control of HIV/AIDS require provision of multiple prevention and treatment services including prevention of mother to child transmission

The Millennium Development Goals

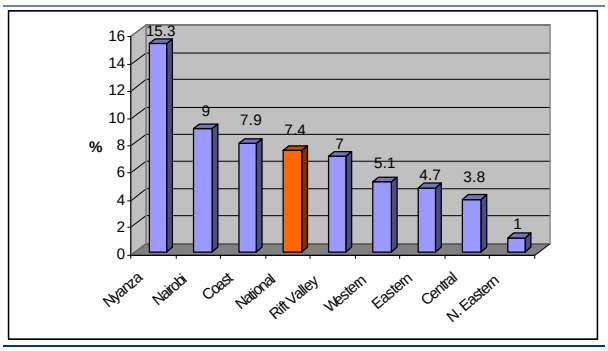
1. Eradicate extreme poverty and hunger.
2. Achieve universal primary education.
3. Promote gender equality and empower women.
4. *Reduce infant mortality.*
5. *Improve maternal health.*
6. *Combat HIV/AIDS, malaria and other diseases.*
7. *Ensure environmental sustainability.*
8. Develop a global partnership for development.

Figure 1.1: Leading causes of outpatient morbidity, 2007



Source: Ministry of Medical Services, *Facts and Figures,* 2008

Figure 1.2: Provincial HIV prevalence



Source: KAIS, 2007

(PMTCT), supply of safe blood, testing and counselling, and ART.

Moreover, in addition to traditional HIV/AIDS services, new services such as male circumcision will add to the health care workload and stretch the capacity of the available health workforce. As more patients access ART, survival is expected to rise and the total number of HIV patients requiring care and treatment is expected to keep increasing in the coming years. Table 1.2 shows the number and proportion of people accessing different HIV/AIDS services.

Table 1.2: Access to HIV/AIDS services

Indicator	National level	Source and year
Number of people accessing ART (2008)	122,000	NASCOP, 2009
% of people requiring ART that access ART (2008)	50	NASCOP , 2009
% of women attending ANC clinics tested for HIV (2008)	93	NASCOP , 2009
% of HIV+ mothers receiving preventive ARVs (2008)	88	NASCOP, 2009
Number of people accessing VCT in 2008	860,000	NASCOP , 2009
% of Kenyans who know their HIV status	36	KAIS, 2007

The HIV/AIDS epidemic has led to a surge in the number of TB cases. In 2007, there were 117,000 TB cases detected in the country. It is estimated that about 50% of people with TB are also infected with HIV. The twin epidemics of HIV and TB will continue to be a significant contributor to overall morbidity and mortality. A new challenge is the emergence of multi-drug resistant TB (MDRTB). It is estimated that 0.9% of people with TB in Kenya have MDRTB (World Health Report (2006).

Sexual and reproductive health (SRH) is another challenge. A maternal mortality ratio of 414 per 100,000, with a range of 600 to 1,400 across the provinces, remains a huge a concern and is a major barrier to the achievement of MDGs and national targets. Deliveries conducted by skilled staff remained at 42%, with a provincial variation of 8–67%.

1.3 Purpose and Objectives of the HRH Strategic Plan

The purpose of the National HRH Strategic Plan is to consolidate the goal of NHSSP II – and beyond – of reducing health inequities and reversing the decline in key health indicators. The plan provides a framework to guide and direct interventions, investments and decision making in the planning, management and development of human resources for health. The HRH plan intends to reduce the extent and impact of health worker shortages and mal-distribution through better workforce planning and other strategies, including the support of HR components of the Community Strategy,[2] task shifting initiatives and retention strategies.

A key goal of this strategic plan is to improve health worker productivity through better management systems and practices. The plan has adopted a sector-wide approach and addresses HRH issues in the public, private for-profit and NGO/FBO sectors. The specific objectives of the strategic plan are to:

- Provide a coherent vision and framework that places HRH at the centre of the health agenda.
- Project the required health workforce within the plan period, identify national and regional gaps, and propose strategies for addressing the gaps.
- Propose strategies for strengthening pre-service and in-service training.
- Support better management of the health workforce so as to improve productivity and morale, address regional disparities in health worker densities, and enhance health worker retention.
- Support strengthening of partnerships to address HRH challenges facing the country.
- Support the necessary resource mobilization needed for stronger HRH.

1.4 Health Care System and Structures

A number of players provide and fund health care services including training in Kenya. The key ones include:

- Public sector through Ministry of Public Health and Sanitation (MOPHS), Ministry of Medical Services (MOMS), Ministry of Local Government (MOLG), and several parastatal organizations. Parastatal organizations include Kenyatta National Hospital (KNH), Moi Teaching and Referral Hospital (MTRH), Kenya Medical Training College (KMTC), Kenya Medical Research Institute (KEMRI), and National Hospital Insurance Fund (NHIF)
- For-profit private sector through private hospitals, clinic and HMOs
- Faith-based organizations (FBOs)
- Non-government organizations (NGOs)

It is estimated that the public sector provides 55% of health services in Kenya. This is borne out by Table 1.3, which shows the distribution of health facilities by

[2] Ministry of Health, 2006, *Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of LEVEL ONE SERVICES*. Four implementation tools have been developed since then and are in use.

This strategic plan takes a sector-wide approach to HRH issues in the public, private for-profit and NGO/FBO sectors, and intends to improve health worker productivity through better management systems and practices.

type of ownership. The table indicates that the Government runs 53% of health facilities in the country.

Table 1.3: Distribution of health facilities by type of ownership

Facility type	MOH	FBO	Private	Total
Hospital	191	76	70	337
Health centres	465	145	158	768
Dispensaries	2,122	617	1,415	4,154
Total	2,778	838	1,643	5,259
	(53%)	(16%)	(31%)	

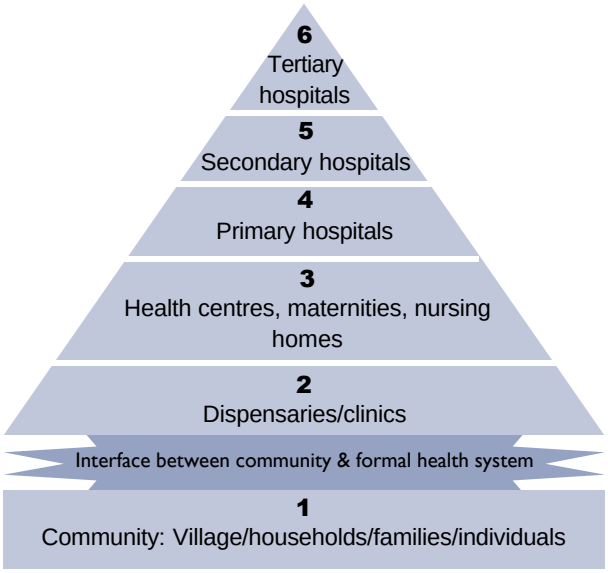
Source: *Facts and Figures*, MOMS, 2008.

NHSSP II introduced the Kenya Essential Package for Health,[3] which defines six levels of preventive and curative services. These are shown in Figure 1.3.

The bulk of the public sector services are provided through the Ministry of Public Health and Sanitation (MOPHS) and the Ministry of Medical Services (MOMS). The different roles and responsibilities of the two ministries were defined by Presidential Order and are shown in Table 1.4.

[3] Ministry of Health, 2007, *Reversing the Trends: The Second National Health Sector Strategic Plan of Kenya –The Kenya Essential Package for Health.*

Figure 1.3: KEPH health service levels



Source: NHSSP II, 2005–2010.

1.5 Process and Methodology of Developing the HRH Strategic Plan

Between December 2005 and March 2006 a draft, sector-wide three-year Human Resources for Health Strategic Plan (2006/07–2009/10) and an implementation plan were developed as part of the Health Sector Rapid Results Initiative (RRI). The HRH/RRI Team comprised representatives from MOH, Directorate of Personnel Management (DPM), FBOs,

Table 1.4: MOMS and MOPHS roles as stipulated by Government of Kenya, Circular No. 2/2008

Ministry of Public Health and Sanitation KEPH Levels 1–3	Ministry of Medical Services KEPH Levels 4–6
• Public health and sanitation policy • Preventive and promotive health services • Community health services (level 1) • Health education • Reproductive health • Food quality and hygiene • Health inspection and other public health services • Quarantine administration • Oversight of all sanitation services • Preventive health programme including vector control • National public health laboratories • Government Chemist • Dispensaries and health centres (levels 2 & 3) • Kenya Medical Research Institute (KEMRI) • Radiation Protection Board • Member of KEMSA Board • Member of KMTC Board	• Medical services policy • Curative services • HIV/AIDS programme and other sexually transmitted infections (STI) treatment and management • Maternal services • Clinics and hospitals • Rural medical services • Registration of doctors and paramedical personnel • Nurses and midwives • National Hospital Insurance Fund • Clinical laboratory services • Member of Kenya Medical Research Institute • Kenya Medical Training College • Kenya Medical Supplies Agency • Regulatory bodies for pharmacy and medicine • Member of KEMRI board

Source: AOP 4 and MOMS and MOPHS strategic plans, 2008.

NGOs, training institutions, regulatory bodies and professional associations. The team collected and analysed HRH documentation and data and consulted with various stakeholders in order to identify and verify the key HRH issues and constraints across the health sector.

In September and October 2007 a secretariat comprising health sector staff and members of the original HRH/RRI Team reviewed and updated the HRH Strategic Plan. They reassessed the policy environment, reviewed recent documents and reports, collected and analysed new HRH data, and consulted diverse stakeholders in order to revise the plan. The second draft was presented to a wide range of stakeholders on October 2007 in order to verify the HRH issues and challenges, validate the strategies and activities proposed to address the challenges, and ultimately to achieve stakeholder consensus. In December 2008 the draft strategic plan was subjected to further review by a taskforce of MOPHS and the MOMS as part of the finalization process and alignment with the strategic thrusts of the two ministries.

1.6 Guiding Principles

Formulation of this HRH strategic plan was guided by a number of fundamental principles. These include:

- ***Equity:*** Equitable delivery of health services in all regions through the deployment of adequate numbers of competent, well motivated and managed health staff.
- ***Partnership and collaboration:*** Strong partnership with development partners, private sector and the community need to be build to strengthen the health workforce.
- ***People-centred approaches:*** The health sector recognizes health workers as the most important asset in the delivery of health care services.
- ***Innovation:*** Innovative approaches will be used in the training, deployment and management of the health workforce.
- ***Strong leadership and accountability:*** There will be strong and accountable leadership at all levels to support HRH strengthening.
- ***Gender responsiveness:*** Gender responsive approaches will be adopted to ensure gender equity in the training, deployment, development and management of the health workforce.
- ***Rights-based approach:*** The health sector will apply a rights-based approach. This will include commitment to the principles of equality, non-discrimination, accountability, empowerment and participation. The health sector will safeguard the rights of employees living with disabilities. No employee will be discriminated against on the basis of known or assumed HIV status.

2. Policy Context

Existing national, sectoral and ministerial policies and plans, along with international commitments and goals, guided the development of this HRH strategic plan. Kenya's 2003 Economic Recovery Strategy for Wealth and Employment Creation (ERS), Vision 2030, the medium-term expenditure framework (MTEF), the Public Service Reform Strategy (PSRS), the MDGs, and other international and global initiatives are among the major external influences. The Kenya Health Policy Framework of 1994, NHSSP II 2005–2010, the National Social Health Insurance Fund (NSHIF) of 2004, and the 2008–2012 strategic plans adopted by MOPHS and MOMS, all shape the environment in which the HRH Strategic Plan will be implemented.

2.1 Vision 2030

The Government of Kenya, through Vision 2030, envisions a middle income industrialized state by the year 2030. The public service is expected to contribute to these economic aspirations and transformation, including the generation of employment opportunities and reduction of poverty. Vision 2030 follows the successful implementation of the ERS, which ran until the end of December 2007.

The Government envisions "a globally competitive and prosperous nation with a high quality of life by 2030". This will be achieved:

a) By maintaining a sustained economic growth of 10% per year over the next 25 years;
b) Through a just and cohesive society enjoying equitable social development in a clean and secure environment; and
c) Through an issue-based, people-centred, results-oriented and accountable democratic political system.

Vision 2030's ambition for the Kenya health sector is to provide "equitable and affordable health care at the highest standards". To achieve this, Kenya will restructure the health care delivery system and also shift the emphasis to promotive care in order to reduce the disease burden. Specific strategies are aimed at significantly improving the health infrastructure and promoting partnership with the private sector. A number of "flagship projects" have been prioritized to accomplish this aim, including:

- Revitalizing community health centres to promote preventive health care (as opposed to curative interventions) and promote healthy lifestyles.
- Creating a National Health Insurance Scheme in order to promote equity in Kenya's health financing.
- Channelling funds directly to hospitals and community health centres (as opposed to district headquarters).
- Scaling up the output-based approach to enable disadvantaged groups (e.g., the poor and orphans) to access health care from preferred institutions.

It is anticipated that by addressing key health priorities such as infant and maternal mortality and by providing an efficient health care delivery system, the livelihoods of Kenyans will be improved.

2.2 Public Service Reform Strategy

Here the aim is to ensure that Kenya has a modern, effective and affordable public service for the future, one that will support the achievement of the ERS objectives, Vision 2030 and the MDGs. The key public service reforms envisaged

NHSSP II proposed a number of specific objectives for HRH: improving management at the central level, decentralizing where appropriate; building additional human capacity in line with the health needs of the population; and making HR development more demand driven.

under the ERS include public service wage bill containment and a lean, efficient, effective and ethically functioning public service.

The PSRS anticipates a public service that is citizen focused and results oriented, and that delivers effective and efficient services in an ethical and equitable manner to all Kenyans. In order to link human resources management (HRM) to the national development goals, the Public Service Reform and Development Secretariat (PSRDS) has developed a comprehensive human resources management reform strategy. It provides a common framework for the planning, management, development and recognition of staff in order to achieve the goals Kenya has set. The government has already begun the modernization of HRM in the public service with the results-based management approach (RBM), which is being institutionalized through the national performance management framework, the management accountability framework, the rapid results approach and the new performance appraisal system (PAS).

2.3 The Health Sector-Wide Approach (SWAp)

In 2005, the major health partners in Kenya agreed that a sector-wide approach (SWAp) should be used as a means of achieving the objectives of NHSSP II. The mission of the Kenyan Health SWAp is to improve the health status of the Kenyan people by working with all stakeholders as partners in the health sector, guided by one sector strategy (NHSSP II) under the leadership of the health sector; one expenditure framework; a common monitoring and evaluation framework; and common management arrangements (CMA) as its guide, with mutual respect, trust, transparency, accountability, openness and readiness for genuine dialogue as the main principles.

2.4 The Second National Health Sector Strategic Plan (NHSSP II), 2005–2010

The vision of the health sector is *An efficient and high quality health care system that is accessible, equitable and affordable for every Kenyan.* The goal of NHSSP II is to contribute to the reduction of health inequalities and to reverse the downward trend in the impact and outcome indicators. In relation to human resources management and development, NHSSP II aims to improve the use and performance of the available human resources for health, as well as to address shortages by increasing numbers, rationalizing deployment, and improving the quality and mix of the workforce. Specific objectives include instituting sound management principles at the central level, while decentralizing certain functions where appropriate; building additional human capacity in line with the health needs of the population; aligning human resources development activities with KEPH priorities; and making the development of the health sector workforce more demand driven.

NHSSP II proposed the outputs for human resources management and human resources development as shown in Table 2.1.

2.5 The Joint Programme of Work and Funding (JPWF)

The Joint Programme of Work and Funding (JPWF) was formulated as part of the RRI during the first quarter of 2006. It provides an action-oriented work programme to implement NHSSP II. The purpose of the JPWF is to guide the activities and investment decisions of the GOK, development partners and implementing partners for the years 2006/07– 2009/10. It also provides the basis for the development of the annual operational plans (AOPs) of the sector, which in turn define the actions to be taken by all stakeholders during each fiscal year.

Table 2.1: HRM and HRD outputs of NHSSP II

Human resources management outputs	Human resources development outputs
Computerized staff tracking system in place	A national HRD plan developed
Recommendations of the HR mapping implemented	Training needs assessment carried out
Results-oriented performance management introduced	A leadership and management development programme developed and implemented
Comprehensive HRM guidelines developed	Decentralized HRD services

The HRH related strategic objective of the JPWF is to "strengthen facility-based health service delivery through increased coverage and effectiveness of the KEPH, with particular attention for the levels 2–4 by developing/implementing the Human resources Management Plan". The JPWF recognizes that the human resources situation is critical and that having adequate numbers of skilled human resources is essential to ensuring the effective implementation of the KEPH.

2.6 The Kenya Essential Package for Health (KEPH)

KEPH was an innovation of NHSSP II. It has a clear policy focus on public health issues, through its prioritization of cohorts 1 and 2, (i.e., pregnancy and the newborn, and early childhood) and support for community and primary health care levels .

Staffing norms and standards for each level of care (levels 1–6) across the whole sector have been defined to guide the efficient, effective and sustainable delivery of the KEPH.[4] The application of the staffing norms should result in improved recruitment and deployment decisions and contribute to the more equitable distribution of HRH across the sector.

2.7 The Community Strategy and Task Shifting

One of the key innovations of NHSSP II and KEPH is the recognition of the community as a formal health service delivery level – level 1 in the KEPH framework. The Community Strategy[5] is now in place to guide the implementation of level 1 services, which are aimed at empowering Kenyan households and communities to take charge of improving their own health. One of the main strategic objectives of the Community Strategy is to "strengthen the community to progressively realize their rights for accessible and quality care and to seek accountability from facility based health services". In addition, the strategy proposes strengthened linkages and dialogue with the formal health sector through community-owned resource persons (CORPs), volunteers who are supervised and supported by community health extension workers (CHEWs) – i.e., public health technicians (PHTs) and enrolled community nurses (ECNs). Implementation of the Community Strategy intends to increase demand for services (EPI, ANC), and improve access through health promotion and reaching out to address unmet needs of under-served populations.

