

**What are the implications and consequences of the decentralization process on health workers performance: Lessons Kenya can learn from the experience of others**

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**WHAT ARE THE IMPLICATIONS AND CONSEQUENCES OF THE DECENTRALIZATION PROCESS ON HEALTH WORKERS PERFORMANCE: LESSONS KENYA CAN LEARN FROM THE EXPERIENCE OF OTHERS**

**A thesis submitted in partial fulfillment of the requirement for the degree of Master of Public Health**

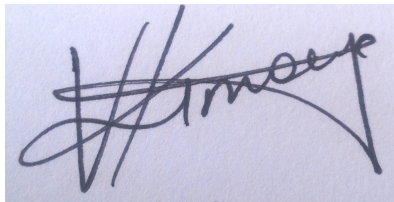
**BY**

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The Thesis "What are the implications and Consequences of the Decentralization process on health workers performance: Lessons Kenya can learn from the experience of others" is my own work.

A handwritten signature in black ink on a light blue background. The signature is stylized and appears to read 'Kanana Kimonye'.

**Signature:**

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## LIST OF ABBREVIATIONS

<b>CHMT</b>	County Health Management Team
<b>CME</b>	Continuous Medical Education
<b>GGE</b>	General Government Expenditure
<b>GHE</b>	General Health Expenditure
<b>HCW</b>	Health Care Worker
<b>HW</b>	Health Worker
<b>HRH</b>	Human Resources for Health
<b>LGA</b>	Local Governing Authority
<b>MCH</b>	Maternal and Child Health
<b>NGO</b>	Non Governmental Organization
<b>SOP</b>	Standard Operating Procedure

## DEFINITION OF TERMS

**SUB COUNTY:** the decentralized units through which the county governments of Kenya will provide functions and services<sup>1</sup>.

**COUNTY:** Geographical units of devolved governments<sup>2</sup>.

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<sup>1</sup> Decentralized Units, Section 48 (1) (b) County Governments Act 2012

<sup>2</sup> Article 6, Devolution and access to Services, The 2010 Constitution of Kenya

## Abstract

**Background:** Kenya is in the early years of implementing decentralization by devolution reforms in the health sector.

**Objective:** To identify and analyse the implications and consequences of decentralization reforms on health care workers and managers performance and to provide feasible recommendations to local authorities for enhancing health care workers availability, responsiveness and competence.

**Methodology:** The study is a descriptive literature review. It examines the implications of the decentralization process on health workers roles, responsibilities and new accountability structures. It further explores the consequences that the decentralization process may bear on Human resources for Health management determinants.

**Findings:** Healthcare workers become a central player in the process of decentralization as they navigate the new accountability matrix that the process demands. Interactions with non-professionals may undermine performance but at the same time, having technical supervisors close at hand may contribute to the improvement of their work. The health worker acquires new skills, such as learning how to effectively communicate technical matters with community members, who are involved in decision-making. Decentralized systems that give local authorities and healthcare managers autonomy, allow for human resources for health challenges to be met more effectively. Decentralization may not necessarily improve or worsen human resources for health management issues but rather amplifies them.

**Conclusion:** To ensure availability, competence and responsiveness, accountability structures must be clear and investments must be made to improve the health workers condition.

**Key Words:** Kenya, Decentralization, Health Care worker, Implications, Performance.

**Word Count:** 12531

## INTRODUCTION

I am Kanana Kimonye, a Medical Doctor by training. I had been working for the three years before commencing this course as a Sub County Health Coordinator, in Meru County Kenya. Most of my duties were thus managerial but I had no previous experience or training on management issues. During this period, decentralization reforms were taking root in the healthcare system and it therefore subsequently brought some changes with it and as such I found my duties sometimes overwhelming. My interest in this topic was borne from my experiences. I wondered if I was having difficulty navigating my new roles in the decentralization system, then perhaps other health workers were facing similar challenges.

The objective of this thesis is to find out how the health worker's performance is affected by decentralization reforms. This is relevant to Kenya today as the reforms are fairly recent and as such there is much to be learned. On a global perspective decentralization has been widely studied and implemented in many countries. Experiences from these places would be valuable information for Kenya, so as to maximize fully and also to avoid potential pitfalls. The health worker is the pivotal point in a healthcare system, they are the technical expert but also the human connection to the patient in their time of illness. It is important to consider their well being always in the fulfillment of their duties.



**WHAT ARE THE IMPLICATIONS AND CONSEQUENCES OF THE DECENTRALIZATION PROCESS ON HEALTH WORKERS PERFORMANCE (LESSONS, KENYA CAN LEARN FROM THE EXPERIENCE OF OTHERS)**

**1 COUNTRY BACKGROUND**

Kenya is an East African Country with a population of approximately 44 Million. Life expectancy at birth is estimated at 61 years and 63 years for Males and Females Respectively (1). In the year 2014, after rebasing National accounts, Kenya confirmed its status as a Middle Income Economy (2,3). The constitution was changed in the year 2010, ushering a devolved system of Government that divided the country into 47 Counties led by a County Government. The basic aim was to take services closer to the people, and help improve and bring up to par, regions in Kenya that had for a long time been marginalized. This will later be discussed in light of this paper.

The structure of the health care system in Kenya has undergone dramatic changes since the country gained independence in 1963. At that time the Government was the major provider and financier of healthcare services in the country. Up until the late seventies it was able to meet the Demand and cost of these services. With time however and the pressures of a rising population, certain economic policies and Governance challenges, health service functions became a strain. Following this, Kenya like many other developing countries with the encouragement of the World bank and the International Monetary fund began to institute reforms aimed at improving efficiency and effectiveness.

In 1986 a policy document “National Guidelines for the implementation of Primary health care in Kenya” was developed. Its purpose was to reorient the existing healthcare system around the principles of decentralization, participation of communities and collaboration between different sectors. From this a cost sharing policy was also instituted to support primary healthcare functions at the district level, and to strengthen clinical performance. Though its intent were noble it quickly led to inequities as different districts levied different charges for services, this was later streamlined with the introduction of the 10/20 policy where clients would pay 10ksh and 20ksh(the equivalent of 10 and 20 cents Euro) for services at

dispensary centre and health centre level respectively (5). These reforms eventually culminated in the first National Health Sector Strategic plan of 1999-2004, and later the National Health Strategic Plan of 2005-2010, which both aimed at providing health to all and to reach the 'most vulnerable' and 'underserved' (4). To further meet this goal, healthcare has been devolved to Local Governments, as part of the wider Decentralization reforms instituted in 2010, as will later be expounded on.

Despite these reforms human resources for health management has remained one of the major challenges of Kenya's health system. The latest WHO statistics have shown that there are approximately 104/100,000 Doctors, Midwives and Nurses. Far below the recommended 230/100,000 (5). Kenya's Health Sector Strategic Investment Plan, 2013-2013, highlighted that up to 15% of health workers were not at their duty stations at one time or other. Also, none of the newly formed counties had at least 80% of staff cadres as per their needs and norms. Further, the attrition rate is above 2% in all 47 counties (6). With these hurdles to cross and the recent decentralization reforms, this study aims to explore the possible implications and consequences to the performance of the Health Care Worker.

## 2 PROBLEM STATEMENT

Green gives four broad strategies used for healthcare reforms. The first strategy is for Governments to diversify and expand ways of collecting revenue. The second involves Governments finding ways to include other stakeholders such as NGO's or the Private Sector. A third strategy is to use market approaches in the organization and management of health services and finally leveraging the advantages of decentralizing power from the central level to the district levels (7).

In particular reference to Kenya all four strategies have been considered in the reforms that have taken place so far. Not in the least is decentralization with the first application of decentralization principles occurring in the early 90's when the management of health services was overseen by District Health Management Boards and transfer of responsibilities to the District Health management Teams through the Ministry of Health (8). Most recently, with the passing of the new constitution in 2010, most functions of Central Government, health services included have been devolved to regional Governments (Counties). Decentralization has been encouraged on an international level and adopted by national Governments as a way to improve efficiency and quality of services as well as an accountability mechanism to the local population (9).

However as with all reforms and decentralization in particular a lot of emphasis is placed on the process of change, delivery of services and the expected benefit of overall efficiency and effectiveness and little on health workers. The place of health workers is significant as they are the link between the clients and health services, they are the ones who translate policy to practice. Historically studies, such as those done by Franco et al and Martineau have tried to fill this gap by relating health reforms with health care workers motivation and development issues.

"When governments devolve functions, they transfer authority for decision-making, finance, and management to local governments with corporate status. Devolution usually transfers responsibilities for services to Counties (in Kenya's case) that elect their Governors, raise their own revenues, and have independent authority to make investment decisions. In a devolved system, local governments have clear and legally recognized geographical

boundaries over which they exercise authority and within which they perform public functions. (9)”

As earlier stated this is what Kenya aimed to do as it ushered in a new constitution in the year 2010 that decentralized some functions of Government including the Health Sector, with it being described by the World Bank “as one of the most ambitious globally”. There were 47 Counties created on regional basis, with Meru County as one of them. Most health functions as will later be presented are now functions of county Government.