The KEPH Life-Cycle Cohorts

1. Pregnancy and the newborn (up to 2 weeks of age)
2. Early childhood (2 weeks to 5 years)
3. Late childhood (6–12 years)
4. Youth and adolescence (13–24 years)
5. Adulthood (25–59 years)
6. Elderly (60+ years)

The Community Strategy proposes that the country be divided into health units each serving a population of 5,000 and each having 50 CORPs (1 for every 20 households) supervised by 2 CHEWs. The CORPs will be motivated volunteers selected and supported by their communities, and the CHEWs will be retrained to effectively conduct these new roles.[6] In scaling up, the Community Strategy invites the participation of all stakeholders in the health sector, including NGOs, FBOs and development partners. The roll-out of the community strategy is currently under way through the establishment of community units and training of CORPs and CHEWs.

Task shifting initiatives that are also currently under way will have significant implications for the health workforce as they envisage significant changes in roles, responsibilities and scopes of practice of health providers in the health sector and the community. There will be need for review of relevant policies and training curricula to support the implementation of these initiatives

2.8 MOPHS and MOMS Strategic Plans

MOPHS and MOMS have both developed strategic plans covering the period 2008–2012. Table 2.2 shows the HR highlights from the two strategic plans.

[4] Ministry of Health, 2006, *Norms and Standards for Health Service Delivery in Kenya*, June.

[5] Ministry of Health, 2007, *Reversing the Trends in Health and Development Indicators – Community Strategy Implementation Guidelines for Managers of the Kenya Essential Package for Health at the Community Level*, March.

[6] Ministry of Health, 2007, *Enhancing Community Health Systems – Partnership in Action for Health: A Manual for Training Community Health Extension Workers*, and *Linking Communities with the Health System: The Kenya Essential Package for Health at Level 1 – A Manual for Training Community Health Workers*, March.

Table 2.2: HRH highlights of MOMS and MOPHS strategic plans

MOPHS strategic plan, 2008–2012	MOMS strategic plan, 2008–2012
• Fill 40% of existing vacancies • Recruit 7,588 new health workers • Identify 321,426 CORPs • Improve staff welfare • Fast track improvement of HRH initiatives • Strengthen HR management • Decentralize the HR function to the province and district levels	• Enhance leadership and management skills for health managers • Institutionalize performance contracting • Develop a training policy and HRD plan • Review pre-service curricula • Establish an integrated HRIS • Review HR norms and standards • Improve staff welfare • Fill existing vacancies • Institute hospital reforms to support greater autonomy

2.9 Millennium Development Goals

Kenya is signatory to the Millennium Declaration, which promulgated the MDGs. Since then , the MDGs have been factored into all key national policies and plans, including NHSSP II andVision 2030. There are nonetheless real concerns that Kenya may not achieve key MDG targets by 2015. In the health sector a major contributor to the slow pace of attainment of these goals is the HRH challenge: an acute health worker shortage, inequitable distribution, low productivity and inadequate skills. Health is at the heart of the MDGs as almost all the goals deal directly or indirectly with health. The goals and some of their key indicators are:

- Goal 1: Eradicate extreme poverty and hunger
  - Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day
  - *Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger*
- Goal 2: Achieve universal primary education
  - Target 3: Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling
- Goal 3: Promote gender equality and empower women
  - Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015
- Goal 4: Reduce child mortality
  - *Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate*
- Goal 5: Improve maternal health
  - *Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio*
- Goal 6: Combat HIV/AIDS, malaria and other diseases
  - *Target 7: Have halted by 2015 and begun to reverse, the spread of HIV/AIDS*
  - *Target 8: Have halted by 2015 and begun to reverse, the incidence of malaria and other major diseases*
- Goal 7: Ensure environmental sustainability
  - Target 9: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources
  - *Target 10: Halve, by 2015 the proportion of people without sustainable access to safe drinking water*
  - *Target 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers*
- Goal 8: Develop a global partnership for development
  - Target 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth
  - *Target 17: In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries*
  - Target 18: In cooperation with the private sector, make available the benefits of new technologies, especially for information and communications

3. Current HRH Situation

It is recognized globally that human resources for health are a crucial element in the delivery of health services and the achievement of the MDGs. Recent health sector studies, as well as policies, strategies and plans, acknowledge that HRH constraints are hampering health sector planning, service delivery and ultimately health outcomes in Kenya. Key HRH challenges facing the country include:

- Staff shortages
- Inequitable distribution
- High attrition especially in hard-to-reach areas
- Out-migration of health staff especially nurses and doctors
- Weak human resources management systems
- Weak leadership and management capacity
- Weak human resources information systems (HRIS)
- Weaknesses in pre-service and in-service training
- Poor sectoral coordination of the HRH agenda
- Low compensation and benefits package

3.1 Staffing Levels

Like many countries in sub-Saharan Africa, Kenya suffers from an acute shortage of health care workers. Table 3.1 shows the mismatch between the disease burden and the health workforce available to provide health care in Africa, while Table 3.2 compares the Kenyan situation with other regions.

Recent figures suggest that there are approximately 18 doctors for every 100,000 people in Kenya, with around 128 nurses per 100,000, which compares favourably with other countries in the SSA region. The data in Table 3.3, however, indicate that Kenya needs to increase its key professional cadres by about 50% to achieve WHO staffing recommendations.

Table 3.1: Global HRH inequities

The Americas	Sub-Saharan Africa
14% of the world's population	11% of the world's population
10% of the global disease burden	25% of the global disease burden
42% of the world's health workers	3% of the world's health workers
>50% of global health expenditure	<1% of global health expenditure

Source: World Health Report (2006).

Table 3.2: Comparisons of health personnel indicators in selected countries

Country	Doctors/ 100,000	Nurses & MW/ 100,000	Health workers / 100,000
Kenya (2007)	18	128	169
Kenya (2003)	15	133	148
Uganda	8	73	82
Malawi	2.2	26.4	28.6
Mozambique	2.6	20	34
South Africa	74.3	393	468
USA	247	901	1,147
UK	222	1,170	1,552
WHO minimum standard	20	100	228

Sources: World Health Report (2006); *Help Wanted: Confronting the Health Worker Crisis, Medicine Sans Frontiers Experiences in Southern Africa,* MSF (2007); MOH data, 2008.

Table 3.3: Kenya health worker levels vs WHO recommendations

WHO recommended minimum staffing levels (doctors, nurses, midwives) per 1,000 population	2.3
Kenya levels (doctors, nurses, midwives) per 1,000 population	1.5
% increase required to achieve WHO minimum recommended levels	53

Source: WHO World Health Report, 2006; *Facts and Figures*, MOMS, 2008.

The number of registered medical personnel provides some indication of the total workforce in the health sector. As shown in Table 3.4, the number of registered health workers in key professional cadres has increased by 15%, from 53,759 in 2004 to 61,559 in 2007.

Table 3.4: Medical personnel registered in Kenya (2004 and 2007

Type of personnel	2004	2004: Ratio/ 100,000	2007	2007: Ratio/ 100,000
Enrolled & registered nurses	40,081	122	44,105	124
Doctors	4,813	15	6,271	18
Clinical officers	4,808	15	5,797	17
Pharmacists	1,881	6	2,775	8
Pharmaceutical technologists	1,404	4	1,680	5
Dentists	772	2	931	3
Total	53,759		61,559	

Sources: MOH (2004) Report on the Human resources Mapping & Verification Exercise, December 2004, with MOH HRMIS June 2007 update; Kenya National Bureau of Statistics, Kenya Facts & Figures, 2007, Facts and Figures, MOMS 2008

3.2 Ministry of Health Staffing Levels

In 2006, the Ministry of Health had 35,627 positions filled, out of an establishment of 44,813, giving a vacancy rate of 21%. By 2008, the vacancy rate had reached 29%, as there were 33,317 positions filled out of an approved establishment of 47,247. That the number of staff in post fell by 6% within two years is an indication that attrition is running significantly ahead of new recruitment. This is clearly a very worrying trend that needs to be reversed urgently. Table 3.5 shows the level of vacancies for various cadres.

The data in the table show that the overall vacancy rate for MOH is 29% (13,930 positions) with high levels of vacancies for almost all the key cadres. The vacancy levels are set to rise significantly if the new staff establishment proposed by the two health ministries is approved as it proposes an increase of the establishment for the two ministries of health from 47,247 to 72,234. Out of the 33,317 MOH staff in post, 83% (27,700) are professional health workers. The 2004 Mapping and Verification Study identified a total of 34,986 MOH staff. This number had declined to 33,317 (5%) by June 2008. Table 3.6 shows the change in the numbers of key MOH cadres between 2004 and 2008.

Table 3.6: Decline in number of MOH staff: 2004–2008

Category	Staff in post		% Change
	2004	2008	
Enrolled nurses	12,664	12,055	-5
Public health officers	4,259	4,027	-5
Registered nurses	3,482	2,903	-17
Clinical officers	2,186	2,116	-3
Doctors	1,203	1,715	43
Total	23,794	22,816	-4

Source: MOH, *HR Mapping and Verification Study 2004*; IPPD, 2008.

The data in Table 3.6 show that with the exception of doctors, the number of staff employed by MOH for all key cadres declined significantly between 2004 and

Table 3.5: MOH vacancy levels

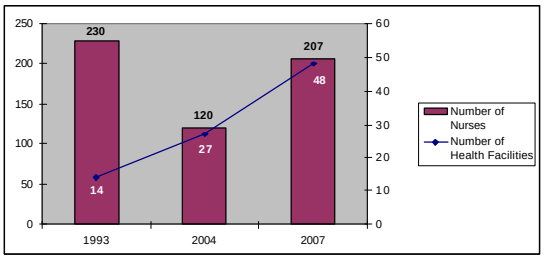
Cadre	Approved establishment	Staff in post	% vacancy level	No. of vacant positions
Medical officers	2,242	1,715	24	527
Clinical officers	2,872	2,116	26	756
Nursing officers	4,231	2,903	31	1,328
Enrolled nurses	13,472	12,055	11	1,417
Dentists	288	216	25	72
Dental technologists	118	110	7	8
Community oral health officers	83	83	0	0
Pharmacists	492	441	10	51
Pharmaceutical technologists	655	211	68	444
Physiotherapists	424	453	-7	-29
Occupational therapists	301	265	12	36
Radiographers and film processors	565	248	56	317
Orthopaedic technologists/ assistants	82	169	-106	-87
Public health officers and technicians	4,498	4,027	10	471
Medical laboratory technologists and technicians	1,758	1,653	6	105
Health administrative officers	189	215	-14	-26
Inspector of drugs	681	13	98	668
Health records and information officers and technicians	520	626	-20	-106
Plaster technicians	372	130	65	242
Medical engineers/technologists/ technicians	744	353	53	391
Human resources officers and assistants	93	56	40	37
Subordinate staff, clerks and drivers	9,057	3963	56	5,094
Others	3,510	1296	63	2,214
Total	47,247	33,317	29	13,930

Source: MOH, 2008; IPPD, June 2008.

2008 in spite of the lifting of the employment freeze. During the same period, the national population increased by 7%, implying that the decline in coverage is even higher. The most striking changes noted are the declines in the number of nurses. Enrolled nurses declined by 5%, while registered nurses declined by a massive 17%. The impact of this high attrition is likely to be worse than these numbers show as attrition is often significantly higher in rural and hard-to-reach areas, which generally have higher levels of shortages.

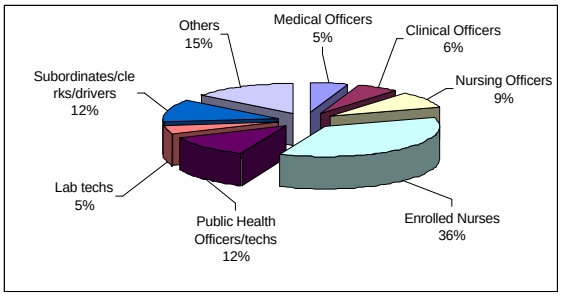
Figure 3.1, for example, shows that the number of nurses in Garissa District has declined significantly even as the population and the number of health facilities have risen. The recent increase in the number of nurses in the district has largely been due to the deployment of contract nurses recruited by development partners. Meanwhile, Figure 3.2 shows proportion of different professional health cadres in the overall MOH workforce. Nurses account for 45% of the total MOH workforce.

Figure 3.1: Trends in number of nurses and number of health facilities in Garissa District



Source: North Eastern PMO, 2007.

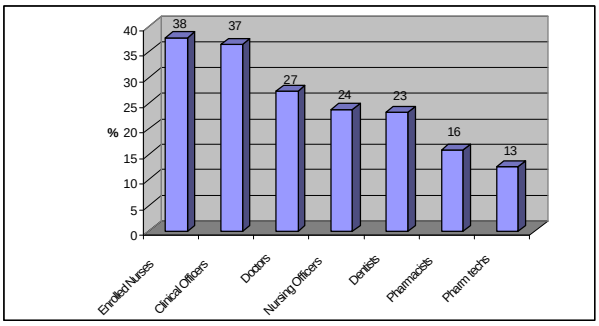
Figure 3.2: Proportion of different cadres in the total MOH workforce



Source: IPPD, June 2008.

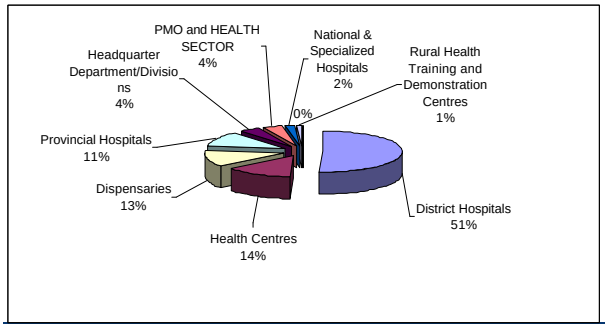
Figure 3.3 presents the proportion of registered health professionals that work for Ministry of Health. The figure shows that the government is the major employer for many health cadres. The distribution of MOPHS and MOMS health workers by health system level is illustrated in Figure 3.4.

Figure 3.3: Percentage of registered health professionals who work for MOPHS and MOMS



Source: MOH data 2008 and IPPD, 2008.

Figure 3.4: Distribution of public sector health workers by health system level



Source: MOH data, 2005.

3.3 Contract Staff Recruited by Development Partners

Over the last few years, a number of development partners have supported the recruitment of health staff to the public and the not-for-profit health subsectors by seconding contracted staff. Many of these have been posted in underserved regions such as North Eastern Province. While the government has pledged to employ these staff once their contracts expire, there are concerns about the sustainability of this programme, especially since a number of districts are very reliant on these contracted staff. A HRH assessment conducted in 2007 by MOH and Capacity Project found that 42% of nursing staff in Mandera District were contract staff seconded to MOH. Table 3.7 summarizes the number of contract staff currently seconded to the health sector.

The data in the table show that the number of contract staff is significant and represents the equivalent of increasing the MOH workforce by approximately 10%.

Table 3.7: Number of contract staff employed by development partners

Development partner	Cadre						Total
	Nurses	Clinical officers	Lab techs	Nutrition officers	Pharm techs	Others	
Clinton Foundation	1,186	134	88				1,408
USAID (Capacity Project)	618	86	90		36		830
Malaria Programme (GFATM)	431		69				500
NASCOP (GFATM)	116	82	48	47	24	77	394
PEPFAR	10	20				170	200
GAVI	90						90
Total	2,451	322	295	47	60	247	3,422

Source: MOH, 2008.

3.4 Health Labour Market

Data on the health labour market remain unclear. The paucity of data is especially notable in respect to the number, cadre and demographic profile of health workers deployed in the for-profit health subsector and those that are unemployed or under-employed. Anecdotal evidence suggests that there is a large number of unemployed qualified health personnel in Kenya, mainly thought to be the result of the long period during which there was a freeze on public sector recruitment. Thus large numbers of people apply for a small number of jobs.

The recent Emergency Hiring Programme (EHP) collected some useful information relating to the labour market. Of the 4,466 suitably qualified applicants for the EHP, 2,064 (46%) were unemployed; 71% of these were under the age of 30, which suggests that they may not have been employed in the public service since graduation. It is difficult to distinguish between the number of health workers who are unemployed, however, and those who are under-employed (such as nurses working in retail pharmacies as pharmacy assistants), those working outside the health sector, or those who are self-employed.

3.5 Staffing in Referral Hospitals and the Private Sector

Kenyatta National Hospital (KNH) and Moi Teaching and Referral Hospital (MTRH) are the largest referral hospitals in Kenya. Both hospitals also provide education, training and internship programmes for health professionals.

3.5.1 Kenyatta National Hospital

KNH is the largest hospital in Kenya – in fact, in the subregion – with a bed capacity of 1,800. The hospital provides specialized quality health care, facilitates training and research, and participates in national health planning and policy development. The hospital has approximately 5,000 staff against an approved establishment of 6,200 (Table 3.8). The table shows that although KNH has high vacancy levels, the extent of the staff shortages are lower than those of MOH.

Table 3.8: KNH staffing levels

Type of staff	Required	Available	% Vacancies
Medical officers and specialists	312	231	26
Dentists	49	30	39
Pharmacists	18	10	44
Nurses	1,948	1,725	11
Clinical officers	134	63	53
Lab techs	163	144	3
Pharm technologists	56	42	25
Radiographers	43	28	35
Nutrition officers	60	57	5
Physiotherapists	86	67	22
Occupational therapist	53	41	23
Medical records officers	137	81	9
Public health officers / techs	35	23	20
Others	3,119	2,413	23
Total	6,213	4,955	20

Source: KNH Strategic Plan, 2005–2010.

3.5.2 Moi Teaching and Referral Hospital (MTRH)

MTRH is Kenya's second national referral hospital. As shown in Table 3.9, it has a capacity of 500 beds and a total workforce of 2,349 against an establishment of 2,950. MTRH has similar levels of vacancies as KNH.

Table 3.9: MTRH staffing levels

Type of staff	Required	Available	% Vacancies
Medical officers and specialists	92	51	45
Dentists	6	5	17
Pharmacists	4	4	-
Nurses	916	664	28
Clinical officers	78	65	17
Lab Techs	153	133	13
Pharm technologists	35	37	13
Radiographers	30	30	-
Nutrition officers	59	42	29
Physiotherapists	65	34	48
Occupational therapist	62	13	79
Medical records officers	56	45	20
Public health officers / techs	29	25	14
Others	1,326	1,201	9
Total	2,911	2,349	19

Source: MTRH, 2008.

3.5.3 Private Health Care Providers

Kenya has many private health care providers. These include the NGO/FBO and the private for-profit subsectors. NHSSP II lists the most important private health providers and their core areas as follows:

- ***African Medical and Research Foundation (AMREF):*** Provides a broad range of activities ranging from clinical services and emergency response, to training and health policy and systems development.
- ***The Christian Health Association of Kenya (CHAK):*** One of the largest health related NGOs in the country.
- ***The Kenya Catholic Secretariat (KCS):*** Has 19 Catholic dioceses all over Kenya.
- ***The Family Planning Association Kenya (FPAK):*** Provider of family planning services and clinic-based reproductive health services.
- ***The Kenyan Aga Health Network:*** Runs several hospitals and training institutions in Kenya.

These private health care providers are recognized as key players in the delivery of health services at national and district levels. Since the GOK stopped grants to faith-based health services in the 1990s these providers have found it increasingly difficult to meet recurrent costs and to operate their services effectively. Revenues from user fees have been declining as a result of decreasing outpatient attendance and low utilization of services, particularly in level 2 and 3 facilities. FBHS are also experiencing staffing shortages and the attrition of core personnel. They are losing staff to the public sector, where employment is perceived to be more attractive: better conditions of service, training opportunities and less remote postings.

In 2006/07, the health sector seconded 51 doctors and 44 nurses to FBO facilities and FBOs requested support to employ an additional 309 nurses in 2007/08. In turn, FBOs will use the savings derived from this support to employ additional staff or provide salary top-ups to their staff to make salaries comparable to government salaries.

In 2006 the number of health workers employed in the private-not-for-profit subsector was estimated to be 9,057 (Table 3.10). No data were available for staffing in the for-profit subsector, which according to the 1998 data had 29% of the total number of facilities – although many of these are likely to be single-handed enterprises such as medical centres and thus do not account for an equivalent share of the sector's human resources.

Table 3.10: Staffing levels of private not-for-profit employees

Type of staff	Number
Nurses (registered & enrolled) 6,558	
Laboratory technologists/technicians	641
Doctor (medical officer and specialists)	569
Clinical officer	231
Pharmacists	219
Pharmaceutical technologist	195
Dentists	165
Public health officer	48
Public health technician	38
Total other professional staff (Kenyatta & Moi)	393
Total	9,057

Source: HR RRI Team members, 2006.

The figures in Table 3.10 include staff employed by local authorities and city councils. In all major towns and cities of the country, the health sector has delegated responsibility for health services to the Ministry of Local Government (MOLG). From Table 3.11, it is possible to estimate that 50–60% of all health cadres work in the private sector (excluding FBOs).

The FBO/local government figure was based on estimates by HR RRI Team members 2006. Among the assumptions that can be drawn from the foregoing are the following:

- The number of registered health workers in active service assumes that 90% of health workers registered in 2007 were in active service. The 10% was to allow for out-migration and health workers working outside the health sector. This number was increased by 5% to arrive at the 2008 figure.

- The private sector category is made up of the for-profit private subsector and includes hospitals such as Aga Khan and Nairobi Hospital, which, although non-profit making, have a health delivery model and target group similar to that of the for-profit subsector.

Table 3.11: Estimates for staffing levels in different subsectors for registered cadres

Type of personnel	Number in active service (2008)	No. of staff					% of active registered cadres in private sector
		MOH	KNH	MTRH	FBO/Local government	Private sector	
Enrolled & registered nurses	41,679	14,958	1,725	664	6,551	17,781	43
Doctors	5,926	1,715	231	51	569	3,360	57
Clinical officers	5,478	2,116	63	65	231	3,003	55
Pharmacists	2,622	441	10	4	219	1,948	74
Pharmaceutical technologists	1,588	211	42	37	195	1,103	69
Dentists	880	216	49	5	165	445	51

3.6 Health Workforce Distribution

Mal-distribution of health workers remains a major challenge for the sector. Hardest hit, as observed above, are the hard-to-reach regions. A survey conducted by MOH/Capacity Project in North Eastern found that Mandera District had filled only 29% of the established nursing positions. Table 3.12 shows the extent of the distribution challenge.

Table 3.12: Provincial distribution of MOPHS and MOMS staff

Province	% of national population (2007)	% of total MOPHS and MOMS doctors working in province	% of total MOPHS and MOMS registered and enrolled nurses working in province
Nairobi	8.2	25.6	6.6
Central	12.3	12.7	17.1
Rift Valley	25.3	18.9	25.3
Eastern	15.6	16.5	17.5
Coast	8.7	8.7	9
Nyanza	14.6	8.9	11.8
Western	11.8	6.4	10.9
North Eastern	3.5	2.3	1.9

Source: CBS and MOH IPPD, June 2007.

Of particular note in Table 3.12 is the gross mal-distribution of medical doctors. The situation is significantly worse if one factors in the many doctors who work in the for-profit private sector where distribution is even more skewed in favour of major urban centres. The nurses appear to be more equitably distributed, but the reality is also likely to be worse than shown. The low nurse numbers shown for Nairobi are deceptive as the employees of local government are not shown, nor are nurses working in the for-profit private sector. The numbers also do not tell the story of distribution by level of skill and experience, as highly qualified and skilled nurses may be deployed in areas where they do not optimally utilize their competencies especially in urban centres. The impact of health worker mal-distribution is aggravated by other factors such as wide variation in disease burden and population densities.

Nyanza, for example, requires more health workers per population given the higher prevalence of malaria and HIV, while North Eastern requires more health workers even though its population is small, because it is spread over an extremely large area. Another factor exacerbating health worker shortages is the proliferation of health facilities driven mainly by CDF funding. The local investment in health facilities not only does not always take into account the MOH norms and standards, it has not been matched by investment in the production of health workers or health worker amenities such as housing. For example, in 2007, nearly a third (32%) of health facilities in North Eastern Province were closed for lack of health personnel.

Figure 3.5: Increase in health facilities and registered health personnel, 2006/07

3.7 Staffing Norms and Establishment

In 2006, MOH developed staffing norms for different levels of health care delivery based on 2003 population numbers – refer to Chapter 4 (Workforce Projections). These numbers do not take into consideration regional variations in disease burden. The norms were also not disaggregated by type of provider – public, FBO/NGO and for-profit private sector. The current authorized establishment for MOH has not been reviewed for over ten years and preceded the scale up of HIV/AIDS services and renewed commitment to the MDGs. See Table 3.13 for the current and proposed MOH establishment for selected cadres.

Table 3.13: Current and proposed MOH establishment

Cadre	Current approved establish-ment	Proposed establish-ment	% Change	Staff in-post (June 08)
Medical officers	2,242	3,862	72	1,715
Clinical officers	2,872	5,779	101	2,116
Nursing officers	4,231	11,690	176	2,903
Enrolled nurses	13,472	13476	0	12,055
Dentists	288	830	188	216
Pharmacists	492	848	72	441
Public health officers/techs	4,498	5718	27	4,027
Health records & information officers	98	343	250	98
Health records & info technicians	422	1848	338	528
Others	18632	27840	49	9218
Total	47,247	72,234	53	33,317

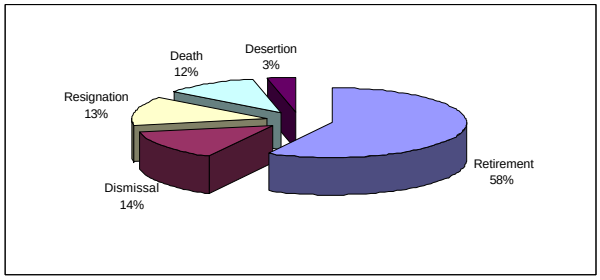
Source: MOH, 2008.

The proposed revised establishment arose from a 2008 joint task force of MOMS and MOPHS that reviewed the current approved establishment and recommended a new establishment that is awaiting approval. Another shortcoming of the approved establishment is that it is an aggregate and does not give a regional breakdown for the different cadres. As a result, regional distribution depends on administrative decisions and this partly contributes to the current inequitable distribution.

3.8 Staff Attrition and Migration

Data from the ministries responsible for health show that retirement (normal, early and medical) is the main contributor to health worker attrition, followed by dismissal and resignation. On average, the ministry loses 2.6% of its staff to retirement annually. Total annual attrition stands at approximately 4.5%. Given the many years during which there was a recruitment freeze, retirement is going to have a significant impact on the numbers and skills of workforce in the coming years as people age and the impact of the recruitment gap begins to bite. Numbers are summarized in Table 3.14 and illustrated in Figure 3.6.

Figure 3.6: MOH attrition by cause: 2005–2007

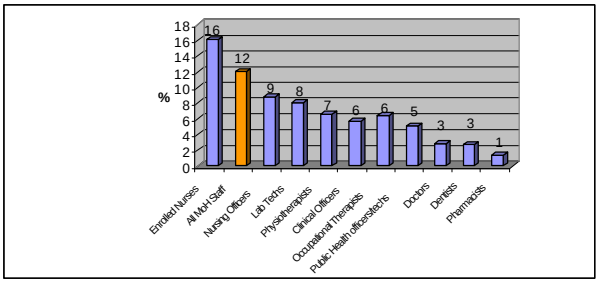


Source: MOH, 2008.

The recent increase in the public sector retirement age from 55 to 60 years will be highly beneficial to the health sector. Without this change, approximately 12% of the total MOH employees would be lost by 2012 (Figure 3.7). As a result of the change, however, it is expected that retirement rates will dramatically reduce and consist mainly of early retirement and retirement on medical grounds. Even so, attrition from other causes including resignation, desertion, termination and death remain a matter of concern. As can be seen from Figure 3.7, the change in the retirement age will mainly affect the nursing cadre.

> This strategic plan takes a gender responsive approach to ensure gender equity in the training, deployment, development and management of the health workforce.

Figure 3.7: Current MOH staff who would have retired by 2012 if retirement age had not changed (%)



Source: MOH, 2008.

3.8.1 Out-Migration

Data from the Kenya Nursing Council indicates that many nurses have left or are planning to leave Kenya for work overseas (Table 3.16 and Appendix Table A3). Between 2002 and 2008, some 5,883 nurses applied to have their certificates validated to enable them to work for employers overseas, with 86% of the requests from the United States and UK. The data do not distinguish between registered and enrolled nurses, But assuming this figure represents mostly registered nurses (who are more likely to emigrate), it is a significant loss. The available out-migration data have significant gaps, especially as they do not give numbers of nurses who actually left the country. Out-migration data are also not available for other cadres such as doctors, dentists and pharmacists.

Figure 3.8 shows that the rate of application for nursing positions has declined in the last few years.

Table 3.14: Number of MOH staff leaving service - 2005–2007

	Retirement	Dismissal	Resignation	Death	Desertion	Total
Three-year total – 2005 to 2007	2,577	643	574	516	144	4,454
Annual average	859	214	191	172	48	1,485
% annual attrition*	2.6	0.6	0.6	0.5	0.1	4.5

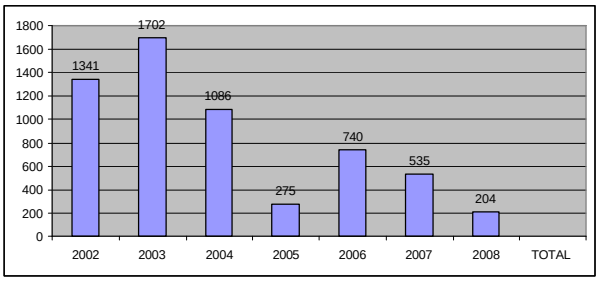
* Assumes an average MOH workforce of approximately 33,000.
Source: MOH, 2008.

Table 3.16: Total nurses verified to work outside Kenya January 2000 to December 2004

Country	2000	2001	2002	2003	2004	2005	2006	Total
England	199	687	210	253	324	158	72	2,118
USA	45	174	356	656	263	255	220	2,096
Australia	-	-	18	11	23	36	27	108
South Africa	7	6	3	-	1	4	5	104
New Zealand	12	18	11	6	6	9	8	72
Botswana	4	2	-	-	3	7	6	74
Uganda	6	10	5	9	11	6	2	64
Canada	6	11	5	3	5	6	6	52
Ireland	3	5	—	-	4	6	30	48
Tanzania	1	4	2	1	2	4	2	20
Saudi Arabia	-	-	-	-	1	0	0	1
Total	283	918	610	939	639	491	378	4,757

Source: Nursing Council of Kenya 2007.

Figure 3.8: Number of nurses applying for overseas positions

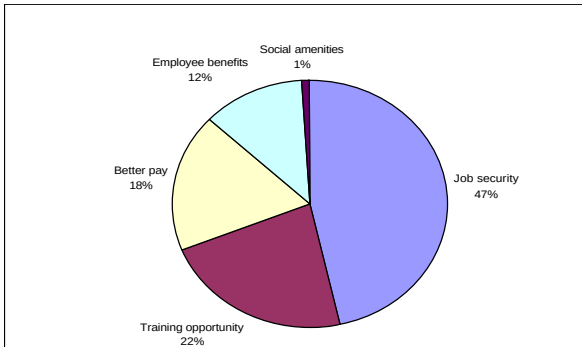


Source: Nursing Council of Kenya

3.8.2 Intra-Sector Migration

Exacerbating out-migration is the increased internal migration and movement between the subsectors (government, private, FBO), particularly from the private-not-for-profit employers to the public subsector. This migration appears to be driven by improved public sector salaries, better training opportunities and perceptions of higher job security for government jobs. Figure 3.9 shows the reasons given by FBO health staff for preferring employment in the public sector.

Figure 3.9: Reasons for preferring the MOH as an employer



Source: FBO Situational Analysis Report, 2007

The large exodus of FBO health staff to the public subsector in 2006 as a result of public sector recruitment precipitated a major crisis as some health facilities faced a looming threat of closure. Data for hospitals under the CHAK network showed that hospitals lost between 2% and 36% of their nurses following the public sector recruitment.

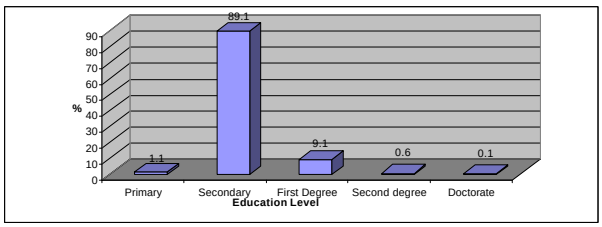
3.9 Age, Education and Gender Analysis of the MOH Workforce

We have seen that the existing health workforce is nearing middle age, which is potentially likely to have a severe impact on the sector. Other issues that require attention are education and gender, especially as the sector aims to rationalize and upgrade training and ensure equality of opportunity to all personnel.

3.9.1 Education

Figure 3.10 illustrates the breakdown of the MOH professional health staff by level of formal education.

Figure 3.10: MOH workforce by education levels



Source: IPPD, June 2008.

The data show that the vast majority (89.1%) of MOH's professional health workers hold secondary school education. However, the IPPD data do not

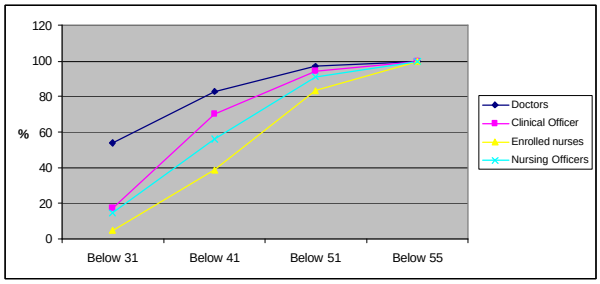
include certificate and diploma qualifications gained in middle level health training institutions. As a result, many of the nurses and clinical officers who hold certificates and diploma from these colleges are still categorized as having secondary school education.

3.9.2 Health Workforce Age Profile

The MOH workforce is showing clear signs of ageing with a median age of 42 years. If the current retirement age remains, MOH will lose half of its workforce in the next 13 years. As noted earlier, this is primarily due to the many years during which there was an employment freeze. An exception is the doctors; more than half of the doctors working for MOH are below 31 years of age. This may be because they stay in the public sector to gain experience and further training and then leave when they have more marketable skills.

As illustrated in Figure 3.11, the profile of enrolled nurses is very different. About 60% are between the ages of 41 and 55. There are only 5% below the age of 31. This may be due to the recruitment restrictions that have been in place since 1998 and the fact that this cadre is being phased out.

Figure 3.11: Distribution of key health sector personnel by age group



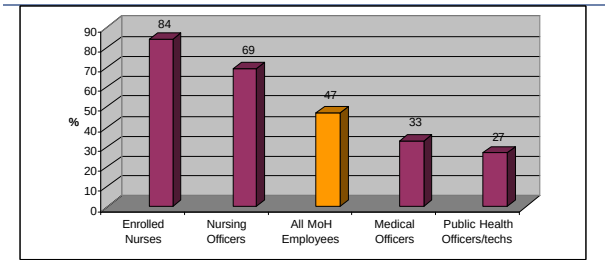
Source: IPPD, June 2008.

In June 2008, there were 30 MOH employees aged above 55 years serving on contract terms. Of these, 16 were medical specialists.