The form of decentralization that has been adapted is complete devolution of health services, with most functions shifted to the local government including planning, promotion of primary care, recruitment and distribution of staff, Management of county referral hospitals and pharmacies.

With decentralization, the people making decisions tend to be closer to the realities that their employees face. This can eliminate some misunderstandings and help to quickly resolve problems. Employees who have queries or problems can resolve them personally rather than navigating through a web of bureaucracy. This personal connection helps to maintain high morale and a feeling of being valued. Managers who live and work in the same community as the people they manage will often know these people outside of the workplace. This can foster a personal concern for the welfare of staff that motivates managers to do their best work. An on-site manager can advocate for employees when there are disagreements with a higher authority (10).

Despite these advantages the rapid changes in the organization of the health system are presenting certain challenges to the counties’ administrative bodies, district or hospital health managers and healthcare workers. A large financial burden is on county administrative structures mandated to manage health care services as well as pay healthcare workers; many of these structures are new and the staff poorly trained in this particular field. This leads to salary delays, which has led to healthcare strikes in certain counties. Budget allocations are often not satisfactory to meet health facilities needs which may leave managers disillusioned and overwhelmed (11).

Healthcare workers are apprehensive about their position in the new organizational structure; many may lack a clear understanding of what decentralization for health really means; others may be confused on their new roles and responsibilities. This may leave them unmotivated to work. Others may perceive a lack of “job security” especially if they do not originally come from the counties in which they work (11).

The decentralization process in Kenya is in its early stages and it is of interest to study some of these factors through experiences of other countries in an effort to ease the process.

## **2.1 PROBLEM JUSTIFICATION**

It is essential to have an understanding of the devolution process and its implications and consequences on healthcare workers. Having been in effect for only 5 years now, it is of value to assess what has happened so far and continue good practices as well as improving on the shortcomings.

As a healthcare worker and Manager for that matter it is of interest to me to learn more on this subject and consequently make me more effective at my work.

Within Kenya there is limited research on the subject and this study aims at making a humble contribution to the growing body of work concerning human resources and healthcare reforms.

## **2.2 OBJECTIVES OF THE STUDY**

### **Overall Objective:**

To describe the effect of decentralization on the health system, from the human resource perspective.

### **Sub-objectives:**

- To describe the design and implementation of decentralization for health system.
- To describe and discuss the implications and consequences of decentralization for health care worker/health care managers.
- To review experiences and responses to Human resources challenges, in relation to decentralization, from other similar contexts

- To formulate recommendations to Local Governments in Kenya on maximizing possible benefits and avoiding possible pitfalls of decentralization on Human resources for Health policies.

### **2.3 METHODOLOGY**

This study has been done mostly through literature review of published peer reviewed articles and grey literature. Four informal interviews were conducted with healthcare workers in Kenya via electronic means.

To answer the first objective concerning the design and implementation of decentralization, grey literature in the form of Government Reports, Policy documents, statistical and financial data was retrieved through Google search engine. Some documents were retrieved directly as their titles were already known. The rest were searched using the key words in combination: 'County and Financing and Kenya'; 'County and Budgets and Kenya'; 'Devolution and health system and Kenya'; 'decentralization and health system and Kenya'.

Peer reviewed scholarly articles were mainly used to answer the second objective. PUBMED was first used to get the relevant articles and other related articles through the links therein provided. Google Scholar was then used to retrieve any documents not found through PUBMED. The search words used in combination were: 'decentralization and healthcare workers'; 'devolution and health workforce '; 'decentralization and health and Sub Saharan Africa'; 'devolution and Healthcare and Kenya'; 'devolution and Kenya and healthcare worker'; 'impact and devolution and health care worker and Kenya '; ' performance and healthcare workers and lower middle income countries'; 'accountability and healthcare reforms'.

Articles were limited to studies done about Kenya, Sub Saharan African Countries, and Lower Middle income Asian countries. Articles had to be written in English with no limitation on the year, but the most recent relevant articles were preferred over older ones.

There are few articles on the process of devolution in Kenya as pertaining to healthcare workers. As such to enhance the literature search, newspaper articles since the year 2012 regarding the subject were sometimes used. Kenyan media houses whose articles were accessed include the Nation Media group, Standard Media Group, Wajir Times and News24. Key words used

were 'doctors'; 'nurses'; 'salary delays' and in combination: 'Healthcare workers and strikes'; 'challenges and devolution.

Further, four interviews with Sub County Health Managers were carried out to further enrich the study.

In the chapter concerning lessons that Kenya can learn from other countries, two countries were identified Mali and the Philippines from the initial literature research as being most suitable. More articles were then retrieved through Google Scholar focusing on these two countries and using the Key words in combination: 'decentralization and Mali'; 'decentralization and Philippines'.

**Table 1: Methodology table**

	<b>Source</b>	<b>Objective 1</b>	<b>Objective 2</b>	<b>Objective 3</b>
Published Peer reviewed	Pubmed  Vu library  Google scholar	-“Devolution and health system and Kenya” -“decentralisation and health system and Kenya”	“decentralisation and healthcare workers”, “devolution and health workforce” “decentralization and health and Sub Saharan Africa” -“devolution and Healthcare and Kenya” -“devolution and Kenya and healthcare worker” -“impact and devolution and health care worker and Kenya” -“performance and healthcare workers and lower middle	- “decentralization and Mali” - “decentralization and Philippines”

			income countries"	
Grey literature Reports	Google	- "county and financing and Kenya" - "county and budgets and Kenya"		
	Government/WHO	- "Kenya bureau of statistics" - "Kenya Law Reports" - "Kenya Health Policy" - "Health Sector Strategic Plan"		
	News Websites		- "Healthcare workers and strikes" - "challenges and devolution" - "doctors"; "nurses"; "salary delays"	

### **Limitations**

Availability of literature that is specific to Kenya's process of decentralization in regard to health workers is scarce. As such there has been reliance on newspaper articles, and experiences from other similar countries. As such regional differences, as may be expected, among the counties have also not been well brought out.



## 2.4 CONCEPTUAL FRAMEWORK

Franco et. al extensively explores the influence of health sector reforms on three determinants of health worker(HW) motivation. They show how individual, organizational and cultural factors play on motivation which in turn influences performance of health workers. Within the organizational context of Franco's model, it is further postulated that reforms impact upon organizational structures by altering accountability relations, changing and increasing the responsibilities of the human resources structures and increasing resources to accomplish organizational goals(12). The conceptual framework for this paper incorporates this aspect of Franco's ideas by linking the decentralization design with its direct implications on two aspects of human resources for health (HRH) functions i.e. new roles and accountability relations. To present the assumed consequences of decentralization on HW's performance, Dieleman's et. al framework for human resource management interventions to improve HW's performance is adapted. The decentralization process is seen as the intervention that bears consequences on human resources for health outcomes that would eventually contribute to the overall health systems performance (13).

Firstly, this paper presents the changes in Kenya's health system organization by describing the design of decentralization and its implementation. This will include elements such as the new financing arrangements, governance structure and finally changes in Human resources for Health Management. Though the nucleus of this paper is on human resources for health, exploring the different aforementioned elements and showing their interrelations will give a clearer picture of the direct implications and consequences on Human Resources for Health functions.

This framework suggests, that the direct implications of the decentralization process on HRH functions will be firstly, on roles and responsibilities of health workers and managers and secondly on accountability relations with central government, local authorities, private/NGO<sup>3</sup> sector, the community and other sectors. It also suggests that the consequences of decentralization for HRH functions will bear on HRH issues such as skills attitude and knowledge, issues of recruitment and production, working conditions,

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<sup>3</sup> Non Governmental Organization

remuneration etc (as will be elaborated within the framework). These implications and consequences are seen as interdependent and not exclusive. For example, managers as part of their new role may acquire the mandate to train, recruit and pay health workers, if this is done well the consequences is the availability of HW's. However if the design of decentralization does not provide a means for the manger to acquire resources for this function, the desired availability of HW's cannot be achieved. This framework therefore aims to analyse the interplay between the different HRH functions in the context of decentralization and how they succeed or fail to achieve the desired dimensions of human resources for health performance outcomes namely autonomy, competence, availability and responsiveness. This will eventually impact on the health system.

Figure 1 presents this framework graphically.