3.9.3 Health Workforce and Gender

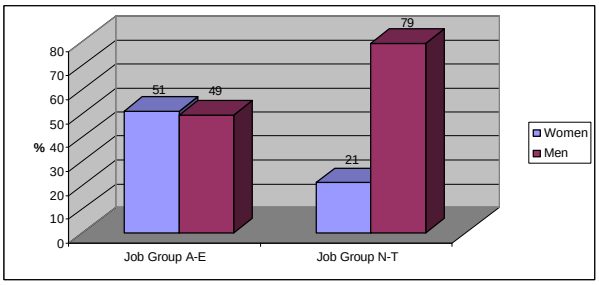
Figure 3.12 shows the gender profile of the MOH workforce. As can be seen, women make up about 50% of the total MOH workforce and dominate in the traditionally "female" careers of nursing. They are not as well represented in medicine, however, which traditionally has been male dominated. When gender is tracked against job seniority, women fare even worse, as shown in Figure 3.13. The chart shows that while women are equitably distributed in the lowest jobs groups (A to E), they are significantly under-represented in the highest groups (N to T).

Figure 3.12: Percentage of women among MOH employees



Source: IPPD, June 2008.

Figure 3.13: Proportion of women on MOH staff in the lowest and highest job groups



Source: IPPD, June 2008.

3.10 Human Resources Management

A number of HRH assessments have identified significant weaknesses in the human resources management systems of both MOH and FBO health care providers. Key HRM challenges include:

- HR management professionals are insufficient at central, regional and facility levels.
- Clear job descriptions for staff are lacking.
- Orientation of new staff is erratic and non-standardized.
- There is no performance management system for the majority of health managers and staff.
- There are long delays in the handling and implementation of routine personnel actions, including promotions, re-designation, payment of allowances, etc.
- The HR function is centralized, which delays implementation of HR actions and handling of grievances.
- The HRIS is extremely weak. As a result, it is difficult to get the accurate HR data needed for decision making.
- There are inordinately long delays in recruitment and deployment even when funding is available.
- The health sector does not have a retention strategy covering all staff.
- The health sector does not have an incentive package for health workers posted to hard-to-reach areas.

Table 3.17 illustrates the critical lack of HR staff to support the HR function.

Table 3.17: Vacancy levels of HR staff

	Number of HR staff required	Number in post	% Vacancies
MOH	93	56	40
MTRH	29	16	45

Source: Revised MOH Establishment, 2008 (draft), KNH and MTRH strategic plans.

3.11 Training and Development

Several institutions train health care professionals in Kenya. These include Kenya Medical Training College (KMTC), University of Nairobi/Kenyatta National Hospital, and Moi University/Moi Teaching and Referral Hospital. Among the others are Aga Khan University, CHAK, the Kenya Episcopal Conference/ Catholic Secretariat (KEC/CS) and Nairobi Hospital.

3.11.1 Basic Pre-Service Training

Most of the training institutions offer basic pre-service training (see tables 3.18 and 3.19). Reports indicate that many of them individually plan for and manage their student intakes. The Professional Councils are responsible for monitoring the quality and standards of the training content and facilities, and administering professional examinations. Some of the training institutions reported that because government funding has been decreasing over the years, they have had to increase the admission of private, fee paying students so as to boost income. Table 3.20 shows the total output for different cadres from these institutions, while Table 3.21 specifically focuses on nurses.

Table 3.18: Kenya Medical Training College (KMTC) training output

Cadre	Training output				
	2005	2006	2007	2008	Average annual output
Clinical officers	449	489	508	855	575
Nursing officer	778	1,046	1,294	2,006	1,281
Enrolled nurse	209	297	112	117	184
Pharmaceutical technology	121	92	145	132	123

Source: KMTC, 2008.

Table 3.19:Training output of other institutions

Institution	Cadre	Capacity	Output: 2002	Output: 2005
University of Nairobi	Doctors	100	98	199
	Pharmacists	40	42	64
	Dentists	33	32	36
	Nurses	40	40	52
Moi University	Doctors	50	41	36
	Nurses	20	19	34
Aga Khan University	Nurses	40		63
CHAK training institutions (x 9 institutions)	Nurses	240	380	460
KEC/CS (x 12 institutions)	Nurses	454	399	429
Nairobi Hospital	Nurses	180	150	-

Source: HR Working Group members, 2006.

Professional Councils are responsible for monitoring the quality and standards of training content and facilities, and for administering professional examinations.

Table 3.20: Total output of pre-service institutions (basic training)

Cadre	Annual output (2005 levels)	% of total registered (2007)
Doctors	235	4
Nurses	2,653	6
Dentists	36	4
Pharmacists	64	2
Clinical officers	575	10

Table 3.21: Training output nursing: Basic and post-basic

Course	2006	2007	2008
Kenya registered community health nursing	1,101	1,921	2,383
Kenya registered nursing	77	128	106
Kenya registered midwifery	36	47	40
Kenya reg. comm. health nursing post basic	8	13	18
Kenya registered community health nursing (BScN)	59	118	64
Kenya registered anaesthetic nursing	0	0	0
Kenya registered critical care nurse	6	12	11
Kenya registered psychiatric nursing	10	20	10
Kenya registered peri-operative nursing	7	8	12
Kenya registered ophthalmic nurse	0	12	4
Kenya registered paediatric nurse	0	0	1
Kenya enrolled nurse	15	38	31
Kenya enrolled midwifery	33	27	29
Kenya enrolled Community Health Nurse	448	397	255
Kenya enrolled psychiatric nurse	0	0	0
Kenya enrolled community health nurse (Post-Basic)	1	0	1
Total	1,801	2,741	2,965

Source: Nursing Council of Kenya, 2009.

3.11.2 Post-Basic and In-Service Training

There have been challenges in the coordination of post-basic and pre-service training. This training is also often not driven by identified needs. The new ministerial strategic plans for MOPHS and MOMS address this issue and propose ways of improving coordination and linking the training to identified needs.

There are Human Resources Development (HRD) and Continuing Professional Development (CPD) units within the two health ministries that are responsible for the training and development of health sector staff. Training responsibility cuts across numerous departments and programmes in the health sector, however, and this perpetuates functional overlap, fragmentation and lack of coordination. The CPD and HRD units fall under different directorates, with the result that most of the HRD function is of a fairly routine and operational nature (i.e., processing scholarships, training approvals, study fees, etc.) with little, if any, strategic focus.

A Ministerial Training Committee is functioning at the central level and meets on a monthly basis to review training submissions, applications and sponsorship requests. In 2007 it announced that as of July, "approval of training will be subject to available replacement and that service delivery will not be compromised". Training committees have also been established at district and provincial levels. These structures are intended to ensure that all district training submissions and plans are prepared, reviewed and forwarded to central MOH for approval through the Provincial Medical Officer (PMO).

A rapid assessment of in-service and pre-service training was conducted in March 2007 and a roadmap proposed for the development of the National Training Policy. A Continuing Professional Development (CPD) Technical Working Group (TWG) was formed in August 2007, with representation across the health sector, regulatory bodies and professional associations. A complementary National Health Training Policy TWG was formed at the same time to look at the National Training Policy including CPD; this group has representation from health sector, training authorities, Ministry of Education, Directorate of Personnel Management (DPM), private training providers and the Commission for Higher Education. Both TWGs report to the National Training Stakeholders Committee (NTSC) and are endorsed by both the PS and DMS.

Central level planning and budgeting for training is conducted by each of the different departments/programmes, with little guidance provided on the resources available. Training projections are submitted in the final quarter of the year and are consolidated into a training plan, incorporating headquarters and administrative services, and technical services, i.e., curative, rehabilitative, preventive, and promotive (including provincial level training). All of the work plans included in AOPs 2, 3 and 4 for the national programmes and departments (e.g., reproductive health, malaria, environmental health, mental health, sanitation, HIV/AIDS, TB, etc.) and the provincial work plans have a capacity development component. What is not clear, however, is how these planned training and development initiatives are aligned with service demands and identified skills gaps.

There are ongoing consultations between Moi University and health sector stakeholders to develop a specialist family physician cadre, through the MOH draft *Family Medicine Policy* (August 2007) and MOH draft *Kenyan Family Medicine Strategy* (September 2007) initiatives. It is proposed that 430 family physicians be trained and deployed to district/subdistrict level.

3.12 Human Resources Information System (HRIS)

At the present time the sector does not have an integrated HRIS to guide HRH decision making. The last HRH mapping exercise was carried out in 2004 and the information has not been updated because of the lack of a functioning HRIS. Even for MOH, the only reliable data are contained in the IPPD, which was set up to support salary processing and not HR management. The situation is most grave for the private-for-profit sector for which virtually no reliable data are available.

With the support of USAID, the health ministries are currently setting up a HRIS that will hopefully begin to change the situation and help process and make available accurate and timely sector-wide HR data.

3.13 Accreditation and Licensing

MOMS is responsible for accrediting health training institutions and courses and licensing professional health practitioners. For certain cadres these roles have been given to regulatory bodies governed by different Acts Parliament. These include the Kenya Medical Practitioners and Dentists Board, the Nursing Council of Kenya, and the Pharmacy and Poisons Board. Their functions are briefly summarized below. A number of other professional bodies represent different health care cadres and also work with the regulatory authorities to support continuing medical education to ensure that members get annual practice licences.

3.13.1 Kenya Medical Practitioners and Dentists Board

The Kenya Medical Practitioners and Dentists Board is charged with the responsibility of ensuring the provision of high quality health care that is safe and ethical, by placing a high premium on quality of human life through appropriate regulation of training, professional practice and services.

3.13.2 Nursing Council of Kenya

The Nursing Council of Kenya (NCK) is a statutory body of the Ministry of Health established under an Act of Parliament (The Nurses Act) Cap. 257 of the Laws of Kenya to make provision for the training, registration, enrolment and licensing of nurses, to regulate their conduct, and to ensure their maximum participation in the health care of the community and for related purposes.

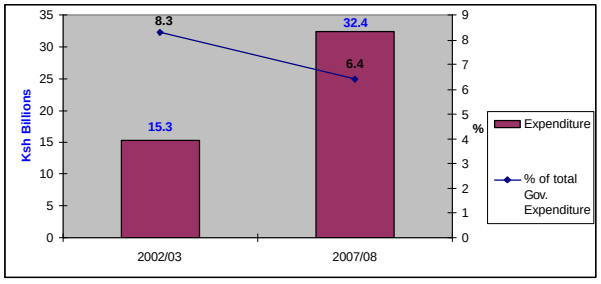
3.13.3 Pharmacy and Poisons Board

The Pharmacy and Poisons Board is charged with the responsibility of regulating pharmacy training and practice.

3.14 HR Financing

Between 2003 and 2007, there was a rapid increase in the Government's health care budget, from Ksh15.3 billion to Ksh32.4 billion. As shown in Figure 3.14, however, health expenditure as a proportion of total government expenditure declined over the same period and remains far below the Abuja Declaration target of 15%.

Figure 3.14: Level of government health expenditure



Source: *Facts and Figures*, MOMS, 2008.

Salaries and other personnel costs as a percentage of total MOH recurrent expenditure have remained at about 67% in the last few years. Given that salaries take up such a large part of public sector health expenditure, it is imperative that this investment yield a good return through the sound management of the health workforce to enhance productivity.

4. Health Workforce Projections and Gaps

One of the major goals of this HRH strategic plan is to address the staffing gaps so as to reduce inequalities in health care access and reverse the decline of key health indicators. As we look into ways of accomplishing this aim it is imperative to determine the actual extent of the staffing gaps for different cadres at national, regional and subsector levels. This can be done by determining workforce requirements and assessing the number of health workers currently deployed. It is also important to look at health worker attrition, the health worker labour market, in particular the number of health workers currently unemployed, and the output of pre-service health training institutions.

Many of the critical parameters needed for workforce projections are difficult to estimate for a number of reasons, including:

- There are different workforce projection models, all of which have merits and demerits.
- There is a paucity of reliable data on the contribution of the different subsectors to health service delivery and therefore their different workforce requirements.
- It is difficult to get reliable data on the number of health workers currently deployed, especially for the private for-profit sector. Even for the public sector, the lack of an integrated HRIS makes it difficult to get accurate and current data. The quality of HRH data becomes even more unreliable as one moves down to the lower levels including the province and district.
- There are no reliable data on the number of trained health workers currently unemployed or under-employed.
- Reliable data on attrition rates at sector and subsector levels are not available.

The workforce projections done here were largely informed by the 2006 *Norms and Standards for Health Service Delivery,*[7], the revised MOH Establishment (2008), and IPPD data (June 2008). Other data came from KNH, MTRH, KEC, CHAK, NCK, KMTC, Aga Khan University Hospital, the Kenya Medical Practitioners and Dentists Board, and different MOH documents.

4.1 Health Service Delivery Units – Required and Available

To determine the health workforce required we based projections on the number of health facilities need at different levels of health service delivery specified in *Norms and Standards for Health Service Delivery* and the expected 2012 national population. These are shown in Table 4.1, with national projections in Table 4.2.

Table 4.1: Number of health service delivery units required and available

	L 1	L 2	L 3	L 4	L 5	L6
Population served	5,000	10,000	30,000	100,000	1,000,000	
Number of health care units available 2006	0	3,382	649	526	20	6
Number of health care units – 2003 projections*	6,425	3,213	1,071	321	32	
Number of health care units – 2012**	7,499	3,749	1,250	375	37	2

* Based on population of 32.1 million
** Based on a population of 37.5 million
Level 6 hospitals are KNH, MTRH, Mathari Mental Hospital. Spinal Injury Hospital, Kijabe Hospital, Nairobi Hospital and Aga Khan University Hospital.
Source: *Norms and Standards for Health Service Delivery* (MOH, June 2006); 2012 population extrapolated from Kenya National Bureau of Statistics data.

[7] Ministry of Health, *Norms and Standards for Health Service Delivery*, June 2006.

Table 4.2: National workforce projections for levels 2–5 (Based on staffing norms, 2006)

Cadre	Level 2			Level 3			Level 4			Level 5			Total
	Number of units	Number required per unit	Total required	Number of units	Number required per unit	Total required	Number of units	Number required per unit	Total required	Number of units	Number required per unit	Total required	
Medical specialist	3,749		-	1,250		-	375		-	37	24	888	888
Medical officer	3,749		-	1,250		-	375	6	2,250	37	16	592	2,842
Nurse	3,749	2	7,498	1,250	14	17,500	375	68	25,500	37	224	8,288	58,786
Clinical officers	3,749		-	1,250	2	2,500	375	8	3,000	37	16	592	6,092
Community oral health officer	3,749		-	1,250	1	1,250	375		-	37		-	1,250
Laboratory technician	3,749		-	1,250	1	1,250	375	2	750	37	4	148	2,148
Laboratory technologist	3,749		-	1,250			375	1	375	37	3	111	486
Pharmaceutical technologist	3,749		-	1,250	1	1,250	375	2	750	37	4	148	2,148
Dentists	3,749		-	1,250		-	375	1	375	37	2	74	449
Dental technologist	3,749		-	1,250		-	375	1	375	37	4	148	523
Pharmacist	3,749		-	1,250		-	375	1	375	37	3	111	486
Radio-grapher	3,749		-	1,250		-	375	1	375	37	3	111	486
Rehabilitative therapist	3,749		-	1,250		-	375		-	37	4	148	148
Physiotherapist	3,749		-	1,250		-	375		-	37	1	37	37
Occupational therapist	3,749		-	1,250		-	375		-	37	1	37	37
Orthopaedic technologist	3,749		-	1,250		-	375		-	37	1	37	37
Social worker	3,749		-	1,250		-	375		-	37	1	37	37
Total professional health staff			7,498			23,750			34,125			11,507	76,880
Support staff	3,749	3	11,247	1,250	8	10,000	375	23	8,625	37	41	1,517	31,389
Grand total			18,745			33,750			42,750			13,024	108,269

Source: *Norms and Standards for Health Service Delivery*, June 2006; 2012 population extrapolated from KNBS data.

4.2 Workforce Projections by KEPH Levels

Level 1, the community, is a particular focus of NHSSP II. The focus requires a significant increase in facilities and staffing. Table 4.3 summarizes the projected workforce required for the community level by 2012. National projections by province for levels 2–5 are given in Table 4.4.

Table 4.3: Level 1 health workforce requirements

Cadre	Number required per unit	Number of units, 2012	Total for all units, 2012
CORPs	50	7,499	374,950
CHEWs*	2	7,499	14,998
Total			389,948

Note: CHEWs will be based in level 2 facilities.
Source: *Norms and Standards for Health Service Delivery*, June 2006; 2012 population extrapolated from KNBS data.

Table 4.4: Provincial staffing projections for Levels 1 to 5 (based on staffing norms, 2006, and provincial population)

Cadre	National requirements 2012	Provincial requirements							
		Nairobi	Central	Rift Valley	Eastern	Coast	Nyanza	Western	North Eastern
CORPs	374,950	30,746	46,119	94,862	58,492	32,621	54,743	44,244	13,123
CHEWs	14,998	1,230	1,845	3,794	2,340	1,305	2,190	1,770	525
Total level 1	389,948	31,976	47,964	98,657	60,832	33,925	56,932	46,014	13,648
Medical specialist	888	73	109	225	139	77	130	105	31
Medical officer	2,842	233	350	719	443	247	415	335	99
Nurse	58,786	4,820	7,231	14,873	9,171	5,114	8,583	6,937	2,058
Clinical officers	6,092	500	749	1,541	950	530	889	719	213
Community oral health officer	1,250	103	154	316	195	109	183	148	44
Laboratory technician	2,148	176	264	543	335	187	314	253	75
Laboratory technologist	486	40	60	123	76	42	71	57	17
Pharmaceutical technologist	2,148	176	264	543	335	187	314	253	75
Dentists	449	37	55	114	70	39	66	53	16
Dental technologist	523	43	64	132	82	46	76	62	18
Pharmacist	486	40	60	123	76	42	71	57	17
Radiographer	486	40	60	123	76	42	71	57	17
Rehabilitative therapist	148	12	18	37	23	13	22	17	5
Physiotherapist	37	3	5	9	6	3	5	4	1
Occupational therapist	37	3	5	9	6	3	5	4	1
Orthopaedic technologist	37	3	5	9	6	3	5	4	1
Social worker	37	3	5	9	6	3	5	4	1
Total professional staff: Levels 2–5	76,880	6,304	9,456	19,451	11,993	6,689	11,224	9,072	2,691
Support staff	31,389	2,574	3,861	7,941	4,897	2,731	4,583	3,704	1,099
Grand total	**108,269**	**8,878**	**13,317**	**27,392**	**16,890**	**9,419**	**15,807**	**12,776**	**3,789**

Source: *Norms and Standards for Health Service Delivery,* June 2006; 2012 population extrapolated from KNBS data.