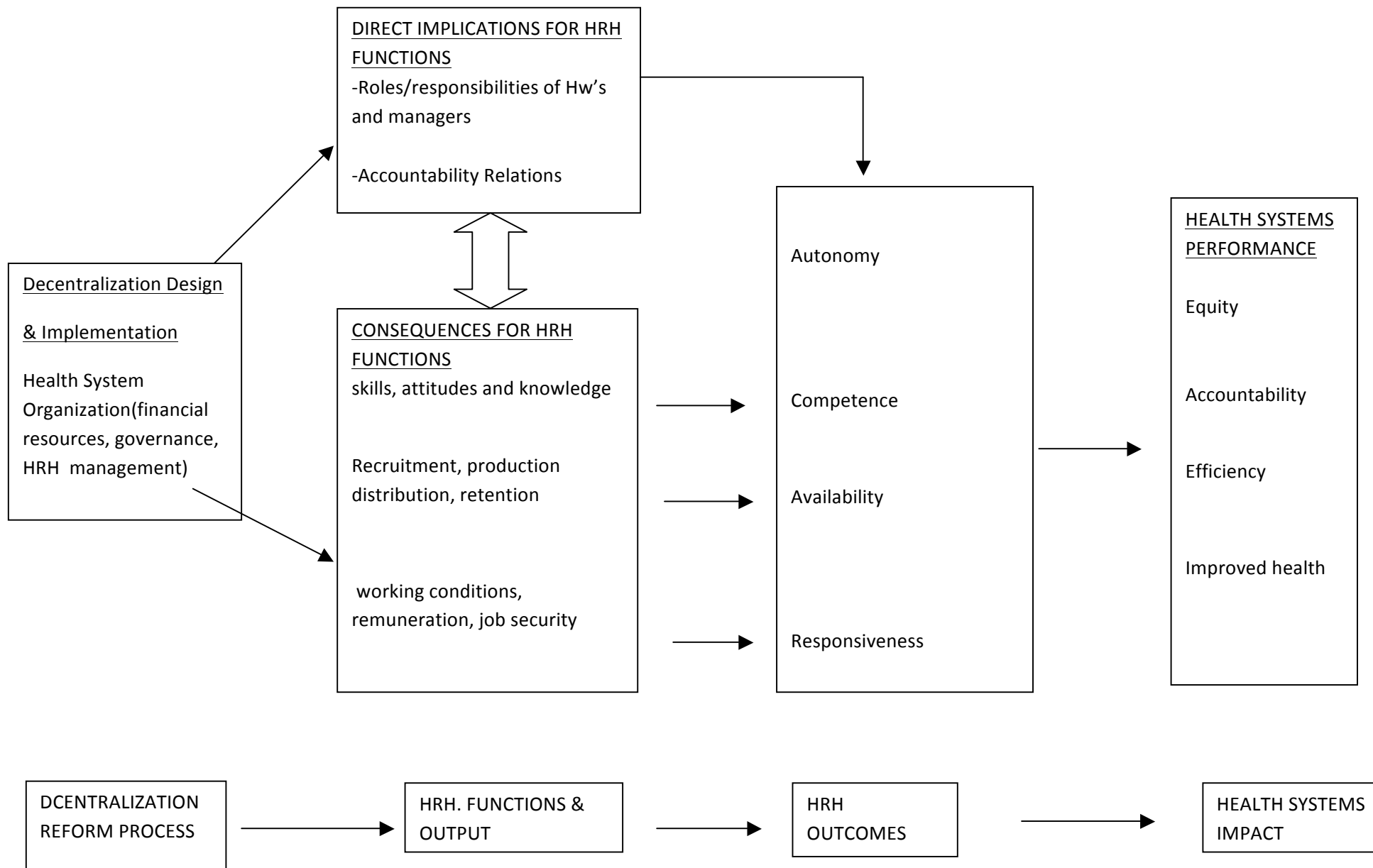


Figure 1: Conceptual Framework (Source: adapted from Dieleman et. al(12))

### 3 Results

This chapter highlights the main findings of literature review in accordance with the conceptual framework presented. It will mainly deal with the design of decentralization in Kenya and then the implications and consequences of Human resources for health (HRH). Where results could not be exclusively found for Kenya, similar contexts were used such as Uganda and Tanzania. In other cases comparisons and similarities are drawn with Asian middle-income countries that have been implementing decentralization and specifically devolution for a long time, to enrich the analysis and discussion. The analysis and discussion will follow after each sub chapter.

#### 3.1 Kenya's Design of Decentralization

Decentralization from a political and administrative point is categorized into four well-known forms; deconcentration, delegation, devolution and privatization. Deconcentration is defined as shifting functions of ministries to regional offices, devolution on the other hand shifts responsibility and authority, usually through constitutional mandate, to local governments. Decentralization through delegation uses semi autonomous agencies to carry out certain functions while in privatization; public tasks and responsibilities are shifted to private for profit entities (14).

As alluded to earlier the type of decentralization adopted in Kenya is primarily that of devolution, where the constitution of Kenya states that the sovereign power of the people will be exercised at the two levels of National and County governments. It further states that though they are distinct, they are also interdependent and will carry out their mandates on the basis of consultation and co-operation (14,15). Furthermore functions can be transferred between the two levels, especially in the case of underperformance, but the burden of implementation specifically lies with county governments (16).

The County government has essentially replaced the provincial, district and local governments that were in place after independence (17). It is responsible for:

- i. County legislation
- ii. Executive functions
- iii. Functions transferred from the national government

- iv. Functions agreed upon with other counties
- v. Establishment and staffing of a public service

## **Financial Resources**

The major resource allocation for counties is derived from at least 15% of all the money raised by national government, that is money raised by the national tax authority and other sources (dividends, sale of securities, divestiture and so on; sale of bonds and other financial instruments, unspecified borrowings and other receipts including concessional fees, tolls, appropriations in aid, amongst others). This will be shared equitably among the 47 counties (18), as will be described next.

In 2013, the sharable revenue available for counties from the national government was approximately 190 billion Kenya shillings<sup>4</sup>. Every county receives a fixed amount of 1 billion Kenya shillings<sup>5</sup>, further allocation depends on the county's population, poverty index and land area. These first two allocations are referred to as the equitable allocation. The third allocation is what is referred to as a conditional allocation and is meant for the development of regional referral hospitals and to ensure continuity of essential services in each county (53).

Counties have the ability to borrow and receive grants as well as to impose local taxes and fees as specified in the constitution (15). Currently, the fees and charges imposed by the local authorities include: agricultural cess, livestock fees, house rents, market rents and fees, single business permits fees; traditional brew permits fees, service delivery charges, road maintenance levy, parking fees, rent for conference halls, county parks and related facilities (18).

As such counties have two main streams of revenue to fund health services. The first being public funds, this include allocation from the national government as earlier mentioned as well as local revenue and charges from public services offered. The second being donation and grants that can be sought directly by the county government.

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<sup>4</sup> Equivalent to approximately 1.6 billion Euro

<sup>5</sup> 1 billion Kenya shillings is currently equivalent to about 8.7million Euro.

Previously Hospitals and District Health management Teams received funding directly from National Government through the Health Sector Services fund and additional revenue was raised from user fees. After decentralization reforms hospitals and Sub county health management teams have now been receiving money directly from county governments, as well as collecting user fees. In general Kenya spends a low percentage of its GDP<sup>6</sup> on healthcare, approximately 4% in the year 2013, further its general health expenditure (GHE) as a percentage of general government expenditure (GGE) was 6% (54). This seems not to have changed much in fact, counties are spending less on health. Four counties have been sampled to get a general picture of GHE as a percentage of GGE among county governments. Meru county spends approximately 5%, Baringo county 4%. These two counties are considered averagely resourced counties. Nairobi, the richest county of the 47, spends 3.4%. Turkana county's GHE as a percentage of its GGE is approximately 7.39%, a little above what the National government used to spend (55).

Moreover disbursement of funds from county governments to healthcare facilities has been irregular in most cases thus retarding some essential functions. Some of the reasons cited have been, i) initial teething problems as is expected with any change ii) Misappropriation of funds by the county governments and iii) inadequate funds from national Government as cited by some Governors.

One of the aims of decentralization is to improve quality of services and this is dependent on whether funds are available to provide these services and how quickly service providers can receive these funds. From the findings it is evident that in Kenya counties so far are spending even less on health than what the National government did. This will likely have repercussions on the health system. It is not enough to institute a reform without investing adequately so as to benefit maximally from it. In respect to human resources for health, this particular aspect will be explored further in the upcoming texts.

## **Governance**

The constitution now provides for 47 county governments as earlier stated. Before this, Kenya was divided into 8 administrative districts, led by a

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<sup>6</sup> Gross Domestic product

provincial commissioner. All governments' services were offered in these provinces through deconcentrated regional offices. Now under devolution each county is headed by an elected Governor and elected representatives sitting in the county assembly (parliament). The Governor then appoints his executive cabinet, who head the various ministries. The county governments are mandated to decentralize functions and provisions of services as far as it is feasible for them to do so. While this provision allows Counties to decentralize to lower levels, the lower entities do not have Constitutional protection and can only operate under legislation which can be changed at the will of the county government. These decentralized units are not assigned any functions and are not revenue allocation centres. Their functions are set by the County governments and in other cases by the National government but in agreement with the County. The latter case usually applies to some services found in cities (18). Table 2, represents this matrix graphically.