4.3 Workforce Projections and Gaps

MOH requires the workforce – and faces the staffing gaps – shown in Table 4.5; similar data are provided in Table 4.6 for KNH and MTRH.

There is a paucity of reliable data on the contribution of the different subsectors to health service delivery and therefore their different workforce requirements. It is particularly difficult to get reliable data on the number of health workers currently deployed, in the private-for profit sector.

4.4 Issues Arising from Workforce Projections and Analysis of Staffing Gaps

Analysis of the workforce projections and staffing gaps raises a number of pertinent questions that need to be factored into the implementation of this strategic plan. Issues relate to private sector requirements and data, MOH vacancies and recruitment targets, the capacity of the various training institutions, and dual employment of health professionals.

Table 4.5: MOH workforce projections and gaps (based on proposed establishment, 2008)

Cadre	No. required MOH staff based on proposed establishment	No. in post (MOH)	2012 staffing gap MOH - Allowing 3% annual attrition (without additional recruitment)	4-year pre-service output	Achievable additional recruitment targets *	Projected in-post 2012	Projected 2012 gaps after additional recruitment
Medical officers	3,862	1,715	2,344	940	658	2,176	1,686
Nurses	25,166	14,958	11,924	10612	7,428	20,671	4,495
Clinical officers	5,779	2,116	3,906	2300	1,610	3,483	2,296
Community oral health officer	477	83	404	144	101	174	303
Laboratory technician	1,289	918	476		-	813	476
Laboratory technologist	4,424	735	3,773	800	560	1,211	3,213
Pharm. technologist	736	211	549	492	344	531	205
Dentists	830	216	639	144	101	292	538
Dental technologist	683	110	586	112	78	176	507
Pharmacist	848	411	484	256	179	543	305
Radiographer	686	248	466	148	104	323	363
Physiotherapist	1,213	453	812	208	146	547	666
Occupational therapist	574	265	339	168	118	352	222
Orthopaedic technologist	285	169	135	120	84	234	51
Total	46,852	22,608	26,837	16,444	11,511	31,525	15,326

* Assumes MOH can employ a maximum of 70% of medical graduates.
Source: Revised MOH Establishment, 2008; IPPD data, June 2008; KMTC data; MOH training data.

Table 4.6: KNH and MTRH workforce projections and gaps

Cadre	Kenyatta National Hospital (KNH)			Moi Teaching & Referral Hospital			Total number of vacant positions
	Required	Available	%Vacancies	Required	Available	%Vacancies	
Medical officers	312	231	26	92	51	45	122
Dentists	49	30	39	6	5	17	20
Pharmacists	18	10	44	4	4	-	8
Nurses	1,948	1,725	11	916	664	28	475
Clinical officers	134	63	53	78	65	17	84
Lab techs	163	144	3	153	133	13	39
Pharm technologists	56	42	25	35	37	13	34
Radiographers	43	28	35	30	30	-	15
Nutrition officers	60	57	5	59	42	29	20
Physiotherapists	86	67	22	65	34	48	50
Occupational therapist	53	41	23	62	13	79	61
Medical records officers	137	81	9	56	45	20	67
Public health officers / techs	35	23	20	29	25	14	16
Others	3,119	2,413	23	1,326	1,201	9	831
Total	6,213	4,955	20	2,911	2,349	19	1,842

Source: KNH and MTRH strategic plans.

4.4.1 Lack of Data on the Private Sector

There is a dearth of information on both the workforce requirements and the number of positions in the private sector especially in the for-profit subsector. This is a significant gap in that the subsector is quite large: it is estimated to employ 50–60% of professional health workers. The current staffing norms (2006) and the recently revised and yet to be approved norms appear to be based more on public sector requirements. These information deficiencies make it difficult to undertake sector-wide planning.

4.4.2 Vacancy Levels and MOH Recruitment Targets

The current vacancy levels of MOH, KNH and MTRH stand at 29%, 20% and 19%, respectively. Kenya also needs to increase its coverage of nurses and medical officers by 50% to reach the WHO minimum targets for the achievement of MDGs. The implication here is that MOH should aim at increasing its workforce by 30–50% in the next four years. After factoring in attrition, this adds up to between 14,000 and 21,000 more staff, of whom 12,000–17,500 should be professional health workers.

4.4.3 Training Output as a Bottleneck to Filling Vacancies

Assuming that MOH is able to recruit 70% of the total output from local training colleges, they would be able to fill approximately 12,000 positions by 2012. Recruitment rates above 12,000 positions would lead to sectoral distortions with a reduction in MOH vacancies being matched by an increase in vacancies in

the other subsectors. This means that for MOH to address its pressing staff shortages in a sustainable manner, there is need for the training output to be increased significantly, especially for cadres such as dental technologists, dentists and medical officers, whose output relative to MOH vacancies is very low. Table 4.7 compares the training output of key health cadres relative to envisaged MOH staffing gaps based on the recently revised (but yet to be approved) establishment. It is clear from the table that the output from pre-service training institutions will remain a major bottleneck to reducing the vacancy levels in the health sector.

Table 4.7: Training output vs staffing gaps

Cadre	2012 staffing gap MOH (allowing 3% annual attrition without additional recruitment)*	4-year pre-service training output	4-year training output vs 2012 gap (%)
Dental technologists	586	112	19
Lab technologists	3,773	800	21
Dentists	639	144	23
Physiotherapists	812	208	26
Radiographers	466	148	32
Community oral health officers	404	144	36
Medical officers	2,344	940	40
Occupational therapists	339	168	50
Pharmacists	484	256	53
Clinical officers	3,906	2,300	59
Ortho. technologists	135	120	89
Nurses	11,924	10,612	89
Pharm. techs	549	492	90
Total	27,141	16,444	61

* Based on proposed MOH establishment

4.4.4 *Dual Employment*

The practice of dual employment is quite prevalent among health workers. This involves people actually holding two full-time positions, as well as the more common scenario where people work part-time (evenings, weekends and during leave, etc.) with other employers or in self-employment. The projections done here do not capture this practice, which although difficult to quantify does mitigate against health worker shortages but in certain cases is associated with other undesirable outcomes.

4.5 Health Worker Recruitment Targets: 2009–2012

Several key assumptions informed the calculation of four-year targets based on the workforce projections detailed above (see Table 4.8). The assumptions include:

- That the two ministries of health have the funding to recruit the additional staff.
- That MOH will not employ staff from the other subsectors.
- That the FBO/NGO and for-profit private sector will mobilize resources to recruit additional staff for their subsectors.
- That the ministries of health will absorb 70% of the training output from pre-service institutions. Another 25% will be absorbed by KNH/MTRH/FBO/NGO/for-profit subsectors, While 5% of the output is accounted for by losses due to out-migration, employment outside the health sector etc.

Table 4.8: Proposed four-year recruitment targets

Cadre	Number to be recruited by MOH	Number to be recruited by KNH/MTRH/FBO/NGO/for-profit subsectors	Total staff recruited
Medical officers	658	235	893
Nurses	7,428	2,653	10,081
Clinical officers	1,610	575	2,185
Community oral health officers	101	36	137
Laboratory technicians	-		
Laboratory technologists	560	200	760
Pharm. Technologists	344	123	467
Dentists	101	36	137
Dental technologists	78	28	106
Pharmacists	179	64	243
Radiographers	104	37	141
Physiotherapists	146	52	198
Occupational therapists	118	42	160
Orthopaedic technologists	84	30	114
Subtotal	11,511	4,111	15,622
Other health professionals and support staff	6236	2,227	8,463
Grand total	17,747	6,338	24,085

There will still be significant staff shortages even if the sector recruits all the projected staff. For the two ministries of health there will still be 25,000 vacant positions in 2012 after achieving the proposed targets. Nevertheless, the recruitment should yield a huge improvement in health service delivery, especially if other changes proposed here are implemented, such as improved in-service training, better health workforce management and improved retention.

5. Strategic Direction

Guiding this strategic direction is the HRH action framework shown in Figure 5.1. This is a framework that advocates for a comprehensive approach to national HRH planning and implementation. The framework addresses key HRH components: policy, finance, education, partnerships, leadership and HRH management systems. These components in turn informed the projected outcomes proposed by this strategic plan.

The HRH strategic plan is also specifically guided by the overall mission of the health sector which is:

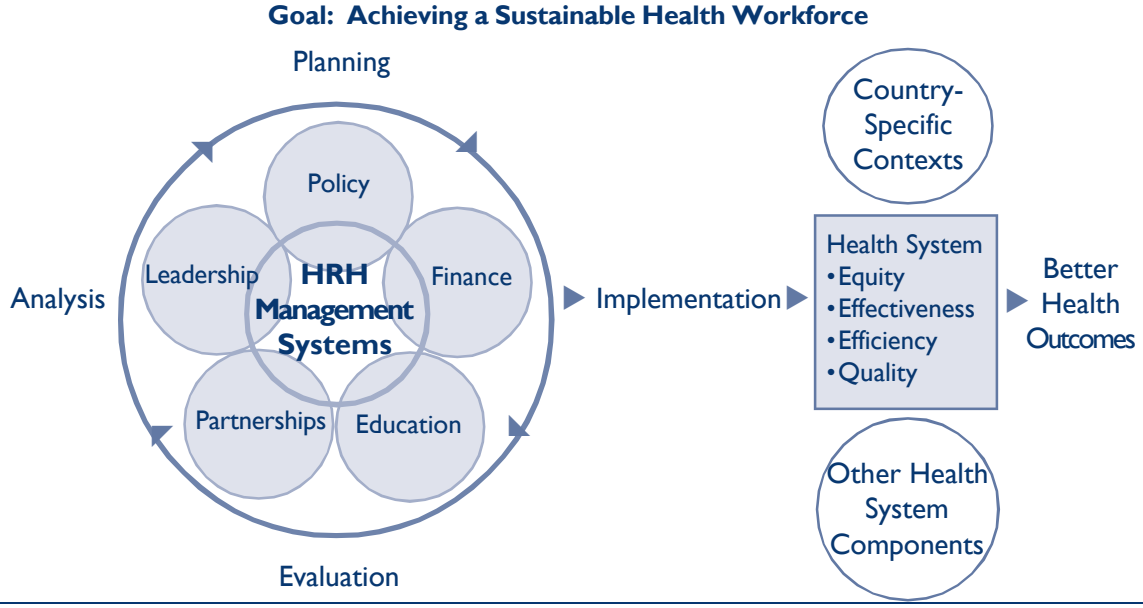
> To promote and provide quality curative, preventive, promotive, and rehabilitative health care services to all Kenyans.
>
> *– MOH, 1999*

In order to contribute to the goals of this strategic plan, strategic objectives and strategies are formulated around the following five projected outcomes:

1. Appropriate numbers and types of health workers in post and equitably distributed.
2. Retention of health workers improved at all levels.
3. Improved institutional and health worker performance.
4. Strengthened human resources development systems and practices.
5. Strengthened human resources planning and management at all levels.

It is envisaged that a detailed operational plan including annual HRH plans will be developed to support the implementation of this strategic plan. The operational plan and annual HRH plans will spell out

Figure 5.1: HRH action framework



Source: WHO/Capacity Project.

the detailed activities that will be carried out to achieve the goals of this plan.

5.1 Outcome 1: Appropriate Numbers and Types of Health Workers in Post and Equitably Distributed

Easily the two biggest HRH challenges facing the health sector are the acute shortage of health staff and the inequitable distribution of the staff that are there. Three strategic objectives and strategies are proposed to address these challenges.

5.1.1 Strategic Objective 1.1: Strengthen Recruitment and Deployment Processes to Address Shortages at All Levels, Especially at the Community Level and Hard-to-Each Areas

Recruitment and deployment bottlenecks have constrained the capacity of the health sector to efficiently recruit and deploy health workers. This strategic objective will be implemented by:

- Reviewing and implementing establishment and staffing norms.
- Reviewing existing recruitment policies and procedures/guidelines and disseminating to all relevant ministries.
- Developing and implementing a deployment policy.
- Regulating the construction of new health facilities.

5.1.2 Strategic Objective 1.2: Scale up Health Workforce Recruitment and Re-Deployment to Improve Equity

It will be important to rapidly scale up the recruitment and deployment of health workers so as to reverse the recent shrinking of the health workforce especially in the public and FBO subsectors. Key strategies to be used include:

- For the health ministries, recruiting additional health workforce in line with identified gaps at all levels.
- Redeploying staff to regions with acute shortages.
- Lobbying development partners to support recruitment and deployment of additional health staff.
- Disaggregating the establishment to district level based on staffing norms.
- Within MOH, developing a mechanism for deployment of staff to faith-based health services.

This strategic plan adopts gender responsive approaches to ensure gender equity in the training, deployment, development and management of the health workforce.

5.1.3 Strategic Objective 1.3: Identify and Train Level 1 Health Workers Required to Implement the Community Strategy

Rolling out the Community Strategy nationwide will be critical in ensuring that a significant proportion of basic preventive and curative services are provided at the community level and empowering communities to take an active part in their own health care. The strategy also aims to ensure that community members are aware of health services they will need to seek at the higher levels of care if necessary. The following strategies are proposed to support this strategic objective:

- Identifying community health workers and training them on the implementation of the Community Strategy.
- Recruiting and deploying CHEWs and training them on the implementation of the Community Strategy.
- Establishing working stations for CHEWs at level 1.
- Developing a retention strategy for community health workers.

5.2 Outcome 2: Attraction and Retention of Health Workers Improved at All Levels

Serious challenges confront health worker retention especially in hard-to-reach regions of the country. As a result of this, the total number of heath workers employed especially by the public and FBO subsectors has declined in the last few years even as demand for services has risen driven by a rising population and increasing disease burden.

To improve health worker retention this plan intends to take steps to make health sector jobs more attractive.

5.2.1 Strategic Objective 2.1: Make Health Sector Jobs More Attractive to Improve Staffing Levels and Reduce Turnover

The following strategies are proposed to improve staffing levels and reduce staff turnover in the health sector:

- Conducting periodic review of compensation packages commensurate with qualification, experience and responsibility.
- Lobbying for improved staff welfare and amenities including housing and recreation facilities in all areas including hard-to-reach areas.
- Improving work climate in all health facilities (e.g., worker wellness, safety, recreation, etc.)
- Exploring options for retention schemes targeting different cadres based on unique needs.
- Regularly reviewing and disseminating all schemes of service in the health sector.

5.2.2 Strategic Objective 2.2: Make Hard-to-Reach Stations More Attractive

The following strategy will be used to make hard-to-reach stations more attractive and improve retention.

- Developing and implementing a retention package for hard-to-reach regions.

5.3 Outcome 3: Improved Institutional and Health Worker Performance

Numerous human resources assessments have shown that whereas staff shortages remain a major bottleneck to the delivery of health services in respect to quality and coverage, issues of institutional and health worker performance are almost of equal importance. The following strategic objectives and strategies aim at addressing institutional and health worker performance:

5.3.1 Strategic Objective 3.1: Improve Leadership and Management at All Levels to Improve Institutional and Health Worker Performance

Leadership and management have been identified as the missing piece in efforts to improve health service delivery. Leadership and management are critical to the design, development and implementation of health systems and programmes and also to the management of the critical human resources for optimal performance. The health sector currently lacks a systematic approach to leadership development. The following strategies are proposed to improve leadership and management:

- Revising and developing leadership and management competencies for key management posts.
- Making key leadership and management positions at all levels substantive.
- Enhancing leadership and management capacity at all levels.
- Improving supportive supervision systems, including mentoring, counselling and coaching, behaviour change programmes, etc.
- Including practical, action-based leadership and management approaches in the pre-service curriculum.

> The Community Strategy aims to make a significant proportion of basic preventive and curative services available at the community level and to empower communities to take an active part in their own health care.

5.3.2 Strategic Objective 3.2: Institute a Results-Based Management System to Improve Institutional and Health Worker Performance at All Levels

The following strategies will be implemented to achieve this strategic objective:

- Strengthening the sanctions and reward system to support performance.
- Strengthening performance contracting through training and other mechanisms.
- Strengthening negotiation and conflict management skills.
- Institutionalizing team work approaches.
- Establishing effective systems for managing staff absence.

5.3.3 Strategic Objective 3.3: Improve Health Worker Safety, Health and Wellness to Improve Staff Welfare and Productivity

It is imperative that health staff work in a healthy and safe environment. They require appropriate education and protective equipment to protect them from work related health hazards. It is also important that health workers are given support to enable them to cope with any work-related stress. Health, safety and wellness programmes are thus critical for enhancing health worker performance and minimizing attrition related to morbidity and mortality from preventable illnesses, occupational or otherwise, including HIV/AIDS. The following strategies are proposed to achieve this strategic objective:

- Providing psycho-social support to health workers in need.
- Ensuring health staff work in a safe and healthy environment in line with the laws of Kenya.

The HR directorates of MOMS and MOPHS will play a crucial role in the implementation of this strategic plan and will be represented in the HRH Leadership Group.

5.4 Outcome 4: Strengthened Human Resources Development Systems and Practices

To strengthen HRH development systems and practices, we propose the strategic objectives and strategies detailed below.

5.4.1 Strategic Objective 4.1: Establish Supportive Policy Frameworks to Manage and Monitor Health Workforce Development

The following strategies are expected to achieve this strategic objective:

- Finalizing, disseminating and implementing the national health training policy.
- Developing and implementing a succession planning policy.
- Developing clear career progressions to support and harmonize staff development in line with service needs.
- Advocating for the introduction of a levy to support health workforce development.

5.4.2 Strategic Objective 4.2: Increase the Capacity and Output of Pre-Service Institutions for Key Cadres

Proposed strategies include:

- Undertaking a comprehensive survey of training institutions including determining their capacity and output.
- Developing and adhering to clear entry requirements for all cadres.
- Developing and implementing a comprehensive plan of scaling up output.

5.4.3 Strategic Objective 4.3: Institutionalize Competence-Based Training Programmes to Increase Volume, Quality and Skill Mix of Health Workforce

Here the following strategies are proposed:

- Developing a HRD plan for pre-service and in-service training that is responsive to the needs of the health sector and allows progression from certificate to diploma to degree.
- Improving in-service training and continuing professional development systems and practices to better meet health sector needs.
- Developing incentives to motivate and retain key staff in training institutions.
- Standardizing and controlling institutional accreditation.
- Ensuring curriculum review and development is done regularly in line with international standards and local needs.
- Developing deployment guidelines for lecturers and tutors.

5.5 Outcome 5: Strengthened Human Resources Planning and Management at All Levels

Human resources planning and management have been identified as major weaknesses in the entire health sector. The situation has been particularly grim in the public and FBO subsectors where HRM systems and practices have stagnated following years of under-investment and a serious shortage of skilled HR practitioners. The few professional HR staff are deployed at the central level and in the referral hospitals. The HR function at regional and facility level is carried out by health administrators and clerical staff, many of whom have additional duties to perform.

Strategic objectives and strategies proposed to enhance HR planning and management especially in the public sector range from strengthening the systems and practices to improving the HRIS and building partnerships.

5.5.1 Strategic Objective 5.1: Strengthen and Decentralize HR Planning and Management

The following strategies are proposed to strengthen HR planning and management systems and capacity:

- Establishing a regular HR planning and review cycle to support regular analysis of staffing data and changing service needs.
- Reviewing and implementing changes to HR structures in light of restructuring and ongoing decentralization.
- Putting in place mechanisms for implementing decentralization of the HR function including development of structures and reporting lines.

- Recruiting additional HR staff for the decentralized system.
- Developing a comprehensive HRH review covering workforce requirements, the labour market and pre-service training.
- Establishing an annual reporting mechanism on HR data and trends in key areas for the entire sector and evaluating progress on the implementation of this HRH strategic plan and other HR initiatives.

5.5.2 Strategic Objective 5.2: Strengthen HR Systems and Practices

This strategic objective will be sccomplished through the following strategies:

- Building the capacity of all HR staff.
- Advocating for the review of job descriptions after every two years or as per service need.
- Advocating for the review of the HR manual to be in line with best practice.
- Introducing an orientation programme.

5.5.3 Strategic Objective 5.3: Strengthen the Human Resources Information System (HRIS)

The following strategy is proposed:

- Developing and implementing an integrated, sector-wide HRIS.

5.5.4 Strategic Objective 5.4: Strengthen Collaboration and Partnership across the Sector

The following strategies are proposed to strengthen collaboration:

- Reviewing current practices and exploring options for strengthening collaboration among stakeholders (e.g., harmonizing structures, systems and resources).

Strategies for enhancing HR planning and management especially in the public sector range from strengthening the systems and practices to improving the HRIS and building partnerships.

- Establishing a high level, multi stakeholder HR steering committee to coordinate and monitor the implementation of this HRH Strategic Plan.

5.5.5 Strategic Objective 5.5: Institute Task Shifting at All Levels

Given the high level of staff shortages, it is important that task shifting be introduced to ensure optimal use of existing staff so as to increase access to health services at all levels. The following strategies will be implemented to support task shifting:

- Developing appropriate task shifting policies and guidelines.
- Providing appropriate training to support task shifting.
- Deploying level I staff, reviewing and aligning with evolving strategy.
- Ensuring recognition and compensation of task shifting by reviewing/developing the schemes of service.

5.6 Results Framework

In this section a series of tables presents the objectives, strategies, indicators and targets proposed for achieving the five intended outcomes of this strategic plan. The tables also include a preliminary timeline.

5.6.1 Outcome 1: Appropriate Numbers and Types of Health Workers in Post and Equitably Distributed

Strategic objective	Strategy	Indicator	Target	Timeline		
				09/10	10/11	11/12
1.1 Strengthen recruitment and deployment processes (to address shortages at all levels, especially at the community and hard-to-reach areas)	Reviewing and implementing establishment and staffing norms	No of establishment and staffing norms guidelines distributed	Print copies of reviewed staffing norms guidelines for all health facilities/ health managers	X	X	
	Reviewing existing recruitment policies and procedures/ guidelines and disseminate to all relevant ministries	Recruitment policy documents	Develop a recruitment policy and guidelines by end of 2010	X	X	
	Developing and implementing a deployment policy	Deployment policy	Develop a deployment policy and guidelines by end of 2010	X	X	
	Regulating the construction of new facilities	Policy on new health facilities	Have regulation in place by end of 2010	X	X	

Continued

5.6.1 Outcome 1, continued

Strategic objective	Strategy	Indicator	Target	Timeline		
				09/10	10/11	11/12
1.2 Scale up health worker recruitment and redeployment to improve equity	Recruiting additional MOH health workforce in line with identified gaps at all levels	No of additional health workers recruited	MOH to recruit 18,000 staff Other subsectors to recruit an additional 6,000 staff	X	X	X
	Redeploying staff to regions with acute shortages	Number of staff redeployed	Develop a re-deployment plan by June 2010	X	X	X
	Lobbying development partners to support recruitment and deployment of additional health staff	No of contract staff recruited	Number of contract staff doubled from the current levels	X	X	X
	Disaggregating the establishment to district level based on staffing norms	Approved disaggregated establishment and staffing norms guidelines	Proposed disaggregated establishment and staffing norms approved by June 2010	X	X	
	For MOH, developing a mechanism for deployment of staff to faith-based health services	Secondment guidelines	Develop appropriate guidelines by June 2011	X	X	X
1.3: Identify and train level 1 health workers required to implement the Community Strategy	Identifying community health workers and train them on the implementation of the Community Strategy	No of CORPs trained	As per targets set in the community strategy	X	X	X
	Recruiting and deploy CHEW and training them on the implementation of the Community Strategy	No of CHEWs deployed and trained	As per targets set in the community strategy	X	X	X
	Establishing working stations for CHEWs at level 1	No of stations established at level 1	As per targets set in the community strategy	X	X	X
	Developing a retention strategy for community health workers	Strategy document	Strategy in place by end of 2011	X	X	X

5.6.2 Outcome 2: Attraction and Retention of Health Workers Improved at All Levels

Strategic objective	Strategy	Indicator	Target	Timeline		
				09/10	10/11	11/12
2.1 Make health sector jobs more attractive to improve staffing levels and reduce turnover	Conducting periodic review of compensation packages in-line with qualification, experience and responsibility	No of salary reviews % salary increase for key cadres	Have in place higher salaries for key cadres by end of 2010	X	X	X
	Lobbying for improved staff welfare and amenities including housing and recreation facilities in all areas including hard-to-reach areas	No of additional staff housing units and recreation facilities constructed	Development plan in place by end of 2010	X	X	
	Improving work climate in all health facilities (e.g., worker wellness, safety, recreation, etc.)	Health worker satisfaction levels Number of initiative to improve work climate	60% of all health facilities have a programme to improve work climate by 2012	X	X	X
	Exploring options for retention schemes targeting different cadres based on unique needs	Approved retention policy % reduction in attrition levels	Develop a retention policy addressing key health cadres by end of 2010	X	X	
	Regularly reviewing and disseminating all schemes of service in the health sector	No of revised schemes of service	Develop a plan for reviewing all scheme of service by mid-2010	X	X	

Continued

5.6.1 Outcome 2, continued

Strategic objective	Strategy	Indicator	Target	Timeline		
				09/10	10/11	11/12
2.2 Make hard-to-reach stations more attractive	Developing and implementing a retention package for hard-to reach regions	Approved retention package for hard-to-reach areas % reduction in attrition levels in hard-to-reach areas	Develop a retention package for hard-to-reach areas by end of 2010	X	X	

5.6.3 Outcome 3: Improved Institutional and Health Worker Performance

Strategic objective	Strategy	Indicator	Target	Timeline		
				09/10	10/11	11/12
3.1 Improve leadership and management at all levels for improved institutional and health worker performance	Revising and developing leadership and management competencies for key management posts	No of senior level jobs specifying leadership and management qualifications and competencies	All job profiles for health managers include leadership an management competencies by end of year 2	X	X	
	Making key leadership and management positions at all levels substantive	No of substantive leadership positions	Define and establish key leadership positions by June 2010	X	X	
	Enhancing leadership and management capacity at all levels	Number of department heads trained in leadership and management	All departmental heads trained in leadership and management by end of year 4	X	X	X
	Improving supportive supervision systems including mentoring, counselling and coaching, behaviour change programmes	No of supervision tools No of managers trained in supportive supervision	50% of managers trained in supportive supervision by end of year 2	X	X	X
	Including practical, action-based leadership and management approaches into pre-service curriculum	No of curricula revised	Management and leadership built into the curriculum for training all key health cadres – medical officers, nurses and clinical by 2011	X	X	X
3.2 Institute a results based management system to improve Institutional and health worker performance at all levels	Strengthening the sanctions and reward system to support performance	% of all health workers who undergo performance appraisal annually	All health workers undergo annual performance appraisal by 2011	X	X	X
		% of MOH staff with performance contracts Performance monitoring tools developed	Plan to strengthen performance management system for health workers in place by June 2010	X	X	X
		No of health facilities and programmes that have held team building activities No of staff meetings and team building sessions	-50% of health facilities and programmes hold a team building activity annually by 2012	X	X	X
	Strengthening the performance management system through training and other mechanisms	No of managers trained in negotiation and conflict management	Training carried out by June 2011	X	X	X
	Institutionalizing team work approaches	Number of health facilities and programs that have held team building activities -No of staff meetings	50% of health facilities and programs hold a team building activity annually by 2012	X	X	X
	Strengthening negotiation and conflict management skills	Number of managers trained in negotiation and conflict management	Training carried out by June 2011	X	X	X

Continued

5.6.1 Outcome 3, continued

Strategic objective	Strategy	Indicator	Target	Timeline		
				09/10	10/11	11/12
3.2 Institute a results based management, continued	Establishing effective systems for managing staff absence	System to track absenteeism Level of absenteeism	Have in place a system for tracking absenteeism at regional and national level by end of 2010	X	X	
3.3 Improve health worker safety, health and wellness	Ensuring health staff work in a safe and healthy environment in line with the laws of Kenya	% of health facilities with functional health and safety committees % of health staff that have received safety training % of staff that have gone through HIV/AIDS awareness training % of staff that have received health and safety handbooks and guidelines Number of integrated wellness programmes developed	All health staff have received safety and HIV/AIDS awareness training and handbooks by end of 2011	X	X	X
	Providing psycho-social support to health workers in need	No of health facilities that provide psycho-social support to health workers in need	50% of all hospitals have trained professionals to provide psycho-social support to staff in need by end of 2012	X	X	X

5.6.4 Outcome 4: Strengthened Human Resources Development Systems and Practices

Strategic objective	Strategy	Indicator	Target	Timeline		
				09/10	10/11	11/12
4.1 Establish supportive policy frameworks to manage and monitor health workforce development	Finalizing, disseminating and implementing the national health training policy	National health training policy	Have a national training policy in place and launched to key stakeholders by end of 2009	X		
	Develop and implement a succession planning policy	Succession planning policy Number of MOH positions	Have a succession policy in place and key managers oriented on its use by end of 2010	X	X	
	Developing career progression support and harmonizing development in line with service needs	No of revised schemes of service	Revise schemes of service for all key health cadres by end of 2012	X	X	X
	Advocating for the introduction of a levy to support health workforce development	No of advocacy meetings Cabinet paper	Have in place a cabinet paper by June 2010	X	X	
4.2: Increase the capacity and output of pre-service institutions for key cadres	Undertaking a comprehensive survey of training institutions including determining their capacity and output	Survey report	Complete the comprehensive survey by June 2010	X	X	
	Developing and adhering to clear entry requirement for all cadres	Guideline on entry requirements	Develop guidelines on entry requirements by June 2011	X	X	X
	Developing a comprehensive plan of scaling-up output	Pre-service training plan	Have in place a plan for scaling up pre-service training output by December 2010	X	X	

Continued

5.6.1 Outcome 4, continued

Strategic objective	Strategy	Indicator	Target	Timeline		
				09/10	10/11	11/12
4.3 Institutionalize competence based training programmes to increase volume, quality and skill mix of health workforce	Developing a HRD plan for pre-service and in-service that is responsive to the needs of the health sector and allows progression from certificate, diploma, degree	HRD Plan	Develop and launch a comprehensive HRD plan by end of 2010	X	X	
	Improving quality and coverage of in-service training (IST) and continuing professional development (CPD) systems and practices to better meet health sector needs	% of professional health cadres that have undergone IST/CPD Annually	60% of health staff that have undergone IST/CPD Annually	X	X	X
	Standardizing and controlling institutional accreditation	No of certified courses	Have certified in-service competencies/courses of all key professional cadres by end of 2011	X	X	X
	Developing incentives to motivate and retain key staff in training institutions	Documented retention package	Develop a strategy to motivate and retain key staff by June 2011	X	X	X
	Ensuring curriculum review and development are done regularly in line with international standards and local needs	No of curricula reviewed	Have a curriculum review plan by June 2010	X	X	X
	Developing deployment guidelines for lecturers and tutors	Deployment guidelines	Develop deployment guidelines by June 2010	X	X	

5.6.5 Outcome 5: Strengthened Human Resources Planning and Management at All Levels

Strategic objective	Strategy	Indicator	Target	Timeline		
				09/10	10/11	11/12
5.1 Strengthen and decentralize HR planning and management	Establishing a regular HR planning and review cycle to support regular analysis of staffing data and changing service needs	No of sector-wide HRH planning meetings	Hold two or more sector wide HR meetings annually	X	X	X
	Reviewing and implementing changes of HR structures in light of restructuring and ongoing decentralization	No of decentralize HR units	Have decentralized HR structures in place by June 2010	X	X	X
	Putting in place mechanisms for implementing decentralization of the HR function including development of structures and reporting lines	No of HR staff at district, provincial and facility level	Have HR staff to support all districts, provinces and level 5 hospitals by end of 2010	X	X	
	Recruiting additional HR staff for the decentralized system	No of addition HR staff recruited	Recruit additional HR staff for all provincial and district levels and level 4 and 5 hospitals by June 2011	X	X	X

Continued

5.6.1 Outcome 5, continued

Strategic objective	Strategy	Indicator	Target	Timeline		
				09/10	10/11	11/12
5.1 Strengthen and decentralize HR planning and management, continued	Developing a comprehensive HRH review covering, workforce requirements, the labour market and pre-service training	No of survey reports	Undertake comprehensive survey by mid-2010	X	X	
	Establishing an annual reporting mechanism on HR data and trends on key areas for the entire sector and to evaluating progress on the implementation on HRH strategic plan and other HR initiatives	No of annual HR reports	Issue first report for 2009 by early 2010		X	X
5.2 Strengthen HR systems and practices	Building the capacity of all HR staff	No of HR staff trained/re-oriented	Provide training for all HRH staff by end 2011	X	X	X
	Advocating for the review of the HR manual in-line with best practice	No of HR manuals printed Number of staff with the popular version of the HR manual	Ensure all staff have a copy of the popular version of the HR manual by June 2011	X	X	X
	Advocating for the review of job descriptions after every two years or as per service needs	No of staff with current job descriptions	Ensure all staff have job descriptions by end of 2010	X	X	
	Introducing an orientation programme	Nor of staff going through a standardized orientation programme	Introduce an orientation package by end of 2010	X	X	
5.3: Strengthen the human resources information system (HRIS)	Developing and implementing an integrated, sector wide HRIS	% of the total health workforce covered by the integrated HRIS	Have in place an integrated sector-wide HRIS by end of 2011	X	X	X
5.4: Strengthen collaboration and partnership across the sector	Reviewing current practices and explore options for strengthening collaboration among stakeholders (e.g. harmonizing structures, systems and resources)	Study report	Undertake a comprehensive study on sector-wide HRH collaboration by June 2010	X	X	
	Establishing high level multi stakeholder HR steering committee to coordinate and monitor implementation of this HRH Strategic Plan	No of members of the committee No of meetings	Have in place a HR Steering committee made up of all key HRH stakeholders by Dec 2009	X		
5.5 Institute task shifting at all levels	Developing appropriate task shifting policies and guidelines	No of policies and guidelines developed	Task shifting policies and guidelines developed and rolled out by June 2010	X	X	
	Providing appropriate training to support task shifting	No of people trained	Training carried out in line with the task-shifting strategy	X	X	X
	Deploying level 1 staff, review and alignment with evolving strategy	No of reviews conducted	Review deployment and performance of level 1 cadres by December 2011	X	X	X
	Ensuring recognition and compensation of task shifting by reviewing & developing the schemes of service	No of schemes of service reviewed after instituting task shifting	Review of implications of task shifting that need to have schemes of service reviewed done by June 2010	X	X	

6. Implementation Plan

Oversight for the implementation of this strategic plan will be provided by the multi-sector HRH Leadership Group. The HR directorates of MOMS and MOPHS will also play a crucial role in the implementation and will also be represented in the HRH Leadership Group. The following are expected to be represented in the HRH Leadership Group:

- HR Directorates of MOMS and MOPHS
- Relevant technical divisions and departments of MOMS and MOPHS
- Provincial and district level representatives of the two ministries
- DPM
- PSC
- CHAK
- KEC
- Nairobi City Council – Health Department
- Nursing Council
- Medical Practitioners and Dentists Board
- KMTC and other training institutions
- KNH
- MTRH
- Relevant NGOs
- Representative of the private for-profit health subsector
- Relevant development partners
- Others to be identified

The HR directorates of MOMS and MOPHS will play a crucial role in the implementation of this strategic plan and will be represented in the HRH Leadership Group.

Implementation of this HRH strategic plan will be guided by:

- The results framework section of this plan that proposes strategies and timelines.
- Annual HRH plans and budgets.

Clear terms of reference will be developed to guide the work of the HRH Leadership Group. It is expected that for the public sector, the relevant HRH plans will be integrated in the annual operational plans of the two ministries.