With respect to health services, previously all lower level hospitals: community units, dispensaries, health centres and sub district hospitals were managed by their respective facility in charges and facility boards, which included representatives of the community. These lower facilities were then overseen by a district health management team that reported to a Provincial Health In charge. Higher level facilities were also governed by a health board, however in practical terms they were more or less independent of the District Health Board even if they were geographically placed within the district.

After devolution representation of the community within the health boards of each facility is still maintained. What was formerly known as a district is now referred to as a Sub county, and hence managed by a sub county management team. Other stakeholders such as private sector/ NGO are not represented within the health boards but can be invited to participate and contribute in the meetings. As shown in the diagram, the county referral hospital is coordinated directly by the County Health Management Team if it is within the County headquarters. If within a different sub county it will usually be coordinated by the respective sub county management team. Figure 2, gives a graphic representation of this structure.

Table 2 has shown political and administrative relationships and functions of the county governments and community representation. Figure 2 has shown

the governance structures linking political, technical and community participants in the health system. It has been mentioned in the text where private and NGO organisations fall in, though this in practice, is really dependent on individual players making effort to seek partnerships and collaborations, when they are not specified. The involvement of county government political representatives is not officially very clear, though in practice, they are usually heavily involved in matters concerning health and specifically in human resources for health as will later be discussed.



**Table 2: County administrative governance structure. Source (Hope K. Devolved Government & Local Governance in Kenya)**

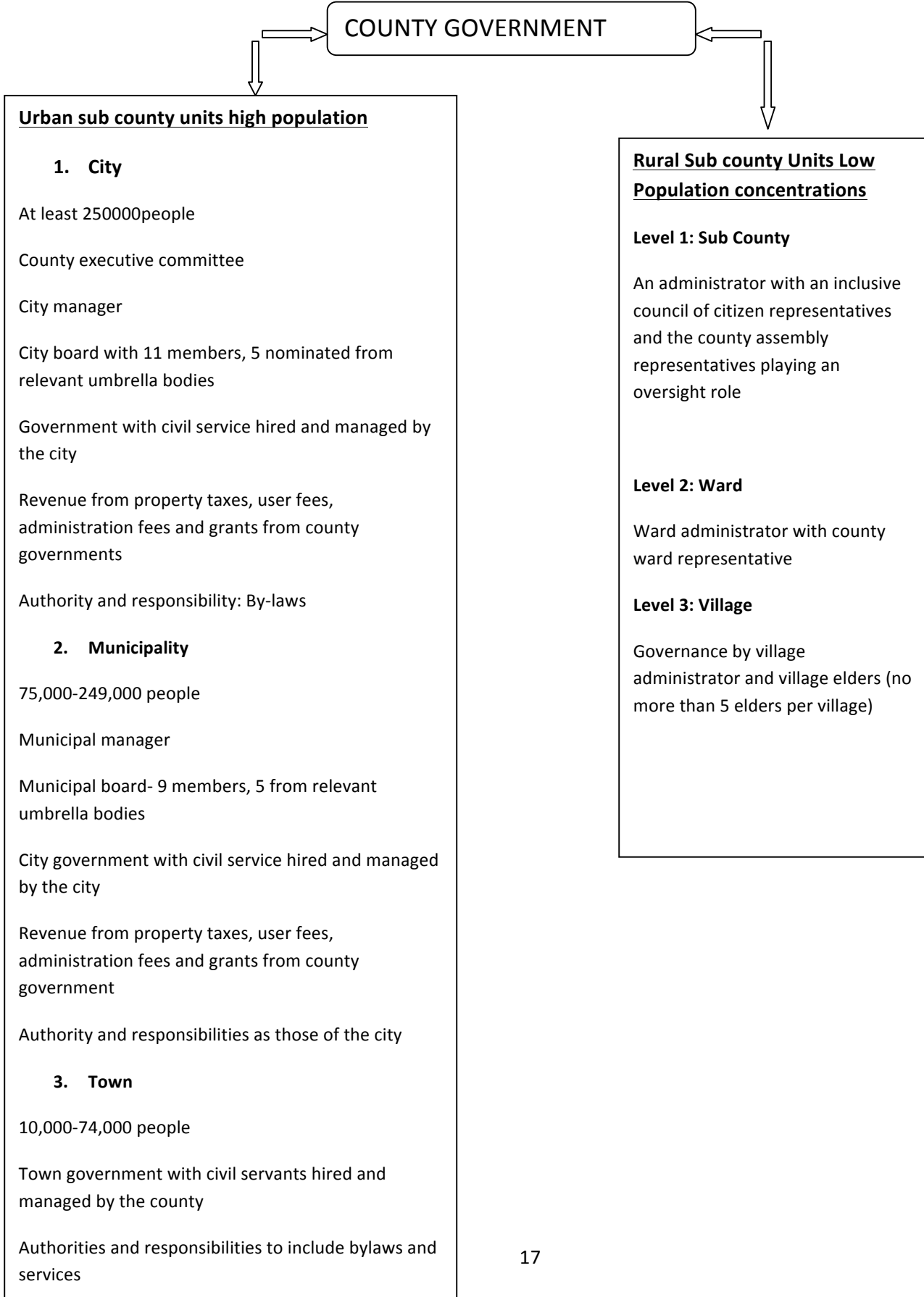
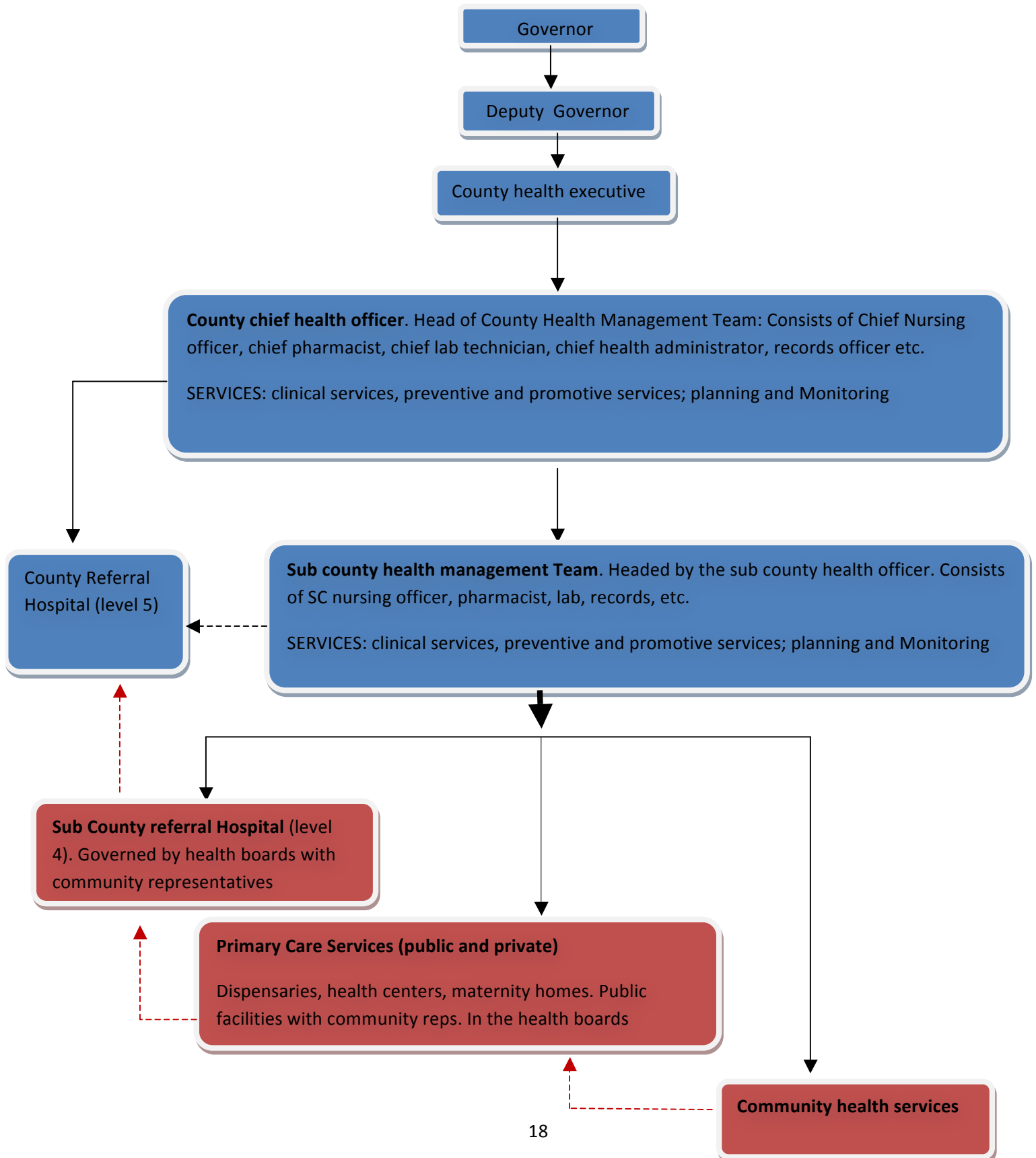


Figure 2: Governance Structure in the County Health System. Source (Adapted from, Kenya Health Policy)



## **Health Service Functions**

Schedule four of the constitution of Kenya has broadly classified the roles of the two governments in respect to health services. The National Government is responsible for development of health policy, management of the two national referral hospitals, capacity building and provision of technical assistance to Counties. County governments are then responsible for operational and infrastructural management and development of all other health facilities and pharmacies. In addition to this is the promotion of primary care, management of sub county and county referral hospitals and ambulance services. Other public health services such as licensure of food vendors, veterinary services and refuse disposal are also functions under the county governments (15,19, and 20). Since 2012 a transitional authority, with a three-year mandate, has been further unpacking these functions so as to better define the roles of both governments.