7. Monitoring and Evaluation Plan

Given the importance and urgency of many of the interventions proposed in this plan, it is important that a robust monitoring and evaluation system be put in place to track performance and identify areas where corrective action will be required. The HRH Leadership Group will have an oversight role in the monitoring and evaluation of this action plan. The operational responsibility for M&E will fall under the technical HR departments at national and regional levels. These will include:

- MOMS and MOPHS HR Directorates
- Provincial and district HR departments of the two ministries
- CHAK and KEC secretariat
- Training Institutions
- Private sector health networks
- Regulatory authorities

M&E will be guided by the targets and indicators given in the results framework of this report and also those that will be developed in the annual HRH plans. As far as possible, M&E data collection should be integrated within the envisaged comprehensive HRIS. It is also important that M&E findings be disseminated to key HRH stakeholders. The proposed HRH annual plan should be one channel for disseminating M&E findings including best practice. The monitoring and evaluation of this plan will also be linked with the established health sector monitoring and evaluation mechanisms.

In addition, this strategic plan should be subjected to a midterm review in early 2011 and an end of term review in 2013.

8. Year 1 Workplan and Budgets

A detailed Year 1 workplan and budget has been developed based on strategic objectives and strategies formulated. Projections are made for years 2–3.

The tables in the following sections present the strategies and their estimated costs by the five anticipated outcomes of the plan.

The implementation of this strategic plan is estimated to cost approximately Ksh32 billion over the life of the plan. This will, among other things, enable the recruitment and deployment of 24,000 new staff so as to increase access and enhance service quality. It will also upgrade training and improve working conditions.

8.1 Outcome 1: Appropriate Numbers and Types of Health Workers in Post and Equitably Distributed

8.1.1 Strategic Objective 1.1: Strengthen Recruitment and Deployment Processes (to Address Shortages at All Levels Especially Community Level)

Strategy	2009/10 activities**	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY2011/12
1.1.1 Review establishment and implement the staffing norms.	Review staffing norms and assess implications for existing establishment	PSs MOH, MSPS/DHRM/ HRM&D Task Forces	1,000	-	-
	Prepare proposals for new establishment/structure (training, role changes, redeployment, etc)		1,000	-	-
	Communicate new establishment to key stakeholders		100	-	-
	Monitor impact of new establishment, e.g., recruitment, deployment, distribution, skills mix etc		250	250	250
	Subtotal		*2,350*	*250*	*250*
1.1.2 Review existing recruitment policies and procedures/guidelines	Review all relevant documents, e.g., existing policies and document good practices	PSC/PSs MOH, MSPS/DHRM HRM&D Task Forces	1,000	-	-
	Prepare proposals and recommendations for submission to relevant authorities - DPM, PSC		500	-	-
	Subtotal		*1,500*	-	-

Continued

Strategic objective 1.1, continued

1.1.3 Develop and implement a deployment policy to guide the deployment processes for all health workers	Review current deployment processes (tracking study) and impact	PSs MOH, MSPS/DHRM HRM&D Task Forces	100	-	-
	Carry out research on best practice and document recommended practices		100	-	-
	Convene stakeholder seminar for consensus and adoption		700	-	-
	Subtotal		*900*	-	-
1.1.4 Regulating the construction of new facilities	Develop guidelines to help regulate construction of new facilities	PSC/PSs MOH, MSPS/DMS/DPHS/ DHRM/HRM&D Task Forces	250		
	Subtotal		***250***		

8.1.2 Strategic Objective 1.2: Scale up Health Worker Recruitment and Re-Deployment to Improve Equity

Strategy	**2009/10 activities****	**Responsible person**	**Budget projections (Ksh 000)**		
			FY 2009/10	**FY 2010/11**	**FY2011/12**
1.2.1 Recruit additional public sector health workforce in line with identified gaps at all levels	Advertise for, recruit and deploy approximately 24,000 health staff: Year 1, 4,000; year 2, 8,000; Year 3, 12,000	PSC/PSs MOH, MSPS/DMS/DPHS/D HRM/HRM&D Task Forces	1,440,000	4,348,800	8,755,776
	Subtotal		***1,440,000***	***4,348,800***	***8,755,776***
1.2.2 Re-deploy staff to regions with acute shortages	Preparation of a staff distribution analysis report	PSs MOH, DHRM/HRM&D Task Forces	100	100	100
	Preparation and implementation of staff redeployment schedule		60,000	30,000	30,000
	Subtotal		***60,100***	***30,100***	***30,100***
1.2.3 Lobby development partners to support recruitment and deployment of additional health staff	Establish an officer to monitor and manage donor support activities	PSC/PSs MOH, MSPS/DMS/DPHS/D HRM/HRM&D Task Forces	1,100	700	750
	Prepare a comprehensive report on donor support activities and proposed programme interventions		100	100	100
	Hold stakeholders/donor support review workshops		2,000	2,000	2,000
	Subtotal		***3,200***	***2,800***	***2,850***
1.2.4 Disaggregate the establishment to district level based on staffing norms	Categorize facilities on the basis of work load and service delivery standards	PSs MOH, MSPS/DHRM/HRM&D Task Forces	100		
	Develop and implement facility establishment proposals		100		
	Subtotal		***200***		
1.2.5 Develop a mechanism for deployment of staff to faith-based health services	Establish an office handle, set guidelines/procedures; monitor staff deployment to FBOs	PSs MOH,/DMS/DPHS/D HRM	300		
	Subtotal		***300***	***-***	***-***

8.1.3 Strategic Objective 1.3: Identify and Train Level 1 Health Workers Required to Implement the Community Strategy

Strategy	**2009/10 activities**	**Responsible person**	**Budget projections (Ksh 000)**		
			FY 2009/10	**FY 2010/11**	**FY2011/12**
1.3.1 Identify community health workers and train them on the implementation of the community strategy	Develop and disseminate guidelines to provincial, district Public Health officers and community leaders on selection criteria for Corps	PS MOPHS,DPHS/ DHRM/DMOH/HR M&D Task Forces	1,000		
	Compile a comprehensive list of all identified CORPs		100		
	Develop training curriculum and training materials for orientation and induction of CORPS		3,400		
	Prepare and conduct District Level training programmes/ Workshops for CORPs		450,000	450,000	450,000
	Subtotal		***454,500***	***450,000***	***450,000***

Continued

Strategic objective 1.3, continued

Strategy	2009/10 activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY 2011/12
1.3.2 Recruit and deploy CHEW and train them on the implementation of the community strategy	Advertise and recruit approximately 16,000 vacancies for filling over a 2-year period.	PSC/PS MOPHS,DPHS/ DHRM/HRM&D Task Forces	2,880,000	5,817,600	5,933,952
	Conduct regional staff Induction workshops		32,000	32,000	32,000
	Subtotal		***2,912,000***	***5,849,600***	***5,965,952***
1.3.3 Establish working stations for CHEWs at level 1	Equip work stations for CHEWs	PS MOPHS,DPHS/ DHRM/HRM&D Task Forces	10,000	15,000	15,000
	Monitor and evaluate implementation		250	250	250
	Subtotal		***10,250***	***15,250***	***15,250***
1.3.4 Develop a retention strategy for community health workers	Develop a retention strategy	PSs MOPHS/MSPS/DPHS/ DHRM/HRM&D Task Forces	2,300		
	Develop and disseminate appropriate guidelines for implementation		2,200	1,600	
	Monitor and evaluate implementation		250	250	250
	Subtotal		***4,750***	***1,850***	***250***
		Outcome 1 total	**4,890,300**	**10,698,650**	**15,220,428**

8.2 Outcome 2: Improved Retention of Health Workers at All Levels

8.2.1 Strategic Objective 2.1: Make Health Sector Jobs More Attractive to Improve Staffing Levels and Reduce Turnover

Strategy	2009/10 activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY2011/12
2.1.1 Conduct periodic review of compensation packages in line with qualifications	Conduct rapid survey of salaries and allowances of health sector employers and comparable professional groups and analyse and collate data	PS/HR Working Group		6,400	
	Convene workshop to present survey findings and get consensus			2,600	
	Prepare briefing paper for policy makers			200	
	Subtotal		***-***	***9,200***	***-***
2.1.2 Lobby for improved staff welfare and amenities including housing and recreation facilities in all areas including hard-to-reach areas	Prepare a staff welfare and amenities improvement plan	PSs MOH, MSPS/MOF/SEC.PS PRB/DHRM/ HRM&D Task Forces	2,300		
	Disseminate planned interventions to stakeholders to inform future budgetary support		700		
	Monitor and evaluate implementation		250	250	250
	Subtotal		***3,250***	***250***	***250***
2.1.3 Improve work climate in all health facilities (e.g., worker wellness, safety, recreation, etc.)	Form Work Climate Task Force (TF) (approx 5 members)	PSs MOH, MOF/DMS/DPHS/ DHRM/HRM&D Task Forces	200		
	Conduct a work climate assessment, identify promising practices that enhance work climate and propose interventions		8,600		
	Disseminate proposed interventions to stakeholders to inform future budgetary support		800	800	
	Monitor and evaluate implementation		250	250	250
	Subtotal		***9,850***	***1,050***	***250***

Continued

Strategic objective 2.1, continued

Strategy	2009/10 activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY2011/12
Strategy 2.1.4 Explore retention schemes for targeted cadres	Form Retention Task Force	PSs MOH, MSPS/MOF/SEC.PSPRB/DHRM/ HRM&D Task Forces	200		
	Review attrition data to identify "at risk" groups		5,600		
	Review of documentation on retention schemes relevant to the "'at risk" groups within and outside Kenya		200		
	Develop retention proposals on targeted cadres		2,100		
	Convene stakeholder conference for consensus and adoption			700	
	Develop simple reporting system for monitoring attrition levels of identified "at risk" groups			250	250
	Subtotal		***8,100***	***950***	***250***

8.2.2 Strategic Objective 2.2: Make Hard to Fill Posts and Hard to Staff Stations More Attractive

Strategy	2009/10 activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY2011/12
Strategy 2.2.1 Develop and implement a retention package for hard-to reach regions (Some activities budgeted under 2.1.4 above)	(Use Retention Task force)	PSs MOH, MSPS/DHRM/ HRM&D Task Forces	-	-	-
	Develop retention proposals on targeted regions		-	100	-
	Propose working systems and share with stakeholders			1,100	-
	Monitor and evaluate activities			250	250
	Subtotal		***-***	***1,450***	***250***
		Outcome 2 total	***21,200***	***12,900***	***1,000***

8.3 Outcome 3: Improved Institutional and Health Worker Performance

8.3.1 Strategic Objective 3.1: Improve Leadership and Management at All Levels to Improve Institutional and Health Worker Performance

Strategy	2009/10 Activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY2011/12
3.1.1 Revision of leadership and management competencies for key Health Management Personnel	Identify key management posts and develop competencies and clear guidelines for recruitment/ filling key health management and administrative positions	PSs MOH, MSPS/DHRM/ HRM&D Task Force	1,100		
	Revise job descriptions and core competencies to improve leadership and management functions		200		
	Develop briefing paper to communicate change to health workers and employers		100		
	Subtotal		***1,400***		
3.1.2 Ensure key leadership and management positions at all levels are substantively filled.	Identify gaps in leadership and management positions		100		
	Deploy staff to fill identified leadership and management gaps especially in the health administrative and management support systems	PSC/PSs MOH, MSPS/DMS/DPHS/ DHRM/ HRM&D Task Forces	10,000	20,000	10,000
	Subtotal		***10,100***	***20,000***	***10,000***

Continued

Strategic objective 3.1, continued

Strategy	2009/10 Activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY2011/12
3.1.3 Enhance leadership and management capacity at all levels	Assess performance, management knowledge and skills of department heads and technical managers	PSs MOH, MSPS/DMS/DPHS/ DHRM/ HRM&D Task Forces	1,100		
	Develop capacity development plan including; performance management systems, results-based management, target setting		250		
	Implement capacity development/leadership and management development training		122,000	122,000	122,000
	Develop M&E indicators and monitor application of training and performance improvements		500	2,000	2,000
	Subtotal		***123,850***	***124,000***	***124,000***
3.1.4 Improve supportive supervision systems including mentoring, counselling and coaching, behaviour change programmes	Assess existing support supervision systems and tools	PSs MOH, DMS/DPHS/DHRM / HRM&D Task Forces	1,100		
	Develop guidelines/tools for improvement of support supervision		250		
	Provide training in support supervision skills and use of tools		30,000	30,000	30,000
	M&E of support supervision systems			250	250
	Subtotal		***31,350***	***30,250***	***30,250***
3.1.5 Incorporate practical, action-based leadership and management approaches into pre-service curriculum	Sensitize pre-service training institutions on the need to incorporate leadership and management into their curricula		1,000		
	Subtotal		***1,000***	***-***	***-***

8.3.2 Strategic Objective 3.2: Institute a Results-Based Management System to Improve Institutional and Health Worker Performance at All Levels

Strategy	2009/10 activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY2011/12
3.2.1 Strengthen the sanctions and reward system to support performance management systems	Review the design, functioning and effectiveness of the system	PSs MOH, DMS/ DPHS/DHRM/ HRM&D Task Forces	1,100		
	Develop proposals for institutionalization of results based performance management systems	PSs MOH, MSPS/DMS/DPHS/ DHRM/ HRM&D Task Forces	250		
	Train senior managers in the best practices of performance management	HR Division		9,000	9,000
	Monitor application and effectiveness of the performance management system	HR M&E TEAM		250	250
	Subtotal		***1,350***	***9,250***	***9,250***
3.2.3 Institutionalize team work approaches	Sensitize managers on importance of and ways of strengthening team work (This will be integrated into the leadership and Management Training)	PSs MOH, MSPS/DMS/DPHS/ DHRM/ HRM&D Task Forces			
	Subtotal		***-***	***-***	***-***
3.2.4 Strengthen negotiation and conflict management skills	Develop training modules on negotiation and conflict management skills and conduct training for selected cadres (This will be integrated into the leadership and management training)	PSs MOH, MSPS/DMS/DPHS/ DHRM/ HRM&D Task Forces			
	Subtotal				

Continued

Strategic objective 3.2, continued

Strategy	2009/10 activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY2011/12
3.2.5 Establish effective systems for managing staff absence	Carry out a survey to review existing systems and practices for managing staff absence as well as understand the levels of absence and underlying reasons	PSs MOH, MSPS/DMS/DPHS/ DHRM/ HRM&D Task Forces	1,100		
	Develop and disseminate guidelines for managing absence		250	250	
	Monitor impact on absence levels		250	250	250
	Subtotal		*1,600*	*500*	*250*

8.3.3 Strategic Objective 3.3: Improve Health Worker Safety, Health and Wellness

Strategy	2009/10 activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY2011/12
3.3.1 Ensure health staff work in a safe and healthy environment in line with the laws of Kenya	Establish facility health and safety committees	PSs MOH, MSPS/DMS/DPHS/ DHRM/ HRM&D Task Forces	250		
	Develop, disseminate and distribute to all staff Health and Safety Handbooks and Guidelines		2,600	5,600	5600
	Subtotal		***2,850***	***5,600***	***5,600***
3.3.2 Provide psycho-social support to health workers in need	Establish and staff counselling and guidance units in the health workplace	PSC/PSs MOH, MSPS/DMS/DPHS/ DHRM/ HRM&D Task Forces	36,000	72,000	108,000
	Provide psycho-social training to health managers and supervisors		10,000	10,000	10,000
	Subtotal		***46,000***	***82,000***	***118,000***
		Outcome 3 total	***219,500***	***271,600***	***297,350***

8.4 Outcome 4: Strengthened Human Resource Development Systems and Practices

8.4.1 Strategic Objective 4.1: Establish Supportive Policy Frameworks to Manage and Monitor Health Workforce Development

Strategy	2009/10 activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY2011/12
4.1.1 Finalize, disseminate and implement the national health training policy	Finalize and launch the National Health Training Policy Document (Activity ongoing and funds available)	DHRM/ HRM&D Task Forces			
	Monitor effectiveness			250	250
	Subtotal		***-***	***250***	***250***
4.1.2 Develop and implement a succession planning policy guidelines	Review current succession planning and career develop-ment guidelines and carry out research on best practice	DHRM/ HRM&D Task Forces		1,400	
	Develop and gain consensus on the draft succession guidelines			1,900	
	Disseminate guidelines and sensitize senior managers			2,800	2,800
	Monitor and evaluate the effectiveness of the policy			250	250
	Subtotal		***-***	***6,350***	***3,050***

Continued

Strategic objective 4.1, continued

Strategy	2009/10 activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY2011/12
4.1.3 Develop clear career progression structures to support and harmonize staff development in line with service needs	Review existing schemes of service for delivery of KEPH	DHRM/ HRM&D Task Forces	3,600		
	Develop draft revised and new schemes		2,600		
	Disseminate schemes for issuance		500	500	
	Monitor and evaluate the implementation of revised/new schemes			250	250
	Subtotal		***6,700***	***750***	***250***
4.1.4 Advocate for the introduction of a levy to support health workforce development	Carry out feasibility studies on the establishment of a National Health Training Fund	PSs MOH, MSPS/MOF/DMS/ DPHS/DHRM/ HRM&D Task Forces		3,700	
	Hold Stakeholder meetings			1,000	
	Development of policy paper on NHTF			500	
	Subtotal			***5,200***	***-***

8.4.2 Strategic Objective 4.2: Increase the Capacity and Output of Pre-Service Institutions for Key Cadres

Strategy	2009/10 activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY2011/12
4.2.1 Undertake a comprehensive survey of training institutions including determining their capacity and Output	Conduct a national survey of health training institutions	PSs MOH, MSPS/ MOF/DMS/DPHS/ DHRM/ HRM&D Task Forces	-	8,400	
	Compile survey findings and recommended interventions		-	1,000	
	Disseminate survey findings and recommended interventions		-	3,360	
	Subtotal		***-***	***12,760***	***-***
4.2.2 Develop and adhere to clear entry requirement for all cadres	Review, Set, document and disseminate entry requirements	PSs MOH, MSPS/ MOF/DMS/DPHS/ DHRM/ HRM&D Task Forces	3,400		
	Subtotal		***3,400***		
4.2.3 Develop a comprehensive plan of scaling-up Output	Develop a 5-year national HRH manpower plan	PSs MOH, MSPS/MOF/DMS/ DPHS/DHRM/ HRM&D Task Forces		5,000	
	Conduct stakeholders buy-in seminars			700	
	Monitoring and evaluation of output			250	250
	Subtotal			***5,950***	***250***