In regards to the health workforce the national government is mainly concerned with the development of guidelines and standard operating procedures in relation to the recruitment, monitoring, appraisal and professional development of health workers. As such the counties are the main 'executioner' and thus are mandated to ensure that health workers are well managed and perform their duties satisfactorily (20,21). Table 3 further highlights the said roles in detail.

There are many more functions in the devolved government. The ones presented are most relevant in the discussion concerning human resources for health. It is evident from these findings that the county governments have mostly medium to wide decision space allowance. Their relatively wide decision space concerning revenue acquisition essentially means that they should be able to adequately meet the health demands of the population. On the other hand if the financial structures are not well managed, this may not be achieved. As such the fiscal freedom in a sense should go hand in hand with responsibility. Essentially, not much has changed from the previous system of government in matters concerning governance, other than the devolved government presents an opportunity for closer monitoring and supervision. There is a strong level of involvement of community members, through their representation in facility health boards. The advantage is to the citizens as those making decisions are now closer to them. This chapter

has given a background setting that will enable discussion of the main HRH issues in the context of decentralization.

**Table 3: Role of National & County Government in Health Care Workers Management. Source (Oyugi, potential Impact of devolution on motivation and job satisfaction, 2015)**

<b>Service Area</b>	<b>Function Areas</b>	<b>Role of National Government</b>	<b>Role of County Government</b>
Appropriately and equitably distributed health workers (HW)	1. Recruitment of HW  2. Skills and expertise inventory  3. Deployment of HW	-development of required competencies -Provision of overall staffing norms -Guidance on defining facility based norms  -Guidance on required skills for service provision  -Monitoring health worker distribution	-prioritization of staff cadres for recruitment -advertisement, recruitment and payment of HW    -planning and execution of deployment
Attraction and retention of HW	4. HW motivation  5. Monitoring Employee satisfaction	-Monitoring HW attrition -Provide guidelines/sop's <sup>7</sup> for HW motivation -Develop career development SOP's  -Coordinate annual employee satisfaction surveys	-Provision of incentives for hard to reach areas -Apply non-financial incentives to improve HW motivation  -Participate in employee satisfaction surveys -Implement employee satisfaction recommendations
Institutional and HW performance	6. Staff performance appraisal  7. Skills development in Leadership and Management  8. Regulatory framework	-Develop processes and sop's  -Develop curricula  -Develop National	-Implement recommendations from the appraisals  -Train staff in Leadership and Management

<sup>7</sup> SOP: Standard operating procedures

	strengthening	HW regulatory framework	-Develop County Specific by laws for HW regulation
Training, capacity building and development of HW	9. Pre- Service  10. In -service	-Develop training policy guidelines -Manage national training facilities -Guidelines for skills inventories. -Develop Internship Guidelines -Update CPD <sup>8</sup> guidelines	-Train HW's(in service) based on training strategy  - conduct skills inventory for HW's -Manage Interns -Implement and Monitor CPD.

### 3.2 Implications

#### 3.2.1 Change/reorganization of roles and responsibilities

##### ***Who is affected by change in roles:***

Managers usually find themselves having to carry out more than one role and one which is usually out of their job description. It is not uncommon to find that medical staff will have management roles in addition to their medical activities. Moreover this often happens more in rural areas where staff are inadequate (22). Local health managers, therefore, usually acquire new roles and responsibilities following decentralization, more so in devolution.

##### ***What are these additional roles:***

These new roles are usually centred on making sure there is an appropriate personnel structure fitting the decentralized system. It includes hiring the right staff and keeping the pay roll under control. What literature has shown concerning Lower and middle income countries is that the powers to do this differ within countries and even where local managers may have a wide decision space, it is usually limited by budgetary constraints (23). Another role they acquire concerns planning for human resources for health, this may include aspects of coordinating in service training or continuous medical education (CME's) and finding ways to motivate and retain health workers. (24,25).

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<sup>8</sup> CPD: Continuous Professional Development

One new role that some managers face in the wake of decentralization reforms is in the direct hiring of health workers, as has already been mentioned. This role has been seen as empowering and giving the manager an opportunity to recruit health workers in line with the needs of the county/district/hospital. One manager was able to take advantage of her new found responsibilities by directly going to training schools and lecturing to medical students on the benefits of working in her district. Her innovative approach to tackling this new responsibility was rewarded when four new doctors applied to work in her district (26)

Conversely in other settings, managers up to facility level, could not only recruit but also reward, dismiss and punish erring staff. These major policy reforms however came with virtually no guidelines on their implementation, inadequate communication to all involved and lacking structural changes needed to ease the managers into their new roles (27).

### ***Discussion***

Decentralization reforms present managers with new responsibilities but the actual implementation of these responsibilities really will depend on the type of decentralization. In regards to devolution, the decision space tends to be wide (23). It is not enough however to give managers responsibilities without the accompanying enabling tools, such as the required financial or technical resources and skills. Managers need to be adequately prepared for the ensuing challenges following decentralization reforms if the maximum benefits of the reforms are to be enjoyed. The findings have shown that decentralization offers an opportunity for managers to use innovative techniques to fulfil their roles and that don't necessarily require financial input. However it is important to consider that this is a good illustration of intrinsic motivation in a health worker but which can be easily frustrated if support structures are not put in place.

### **3.2.2 Change of accountability structures and relations**

***With Local authorities; an interaction between healthcare workers, managers and local representatives of the decentralized governments***

Tanzania adopted a 'decentralization by devolution' policy in the 1990's. Authority was transferred to Local Government Authorities (LGA's) who formed Council Health Management teams (CHMT). These teams prepare the

comprehensive council health plans which are then reviewed and approved by members of the LGA's full council. It was perceived among health managers in the CHMT that members of the full council, who were not necessarily health professionals, were unable to grasp the technical issues presented in the plans so as to make sound decisions. Technical aspects of the managers' work having to be accountable to non-professionals were perceived as a demotivating factor by the health workers (28). On the other hand there could have been a breakdown in communication between the two parties. Health care workers were probably not able to explain these technical aspects to the council members.

This was similarly the case in Kenya where health workers were apprehensive and felt threatened about non-health professionals having control over resources, planning schedules and monitoring them more closely. As a result they demanded that guidelines and standard operating procedures be developed and followed to the letter to enable them to have faith in the process (29). On the other hand however, the reduction of bureaucratic processes in the implementation of the plans, since they were being done at local level, encouraged and emboldened managers to be more ambitious and independent (28).

In some areas of study in Kenya it was found that local leaders including the top most officer (governor) in the county were frustrating healthcare workers by making "surprise" visits to hospitals and asking patients and other health care workers to name and shame poorly performing healthcare workers (30). However at the same time this was found to be effective in places where there were high incidences of absenteeism (31). These scenarios present the dilemma that healthcare workers are presented with as new accountability relations develop in the context of decentralization. While some improve their performance others threaten it and thus need to be carefully navigated.

***With technical authority:*** *this interaction is mostly between healthcare workers and their technical supervisors. (Ministry of Health, County Health Management Teams)*

Within Kenya there seems to be mixed views on the accountability between healthcare workers and their immediate technical supervisors. Many are

generally pleased with having their technical supervisors closer by as they are more conversant with the issues facing the district/facility. Supervision and monitoring is expressed as being more relaxed and helpful than condemning (32). For some however, these supervisory meetings are not adequate as was expected since the decentralization process (33). It is interesting to note that visits from Central government may have been fewer but this was seen to be normal, so the disappointment expressed is mainly due to unmet expectations, health workers may have wanted more supervisory visits, rather than the need for actual supervision.

Some sub county managers in Meru county, found it difficult to carry out their supervisory duties as they reported not receiving financial resources and vehicles from the County level management team. Others within the same county reported not to have had the same problems, since they put in their plan and budgets in time and regularly followed up with the concerned administration so as to receive what they needed for supervisory visits (33). What is clear here is that in the wake of decentralization some procedures were not clearly set out as they were not formally documented, so those who benefited may have been those who were in regular contact with higher level managers and these would normally be those geographically closer to the headquarters.

It was found that in some instances, top management concerns are different from middle level managers concerns. While the latter may be more concerned with quality of care and keeping patients happy, the former worry more about keeping costs as low as possible, having to deal with the new challenges that the reform process may have presented to them. This causes tension between the two, as priorities often clash (27).