8.4.3 Strategic Objective 4.3: Institutionalize Competence-Based Training Programmes to Increase Volume, Quality and Skill Mix of the Health Workforce

Strategy	2009/10 activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY2011/12
4.3.1 Develop a HRD plan for pre-service and in-service that is responsive to the needs of the health sector and allows continuous professional development	Develop a comprehensive, costed national HRD plan for achieving the required numbers of health workers with requisite competencies bases on the performance needs assessment and the manpower plan	PSs MOH, MOLHRD/DMS/ DPHS/DHRM/ HRM&D Task Forces		3,000	
	Host stakeholder consensus workshops			1,000	
	Finalize plan and disseminate to all stakeholders			1,000	
	Conduct M&E			250	250
	Subtotal		***-***	***5,250***	***250***
4.3.2 Improve quality and coverage of in-service training (IST) and continuing professional development (CPD) systems and practices to better meet health sector needs	Develop training need assessment tools for identifying training needs	PSs MOH, DMS/DPHS/DHRM / HRM&D Task Forces		1,300	
	Integrate tools with performance management systems (e.g. appraisal systems) and sensitize stakeholders			2,000	2,000
	Subtotal		***-***	***3,300***	***2,000***

Continued

Strategic objective 4.3, continued

Strategy	2009/10 activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY2011/12
4.3.3 Standardize and control institutional accreditation	Establishment of a National Health Training Commission (Consideration under the National Health Training Policy)	PSs MOH/ DMS/DPHS/DHRM / HRM&D Task Forces			
	Subtotal				
4.3.4 Develop incentives to motivate and retain key staff in training institutions	Formation of task Force to review and develop a HRH deployment and Incentives strategy	PSs MOH, MSPS/ MOF/DMS/DPHS/ DHRM/ HRM&D Task Forces		5,000	
	Subtotal			***5,000***	
4.3.5 Ensure curriculum review and development is done regularly in line with international standards and local needs	*see 4.3.3*	PSs MOH, DMS/DPHS/DHRM / HRM&D Task Forces			
	Subtotal		**-**	**-**	**-**
		Outcome 4 total	***10,100***	***44,810***	***6,050***

8.5 Outcome 5: Strengthened Human Resource Planning and Management and Leadership at All Levels

8.5.1 Strategic Objective 5.1: Strengthen and Decentralize HR Planning and Management

Strategy	2009/10 activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY 2011/12
5.1.1 Establish a HR planning and review mechanism	Develop and disseminate guidelines and mechanisms for sector-wide HR planning and review	PSs MOH, DMS/DPHS/DHRM / HRM&D Task Forces		2,900	
	Subtotal		**-**	***2,900***	**-**
5.1.2 Review HR structures in light of ongoing restructuring	Review and revise HR planning and management structures at all levels in the two ministries of health structures and referral hospitals in view of the revised mandates	PSs MOH, DMS/DPHS/DHRM / HRM&D Task Forces	1,000		
	Subtotal		***1,000***		
5.1.3 Put in place mechanisms for implementing decentralization of the HR function including development of structures and reporting lines	Establish HRM posts at administrative and facility level 4 and above	PSs MOH, DHRM/ HRM&D Task Forces	100		
	Develop guidelines and clear reporting structures for field HR officers		200		
	Subtotal		***300***	**-**	**-**
5.1.4 Recruit additional HR staff for the decentralized system	Create and declare an additional 300 HRM posts to MSPS for filling	PSC/PSs MOH, MSPS/DHRM/ HRM&D Task Forces	36,000	36,000	36,000
	Subtotal		***36,000***	***36,000***	***36,000***
5.1.5 Develop a comprehensive HRH review covering, workforce requirements, the labour market and pre-service training	Covered under 4.2.3 and 4.3.1	PSs MOH, DHRM/ HRM&D Task Forces			
	Subtotal				
5.1.6 Establish an annual reporting mechanism on HR data and trends on key areas for the entire sector and to evaluate progress on the implementation on HRH strategic plan and other HR initiatives	Covered under 5.1.1 and 5.4.2				
	Subtotal		**-**	**-**	**-**

8.5.2 Strategic Objective 5.2: Strengthen HR Systems and Practices

Strategy	2009/10 activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY2011/12
5.2.1 Build the capacity of all HR staff	Conduct HR planning and management training programmes	PSs MOH, MSPS/DHRM/ HRM&D Task Forces	3,000	4,500	4,500
	Increase the ICT capacity of HR staff		3,000	4,500	4,500
	Subtotal		***6,000***	***9,000***	***9,000***
5.2.2 Advocate for the review of the HR manual in-line with best practice	Develop a comprehensive HR manual in line with PSC guidelines and DPm circulars (for use by managers)	PSs MOH, MSPS/DHRM/ HRM&D Task Forces		2,900	
	Develop a popular version of the HR manual to be (to be distributed to all staff)			1,000	
	Disseminate and distribute the two manuals			1,000	1,000
	Subtotal		***-***	***4,900***	***1,000***
5.2.3 Advocate for the review of job descriptions after every two years or as per service needs	Develop guidelines and procedures on development of job descriptions in the health sector (Review of schemes of service currently ongoing refer - 4.1.3)	PSs MOH, MSPS/DHRM/ HRM&D Task Forces			
5.2.4 Introduce an orientation programme	Develop and disseminate orientation guidelines and checklists to guide the two ministries of health			1,500	
	Subtotal		***-***	***1,500***	***-***

8.5.4 Strategic Objective 5.3: Strengthen the Human Resources Information System (HRIS)

Strategy	2009/10 Activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY2011/12
5.3.1 Develop and implement an integrated, sector wide HRIS	Strengthen established HRIS task force	PSs MOH, MSPS/ DHRM/ HRM&D Task Forces	1,000		
	Develop HRIS and data protection Policies		1,000		
	Procure and install hard/soft-ware equipment and supplies for the HRIS centre and field units		2,000	2,000	2,000
	Develop HRIS database*		1,000	1,500	
	Conduct end user training		1,000	1,000	1,000
	Develop and distribute end user materials		500	500	500
	Create linkages to existing data-bases (HMIS, CNO Office, etc.)		1,000	1,500	1,000
	Hold stakeholder buy-in seminars		3,000	1,000	
	Populate the database		4,000	2,000	2,000
	Monitor and evaluate the system		1,500	500	500
	Subtotal		***16,000***	***10,000***	***7,000***

8.5.4 Strategic Objective 5.4: Strengthen Collaboration across the Sector between Service Providers to Ensure Optimal Service Provision

Strategy	2009/10 activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY 2011/12
5.4.1 Review current practices and explore options for strengthening collaboration among stakeholders (e.g., harmonizing structures, systems and resources)	Conduct a study and propose recommendations on coordination and collaboration of HR programs and initiatives in the health sector	PSs MOH, MSPS/DHRM/ HRM&D Task Forces	1,500		
	Subtotal		***1,500***	***-***	***-***

Continued

Strategic objective 5.4, continued

Strategy	2009/10 activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY 2011/12
Strategy 5.4.2 Establish a high level multi stakeholder HR steering committee to coordinate and monitor implementation of HRH Strategic Plan	Establish a broad-based national HRH steering committee composed of members with requisite experience and seniority and guided by clear terms of reference	PSs MOH, MSPS/ DHRM/ HRM&D Task Forces	1,500		
	Hold regular meetings of the National HRH management Committee		3,000	3,000	3,000
	Establish regional (provincial/ district) HRH leadership groups and technical teams - by outcome and Subsector		11,000	11,000	11,000
	Arrange for an annual National HRH Conference for stakeholders and policy makers		4,000	4,000	4,000
	Subtotal		***19,500***	***18,000***	***18,000***

8.5.5 Strategic Objective 5.5: Institute Task Shifting at All Levels

Strategy	2009/10 activities	Responsible person	Budget projections (Ksh 000)		
			FY 2009/10	FY 2010/11	FY 2011/12
5.5.1 Develop appropriate task shifting policies and guidelines	Establish Task Shifting Task Force	PSs MOH, MSPS/DHRM/ HRM&D Task Forces	100		
	Develop and disseminate HR policies and guidelines for task shifting		1,500		
	M&E		250	250	250
	Subtotal		***1,850***	***250***	***250***
5.5.2 Provide appropriate training to support task shifting	Develop and implement training modules	PSs MOH, MSPS/ DHRM/ HRM&D Task Forces	1,500	5,000	5,000
	Subtotal		***1,500***	***5,000***	***5,000***
5.5.3 Deploy level 1 staff, review and align with evolving strategy	see above	PSs MOH, MSPS/ DHRM/ HRM&D Task Forces			
	Subtotal				
5.5.4 Ensure recognition and compensation of task shifting by reviewing and developing the schemes of service	Review and incorporate task shifting in job descriptions and core competencies	PSs MOH, MSPS/DHRM/ HRM&D Task Forces	500		
	Subtotal		***500***		
		Outcome 5 total	***84,150***	***87,550***	***76,250***
Grand total			**5,225,250**	**11,115,510**	**15,601,078**

Notes:
*List of ST members: MOH, DPM, PSC, KNH, MTRH, KMTC, MOLG, KEC (Catholic Church), AMREF, professional associations, University of Nairobi, private hospitals
** Activities with no budgetary allocation in 2009/10 will be carried out in subsequent years.

Appendix: Selected Staffing Data

Table A1: Distribution of MOH staff by province (medical cadres)

Designation	Head-quarters	Nairobi	Central	Eastern	North Eastern	Coast	Western	Nyanza	Rift Valley	Grand total
Medical officers	55	376	260	230	40	162	109	167	317	1,716
Clinical officer	31	116	267	292	80	191	208	301	630	2,116
Orthopaedic technologist/ plaster technician	2	28	40	23	8	15	10	18	58	202
Orthopaedic appliance maker assistant	0	4	24	16	0	4	6	7	16	77
Dental specialist	9	84	24	17	5	22	8	19	29	217
Deputy dental technologist	1	5	20	18	2	12	9	13	30	110
Community oral health officer	2	13	10	13	0	5	7	8	25	83
Pharmacist	49	118	52	49	5	36	26	31	75	441
Pharmaceutical technologist	12	26	14	32	11	19	15	19	58	206
Pharmaceutical assistant	0	0	5	0	0	0	0	0	0	5
Nursing officer	71	249	474	411	68	327	226	328	722	2,876
Enrolled nurse	7	719	1,946	1,866	178	940	1,208	1,467	2,818	11,149
Enrolled nurse assistant	1	29	67	99	43	46	86	128	152	651
Health administration officer	9	14	29	39	12	23	14	30	53	223
Social welfare officer	3	7	3	2	1	2	4	3	4	29
Health records & information officer	46	35	85	66	7	47	41	51	134	512
Health records & information technician	0	2	12	11	4	13	3	9	10	64
Nutrition officer	16	50	63	47	13	23	25	42	121	400
Nutrition assistant	0	0	0	0	0	0	0	0	7	7
Radiographer	6	16	43	41	6	24	17	33	62	248
Physiotherapist	4	37	78	82	7	61	40	56	88	453
Occupational therapist	6	30	46	48	2	23	27	25	58	265
Public health officer	43	246	596	536	101	313	325	520	1,347	4,027
Inspector of drugs	4	1	1	1	0	1	1	1	1	11
Assistant psychiatry	0	0	2	0	0	0	0	0	1	3
Lab technologist	65	59	208	201	27	137	143	181	324	1,345
Lab technician	9	0	2	2	2	1	5	1	5	27
Medical parasitologist/entomologist	8	0	0	0	0	1	0	0	0	9
Biochemist	5	0	0	0	0	0	0	0	0	5
Medical lab technologist	39	24	30	36	13	42	23	42	125	374
Engineer	1	0	1	1	0	3	0	2	5	13
Mortuary attendant	0	1	8	9	2	3	2	3	3	31
Radiation protection officer	19	0	0	0	0	2	0	2	0	23
Medical engineering technologist	9	18	52	50	11	29	26	39	82	316
Medical eng. technician	0	0	1	2	0	2	1	0	3	9
Chemist/Analyst	2	35	0	0	0	9	0	7	0	53
Subtotal	534	2,342	4,463	4,240	648	2,538	2,615	3,553	7,363	28,296

Source: MOH IPPD, June 2009.

Table A2: Distribution of MOH staff by province (non-medical cadres)

Designation	Head-quarters	Nairobi	Central	Eastern	North Eastern	Coast	Western	Nyanza	Rift Valley	Grand total
Administration	5	1	0	0	0	0	0	0	0	6
Assistant secretary	5	0	0	0	0	0	0	0	0	5
Clerical officer	149	30	109	111	4	40	68	117	136	764
Accountant[	27	0	0	0	0	0	0	0	1	28
Accounts assistant	14	4	1	2	0	1	1	4	3	30
HRM officer	29	0	0	0	0	0	0	0	0	29
HRM assistant	27	0	2	1	0	0	0	0	0	30
Economist	9	0	0	0	0	0	0	0	0	9
Statistical officer	2	0	0	0	0	0	0	0	0	2
Secretarial services officer	57	4	6	12	2	9	5	8	10	113
Copy typist	34	4	15	19	1	12	10	8	14	117
ICT officer	1	0	0	0	0	0	0	0	0	1
Data machine supervisor	1	0	0	0	0	0	0	0	0	1
Procurement officer	17	1	4	3	0	0	1	0	4	30
Supplies assistant	15	7	21	13	2	17	10	14	27	126
Librarian	2	0	0	1	0	0	0	0	0	3
Records management officer	15	2	3	3	0	0	0	1	3	27
Security officer	5	3	0	0	0	0	0	0	0	8
HRD officer	1	0	0	0	0	0	0	0	0	1
Animal house officer	1	0	0	0	0	0	0	0	1	2
Assistant livestock prod officer	1	0	0	0	0	0	0	0	0	1
Livestock health assistant	1	0	0	0	0	0	0	0	0	1
Chargehand/Inspector building	18	13	36	20	0	5	4	16	14	126
Inspector/Chargehand mechanical	1	0	0	0	0	0	0	0	0	1
Electrical	3	0	1	0	0	1	1	0	2	8
Chargehand electronic	0	0	3	0	0	0	0	0	0	3
Boiler assistant	0	0	1	0	0	0	1	1	0	3
Technical officer/Technician	0	0	1	0	0	1	0	0	1	3
Kadhi	1	0	0	0	0	0	0	0	0	1
Finance officer	4	0	0	0	0	0	0	0	0	4
Telephone supervisor	18	13	39	25	0	16	18	16	24	169
Teleprinter operator	0	0	0	0	0	0	1	0	0	1
Principal information officer	2	0	0	0	0	0	0	0	0	2
Driver	118	18	105	91	23	51	56	101	140	703
Coxswain	0	0	0	0	0	1	0	1	0	2
Printing assistant	0	0	0	0	0	0	1	0	0	1
Office machine operator	4	0	0	0	0	0	0	0	0	4
Radiographic film procsr	0	0	0	0	0	0	0	0	1	1
Housekeeper/Cateress	0	4	3	0	0	1	2	2	5	17
Cook	3	14	29	17	1	3	3	9	5	84
Laundry assistant	0	0	1	0	0	0	0	0	0	1
Chargehand tailor	6	21	25	3	0	3	6	9	6	79
Lecturer	1	0	0	0	0	0	0	0	0	1
Monopolies & prices officer	0	1	0	0	0	0	0	0	0	1
Licensing officer	0	0	0	0	1	0	0	0	0	1
Cleaning supervisor	36	32	54	107	2	45	46	110	105	537
Subordinate staff	41	57	249	318	48	200	161	414	438	1,926
Subtotal	674	229	708	746	84	406	395	831	940	5,013

Source: MOH IPPD, June 2009.

Table A3: Intent to migrate data

Country	No. of applicants
United States	3,452
United Kingdom	1,583
Australia	295
Canada	134
New Zealand	90
Ireland	88
Uganda	70
Namibia	39
Botswana	36
Tanzania	30
South Africa	27
Italy	8
Malawi	4
Denmark	3
Nigeria	3
Seychelles	3
Colombia	2
Germany	2
Swaziland	2
United Arab Emirates	2
Argentina	1
Egypt	1
France	1
India	1
Nauru	1
Niger	1
Saudi Arabia	1
Switzerland	1
US minor outlying	1
US miscellaneous	1
Total	5,883

Source: Nursing Council of Kenya, 2009.

Table A4: Staffing data for Aga Khan University Hospital – Nairobi

Category	Number
Medical interns	8
Residents	69
Full time faculty	32
Part-time faculty	45
Allied health	270
Nurses	360
Doctors	206
Admin. & support staff	483
Total	1,473

National HUMAN RESOURCES FOR HEALTH Strategic Plan 2009–2012

This booklet presents the National Human Resources for Health Strategic Plan developed by the Ministry of Public Health and Sanitation and the Ministry of Medical Services. The plan intends to support the goal of the second National Health Sector Strategic Plan (NHSSP II – 2005–2010) to reduce health inequities and reverse the decline in key health indicators by providing a framework to guide and direct interventions, investments and decision making in the planning, management and development of human resources for health.

The plan recognizes a significant shortfall in the numbers, quality and deployment of the existing health work force. Only with sufficient numbers of well-trained, appropriately distributed health care providers will the health sector be able to *reverse the trends.* To redress the shortcomings, the plan proposes a comprehensive approach to improving training, increasing the number of available personnel, and ensuring that under-served and hard-to-reach areas have equitable access to quality personnel. The plan also provides for institutional management frameworks, monitoring and evaluation, and resource mobilization.

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