### ***With communities***

One of the apparent benefits of decentralization is to involve communities from the grass root level in decision-making. This is widely appreciated by many health workers who recognize it as widening and enhancing the democratic participation of local communities in matters concerning their health.

Some studies however found that this is a concept that many health workers find difficult to accept and constitutes one of the biggest challenges within



the process. A common feeling among some health workers is that matters of planning and management of health sector activities should be the sole responsibility of experts and not community members. The health workers sighted the fact that they thought that community members did not know their health needs and priorities (30). This may present health workers as being arrogant, as community members usually do have their own perception of needs, however this may differ from the professionals perspective of things. This further brings out the delicate skill of good communication required between the two different parties as earlier pointed out.

In the extent where community associations participation includes being able to hire health workers, accountability is challenged because more often than not they are technically supervised/ report to district managers but also to the community representatives who may feel that they have the right to monitor their work (22).

### ***With private stakeholders/Non Governmental Organizations (NGO'S)/other sectors***

Health managers at all levels do not usually feel obliged to involve private providers/ NGO's in the planning and execution of their health activities, if this activities do not include supervision and monitoring or if they are not in line with the private/NGO's area of interest. With decentralization this scenario has not changed much. This is much the case with other sectors such as health departments or water and sanitation departments, while there exists a forum at sub county level to interact; action is very dependent on the sub county managers' initiative to foster intersectoral collaboration (personal experience).

### ***Relationship between all levels of accountability***

In Mali after having devolution in place for about ten years, different levels of accountability emerged. It was noticed that local governments progressively became the middlemen between clients and service providers. Clients would raise their complaints/concerns, for example absenteeism or harsh treatment, over service providers with their locally elected councillors, who would in turn approach the providers to seek solutions. This was usually done after thorough investigations and in collaboration with the providers and the Ministry of Health. Unfortunately other issues slowly came to

surface, for example: there were some health workers who were directly supervised by the Central Ministry of Health under a special program, but contracted by local governments. They essentially were operating in an accountability vacuum and were reported to be frequently absconding duties (22).

Community associations had the mandate to recruit health workers who could then be dismissed by the local authorities. Similarly the Central Ministry of health could fire doctors hired by local authorities. Having these different lines of authority essentially blurred the accountability structure and threatened the initial aims of decentralization (22).

### ***Discussion***

From these findings, it is obvious that the health worker whether ordinary or manager has become the central player in what is the accountability matrix in the decentralization process. The health care worker (HCW) has to juggle different players at the same time while dispensing her/his duty. The findings show that healthcare workers and managers can thrive and have the opportunity to plan for and implement their duties faster and perhaps more efficiently when interactions between all the accountability levels are well set out and clear.

Probably what is the most challenging aspect is the new relationship with local authorities which did not exist before decentralization. Local authorities are zealous to dispense their duties so as to justify their elective positions to the general public but this may frustrate the health worker if this interaction is too frequent and unreasonable. A HCW should not feel smothered or policed, as this would obviously impede their ability to be effective at their work. Without a clear policy on the accountability structure, HCW's may be left confused as to who to see and for what. It is also evident that as the decentralization process ensues different accountability levels interact, each with their own interests and objectives to meet, the findings show that a clear map showing the different interactions and responsibilities should be one of the priorities, as the reform process continues.

As earlier alluded to, clear communication between different actors within the accountability structure is also essential to ensure that maximum gains are achieved from the different perspectives of the actors.

If superiors or Local authorities are heavy handed, they are likely to stifle creativity and innovation, if HCW's are not adequately prepared to work with communities and their representatives, they are likely to feel that their professional abilities are being undermined. These factors would threaten their sense of autonomy and finally affect their performance.

### 3.3 Consequences

#### 3.3.1 Skills, Knowledge and Attitudes:

##### ***What new skills are required:***

As has been earlier discussed health workers are presented with the possibility of acquiring new roles and responsibilities in the context of decentralization. This often requires that they acquire some new skills, such as writing health plans and budgeting. As reported in one of the studies by a respondent ..... *"developing a council comprehensive health plan is a technical activity requiring people who are knowledgeable and skilled in planning health-related activities, but our staff have not been well exposed to such type of trainings"* (28). Further, it is important for health workers not only to acquire new skills, such as learning how to communicate with non technical people, as discussed in the previous chapter, but to also continuously develop what they already know (23).

##### ***Do decentralization systems maintain, improve or worsen policies in relation to training:***

Local authorities may be better placed to plan and provide tailor made training opportunities for their staff (21) as one study showed that it improved performance in health workers as it served as a motivating factor (34).

In settings where decentralization gave managers of hospitals the mandate to fund and select participants, in service training increased for health workers. The increase however was minimal. In addition, managers tended to select health workers whose training would immediately benefit the facility by bringing in more revenue. As one manager reported *"Last time there was a training course on MCH, I sent nobody to take the training course since it cannot make money for me"* Another unfortunate

consequence was that managers from poorer areas held back training opportunities. This is because they feared that their staff would seek promotion and leave for better paying jobs elsewhere, essentially causing the hospital to lose its investment (27).

In Uganda health workers expressed disappointment in the fact that decentralization did not improve training opportunities, it was found that district administrations (local authorities) did not have enough funds for training of their staff (35). The trainings that were available were seminars which were mostly funded by Nongovernmental organizations and which followed the NGO's interests. There was further dissatisfaction with the selection procedures for the available seminars. Department heads were accused of nominating themselves for the seminars and not following needs based formula. Though this was happening even before decentralization, it could have been amplified further at local level. Health workers also felt that the information given in those seminars was not disseminated adequately. All in all in Uganda; it was felt that decentralization actually led to a decrease in training opportunities (35).

In other cases some local authorities that received the biggest share of their budget from the central government could not prioritize on training following the tight regulations imposed on them, concerning how they were to spend the money (28). Financial limitations were not the only reason for the inability of districts to train their staff but a lack of co-ordination between the two levels of government as was seen in South Africa where important personnel data was not transferred in time from the central government and thereby impeding training programs (36).

### ***Discussion***

These findings show that though decentralization offers an opportunity for training that can meet HCW's needs for the communities they serve, it may not always be the case and most especially in Lower and Middle income countries (LMIC). The findings show the interaction between the type of decentralization, the decision space accorded to the local units and the influence of managers in determining the availability of training opportunities. There is pressure on managers in a devolved system to earn adequate revenue for the hospitals, and thus this will influence which staff they choose to train. On the other hand in a decentralized system where funds may be disbursed but restrictions placed on how to use them, choices

may be made to fund other activities at the expense of training HCW's. Corrupt practices may emerge in decentralization settings where managers are given a wide decision space in HRH issues, without proper oversight or well laid out policy guidelines.

One of the aims of decentralization policies is to ensure equity but from the findings, HCW's in poorer isolated areas do not receive training. This likely leads to poorer outcomes in their patients and the HCW's competence and motivation to work are threatened.

Health care is a constantly evolving subject. When healthcare workers do not get the opportunity to upgrade their knowledge and gain new technical insights they are likely to underperform and lose confidence in their own skills (21).

### **3.3.2 Recruitment, Distribution, Retention and Staff Mix**

#### ***How do recruitment policies change after decentralization?***

Local governments, through decentralization have the opportunity to hire staff from their localities. Health workers resulting from such recruitments are conversant with their environment, have probably settled in these areas so are unlikely to look for other postings as will be discussed later. In some settings, local governments are also able to include incentives such as transportation or housing so as to attract HCW's, however studies show that this applies mostly to lower cadres of hcw's and not the highly skilled such as doctors (22).

The challenge faced by local authorities is in attracting HCW's. For instance, doctors in Kenya express fear that local authorities would be unable to pay them well (37). Conversely nurses do not seem to have such fears, though this could be attributed to the fact that many of them are unemployed (38). It may seem that for highly skilled staff such as doctors richer local authorities end up having an advantage over poorer ones. Firstly, local authorities from more affluent regions could offer candidates more in terms of salary/ allowances. Secondly, prospective employees will naturally lean more to working in cities/ urban towns and not rural areas (27).

Devolving staff recruitment to the lower levels also opens up opportunities for cases of nepotism, where influential members of health boards or politicians have their own people hired, in some cases regardless of whether they are fully qualified. As one manager said of some newly hired staff ".....have no professional knowledge, once they come in, it is very difficult to remove them" (27). This literally leaves very technical aspects of recruitment under the influence of corrupt politicians and makes it very difficult for managers to remedy the situation as they are most often threatened (26). In other settings of decentralization specifically Zambia and South Africa, though recruitment occurs at the district level, confirmation has to be done at a level higher. Limits to recruitment processes are set either by budgetary ceilings or legislature in many decentralized units (36).

In Kenya it is feared that tribalism can come into play during recruitment, with preference being given to employees coming from the communities. This would cause demotivation and loss of well-qualified and proficient health workers previously posted by the central government. Unfortunately this has actually happened in Machakos County where "non-residents" have been forced out (21). As a result there have been calls by the Doctors 'and Nurses' associations to revert the recruitment process back to central government (39).

### ***Does decentralization mean better distribution and retention of staff?***

Issues of equity in distribution of staff that existed in health systems before decentralization seem to be exacerbated by the process. Health workers seeking transfers to their home areas in anticipation of the changes brought about by decentralization, results in under or over staffing in some areas. Further a lack of coordination and communication between central, local governments and other agencies is said to leave the issue of distribution of staff to market economies (36). As will later be presented, issues of distribution are linked to working conditions, salary payment and other myriad of factors culminating in health workers choosing to work in richer areas.

Issues of retention are also closely linked to working conditions as will be examined later. There seems to be a consensus within the literature that

once good working conditions are in place and salaries are paid on time, staff stay in their posts. More so if they apply and are recruited in their desired locations (40). In other settings, it is shown that if local authorities are able to retain experienced staff after decentralization, it results in good health outcomes (35).

### ***How is staff mix influenced by decentralization?***

Staffing mix, as a direct consequence of decentralization is not convincingly evidenced within literature covering developing countries. It has however been reported that it occurs as a result of other health initiatives. For example due to shortage of doctors, South Africa has developed the cadre of nursing practitioners, who are able to diagnose and treat patients at primary care level, and refer when necessary (41).

Studies show that some local authorities are unable to get qualified staff within their jurisdictions because of inadequate funds from central government and an inability to collect revenue to pay for the health workers that they need. Consequently it results in questionable practices; for example, some local officials employ community health workers (who are usually relatives) with no formal training at all to work in lower level health centers (36).

On the other hand, decentralization systems can offer managers an opportunity to apply nonconventional solutions to address their community's health concerns. Case in point, in one of Kenya's most remote sub counties, a sub county manager having been frustrated by the lack of health workers due to security concerns, trained a local young man with secondary education on first aid and basic wound management. The young man was then appointed to work at a health centre, which had no health staff at all. He could offer first line care to local community members who frequently presented with wounds received from cattle rustling related attacks. The young man would then call for an ambulance for very serious cases having been provided with a mobile phone. (Report from a Sub county Health Manager, Turkana County). Though an action such as this one seems highly irregular, it may be an acceptable response for that particular situation.

### ***Discussion***

These findings by and large show that decentralization systems in LMIC have not yielded the expected results in addressing issues of availability of HRH. In fact, they seem to worsen these issues. HCW's are not confident that their needs will be met in the new system due to the potential of patronage systems being developed under the influence of politicians, and as well as different local authorities having their own rules and regulations, leading to inequalities. On further analysis the latter may come at an advantage to the HCW, as they are now able to seek employment in their home areas, or in an urban setting where there are more opportunities.

Recruitment procedures under decentralization tend to be competitive, and this may act as a catalyst for HCW's to improve their skills or further their training to improve their chances of employment in competitive counties. This eventually means a mass of competent HCW's can be achieved in certain regions, thereby enabling an environment that can potentially provide quality healthcare. Unfortunately, this may lead to unequal distribution of HCW's throughout the entire country. Rural areas have less training and continuous medical education opportunities. As earlier discussed, poorer areas will only get poorer if local authorities cannot offer HCW's good employment terms.

Another issue affecting local authorities' (LA) ability to ensure availability of staff is the degree to which decentralization allows them. LA's can employ the staff they need but require confirmation from central government. Though they will be able to choose the most suitable candidates, the bureaucracy and arduous procedures synonymous with central ministries can dilute these advantages, by creating staff shortages as HCW's wait for confirmation, or are lost to other organizations such as private facilities or NGO's.

### **3.3.3 Job security; Working Terms and Conditions; Remuneration**

#### ***Real/perceived threats to job security***

It has been shown that health workers are increasingly motivated and perform well when their jobs are well defined as they are able to objectively measure their progress (42). The process of decentralization seems to threaten this.



One study shows that although government guidelines are usually in place concerning staff job descriptions and terms of service, they are not being adhered to within local authorities after decentralization. To remedy this situation district service commissions are usually formed. Health workers however complain that despite these measures they are still unclear about their terms of service. Many cannot distinguish whether their responsibilities fall under central or district health services. It is the general feeling among health workers that decentralization has not improved employment terms but rather encouraged unequal working terms among colleagues at the same level/working grade. For instance, the government policy is to confirm and promote employees as a means of motivation. If an employee is not confirmed they usually receive lower wages and are illegible for pension after retirement. Following decentralization, HCW's that are still under central government could be confirmed, however those under local (district) authorities are not confirmed, as district service commissions that are responsible for this have not yet been formed. In other districts financial constraints are blamed for the non-confirmation of health workers. In others Hcw's who are confirmed do not receive communication on the changes and their wages do not reflect their new status. Suffice to say this causes immense stress and frustration on health workers concerning their job security (35).

### ***Does decentralization improve the working environment?***

In some cases reforms have been shown to improve the working environment, through supervisory visits. Health workers report that supportive supervision from superiors that work within their localities fosters learning between colleagues. Their immediate supervisors are perceived to be more understanding and can identify with their challenges. This is a far cry from national level supervisors who are seen as blaming and shaming rather than helping (43). However, local authorities that lack resources such as vehicles, or have vehicles that are poorly maintained or have inadequate staff to carry out supervisions are not able to meet this need. Health workers in these areas are therefore unable to receive the support that they require (28).

Furthermore, following decentralization, local authorities and in many cases, those in the rural, remote areas are not able to attract potential employees, especially the young, to their health facilities due to lack of staff housing, ample security and amenities such as electricity and water. Employees in rural facilities cite frustrations due to lack of equipment and medication which is essential in carrying out their duties. Moreover those in lower facilities tend to carry out dual roles (attending to patients and also dispensing medicine) they remain pessimistic about the process as no tangible improvements are felt. It is interesting to note as will later be shown that one of the reasons given for this problem is that newly elected politicians under the decentralized system, push for the establishment of more dispensaries. This is usually done without accompanying additions to staff numbers. Therefore those already working have to bear the increased workload(34).

In Kenya, one study shows that half of the health workers in Garissa county want to leave the county as conditions are harsh (Garissa county borders Somalia and has been grappling with recent Al Shabab attacks) and they are far away from their homes. They also want to work in a place where they can earn an extra income, communicate better with patients, and have further study opportunities which are not readily available within the county (42). The issue here is that after decentralization, they fear that seeking transfers or opting to leave may prove more difficult than before. Many are of the view that their work would improve if they could transfer to their home counties, where they will be accepted (38).

### ***How has decentralization changed remuneration structures?***

In some cases, in the context of devolution, smaller local authorities that do not manage a large number of staff, are able to structure and regulate their payment systems well, thus avoiding delays in disbursement of salaries(38).

Other decentralization policies that give district and hospital managers a wide decision space enable them to offer financial incentives, in the bid to improve health workers performance. One such system is a bonus program where a percentage of surplus funds, from health facility revenue can be evenly distributed among health workers. In one highly devolved setting, managers were able to do this and further carve out a smaller percentage of the surplus and give it as a reward to well performing staff. Managers in

institutions could further implement a type of salary scheme for their employees which constituted of a fixed component and another component that would be performance related. In this particular case health workers reported being motivated to work, so as to attract more income. This system however attracted a lot of abuse from unscrupulous managers and health workers who overprescribed medicines and compromised the quality of their work. Suffice to say these particular reforms were eventually ceased (27).

Local authorities in Uganda have the mandate to create and abolish posts and set their own allowances though they are to stick to a standardized pay scale, despite this they faced a lot of challenges concerning salaries and allowances when decentralization was effected (45). Though it has always been a problem, the reforms worsen the situation. Nurses working in hospitals and other health workers who are seconded receive salaries from the central government. District health workers received salaries from local governments and some cadres such as nursing aides received salaries from user fees collected in the facilities (35). As was the case in Kenya in 2012, where nurses under the national public service commission received higher allowances than same cadre nurses hired under the local economic stimulus program (38). Because of these different lines of administration, many health workers especially those under local authorities experience salary delays of even up to 36 months. This has been mostly attributed to local administrators being confused by the salary payment system, as well as lack of financial resources to some degree (35).

In Kenya nothing has caused more friction in the decentralization process than the issues of salaries. There are reports on salary delays or lack of salaries altogether from various counties around the country. This has led to strike threats and actual strikes, with one case from Nakuru County where 5,000 health workers threatened to down their tools. Counties have been blamed for mismanaging funds at the expense of health workers (46). In the County of Wajir, health workers report that County officials are not willing to listen to their grievances concerning salaries and allowances but seemed to be more interested in building dispensaries and health centres for political mileage, which prompted them to strike and thereby cripple health services (47). Doctors have taken even more drastic measures with 200 having been confirmed to have resigned and sought greener pastures in private and non-governmental institutions (29). To date unconfirmed reports from officials of

the Kenyan Medical Practitioners and Dentists union state that approximately 500 doctors have resigned from public service.

### ***Discussion***

From the findings, the process of decentralization potentially threatens HCW's ability to be responsive. Hcw's are not able to focus on their duties but rather worry about their state of employment. Decentralization itself as a system may not cause this but rather the transitioning period from central authority to local authority. Having different lines of administration of HRH issues such as employment confirmation and salary payments, without coordination between central authority and local authority shows a gap in governance structures. This gap is also evident in relations between political representatives and technical representatives of local authorities. A lack of coordination between the two entities may lead to making decisions which are noble, but not well informed. Unfortunately, it is the HCW who has to bear the consequences. Though intentions may be good on both sides, without proper communication and preparation of HCW's on expected challenges, or the ensuing changes, Hcw's are left in a very precarious state, where they are likely to be dissatisfied, which eventually affects their performance.

Decentralization, specifically devolution gives local authorities autonomy to set Hcw's salaries and allowances. As has already been shown where local authorities are dealing with a small number of Hcws, few problems arise. Most likely due to the fact that the administrative processes are easier to manage. On the other hand, even when central governments attempt to regularize salaries for all employees by setting out standardized payment guidelines, the findings show that many local authorities are unable to pay their health workers on time and well enough. A balance needs to be reached between autonomy of local authority and the capability of human resources management personnel in carrying out their administrative duties. When this is achieved, local authorities are able to critically appraise their limitations and seek solutions. Autonomy also opens the door for corrupt practices which threaten the aims of the decentralization process. It is not that these practices are new but are rather amplified in decentralized systems.

Hertzberg in his work concerning motivation, showed that people are unhappy at work if the environment is bad in as far as physical conditions, interpersonal relations, organizational policies, job security and salaries are concerned. This dissatisfaction is likely to make them want to leave (44). The findings above seem to reflect this, however they are not caused by decentralization but rather exacerbated by the transition period, as change often causes anxiety. The perception that HCW's have towards the reforms only seems to worsen conditions that are already bad. This further shows a lack of communication between vertical authorities and HCW's. Another issue that is brought to light is the vulnerability of marginalized communities in the process of reforms. Decentralization though postulated to improve such situations in itself cannot do so without the requisite investments and resources and more so in poorer areas so as to ensure equity.

### **3.4 Summary of Challenges**

The following challenges emerged as the main issues to consider in reviewing how other countries have responded to human resources for health issues in the context of decentralization.

- i. Lack of clear accountability structures during the decentralization process.
- ii. Lack of proper communication to health care workers of the expected changes.
- iii. Inability of local authorities to coordinate or undertake HRH management functions such as salary payments, or improve working conditions, either due to financial limitations or inexperienced administrative personnel.
- iv. Potential to further marginalize HCW's in low resource settings.

## **4 What can Kenya Learn: Selected Countries**

The Philippines and Mali have been selected because of their unique approaches to devolution while the Philippines experienced a lot of challenges at the beginning; their commitment to make devolution work amidst calls of recentralization is worthwhile to look at. Mali's community centred approach also offers valuable lessons for Kenya to pick up.

### **4.1 Philippines**

Philippines is an Eastern Asia country of middle income status that instituted decentralization by devolution in 1991. These two reasons make it an interesting case study in relation to Kenya's process of decentralization.

They have several levels of local governing units: Villages which are primarily in charge of primary health care services, Cities and municipalities in charge of primary level health facilities, Provinces in charge of secondary level facilities and finally the central government which is responsible for tertiary facilities and specialty hospitals. Each tier of government is overseen by the local chief executive; governor / mayor/ captain corresponding to the three lower levels, mentioned above. As far as human resources for health is concerned the local governing units can hire, fire, and promote staff. They have full control over dismissal of surplus staff, promotions, transfers within local government units, directing and supervising activities, evaluations, setting incentives and allowances. They can only partially determine wages that are set centrally. Discipline is also a shared responsibility with the central government. With this fairly wide decision space over human resources local leaders are encouraged to develop innovative solutions to meet their communities needs (48).

One year after devolution the main challenges that the Philippines experienced were: unmotivated staff, resignation of experienced and key personnel, patronage, underfunding and worsening of health outcomes in poorer areas. The Philippines attitude to these challenges was to make devolution work and not revert to the older system as many critics, at that time had suggested (49).

### ***Formation of Inter- Local Government Unit's health system***

This was formed by the League of Governors under presidential approval and subsequent legislation. Governors or their representatives, use this platform to build their capacities in understanding the health system, it also acts as an accountability forum. Representatives of the LGU's are equal partners in this collaboration and they set their own terms of operation (49). As a result LGU's can share best practices, approach to challenges and ensure that all stakeholders in the healthcare system are treated in an equitable way.

### ***Increasing revenue source***

One Governor was able to institute a form of socialized payment mechanism for health services. In this model community members paid hospital fixed charges based on their income. As a result hospital revenue increased. With the extra revenue, facilities were upgraded and much needed equipment was bought. It further ensured a constant supply of medication and other non-pharmaceutical products. Health worker performance improved as conditions had improved. It also enabled the addition of health services as demanded by clients and thus ensuring allocative efficiency and responsiveness (50).

### ***Capacity Building***

Training was essentially a central government responsibility; this meant new recruits preferred to stay within cities or in the employ of central government, as pay was better. This made it very difficult for LGU's to meet their need for skilled individuals. To meet this challenge LGUs instituted extensive local trainings, as a way to attract and retain health workers. In partnership with the central government doctors were recruited on a temporary basis of about two years with very high pay, as an incentive to work in rural areas and offered an attractive package as well as incentives such as accommodation by the local governments (48).

## **4.2 Mali**

Mali's model of decentralization emphasizes heavily on community participation. In regards to healthcare there are two distinct decentralized systems.

The first one initiated in the 90's mandates the management and financing of primary healthcare clinics covering a radius of about 15kms, to community health associations. Members who serve in these associations are duly elected by citizens. In 2002 decision making power was then transferred to devolve locally elected governments. These two systems function separately but they each nominate representatives who sit in the commune health commission that discusses health programs.

Local governments are responsible for HRH management while training and supervision are under the jurisdiction of District Health Management Teams.

### ***Community participation***

Mali has a well-established foundation in community based development approaches. Communities readily participate and even finance development initiatives. The involvement of locally elected officials, taking precedence over technical experts, in the community health associations shows confidence in community structures at operational level.

### ***Capacity Building***

Mali invested heavily in training during the decentralization process. The uniqueness of the training model was that it included all the stakeholders involved in the process. Health workers, community members, local political leaders and policy makers. They were able to recognize that decentralization presents stakeholders with changing and new responsibilities and as such adequate preparation is paramount so as not to undermine the process. Further, the training modules were aligned to the existing healthcare functions such as planning and supervision, maternal audits etc. Apart from reducing costs, and building a sense of ownership, it enabled new players such as local authorities understand what healthcare workers do and as such be more aware when making decisions (22).

## **Discussion**

### **Lessons that Kenya can learn**

There have been calls from health care workers and politicians in Kenya to recentralize Health care, due to the many challenges being experienced during this transition period as has earlier been shown. Local authorities have been blamed for misusing funds and thus not being able to pay health care workers salaries, or improving working conditions. It was earlier shown that counties are spending far less on health than even what the National Government used to spend, and thus would be unable to invest adequately in health. What Kenya can pick from the Philippines and Mali, is the firm commitment to make devolution work, by improving accountability mechanisms and investing in healthcare and most specifically HRH.



For decentralization to work a good accountability structure is undoubtedly required. The formation of the Inter- Local government units health system in the Philippines, aims to do this. Horizontal accountability between local authorities can contribute to equitable healthcare in a decentralized country. The potential sharing experiences as well as ensuring that the provision of health services in one region does not differ from another, can create uniform gains. Health care workers as part of the general health system stand to benefit from this.

Giving autonomy to local authorities without accountability undermines transparency and therefore can lead to corrupt practices (51). The benefits of giving local authorities wide fiscal decision space is also further illustrated in the case of the Philippines. Having adequate financial resources is necessary to ensure an available and responsive health workforce. Decentralization offers local authorities an opportunity to meet these needs through introducing innovative solutions. This can work only if accountability mechanisms are strong enough to hold these local authorities responsible for their actions, as has been mentioned.

Accountability at community level has been well illustrated by Mali's example. The obvious benefit to extensively involving communities is that allocative efficiency can well be achieved, as resources are directed to the particular needs of the community. Healthcare workers are then able to focus their activities to the demands of their communities, thus making them more responsive.

In both the Philippines and Mali, strong emphasis has been placed on building the capacity of Healthcare workers and other stakeholders. This is essential in preparing all that are involved in the new roles that they will acquire. It further gives health workers a sense of confidence in what they are doing. Improving health workers competencies can ensure that quality health care is given. This however yields the maximum benefit if accompanied by managerial aspects, specifically supportive supervision, monitoring and giving feedback (52).

## 5 Conclusion

Decentralisation, as earlier mentioned, aims to improve efficiency, quality of service and accountability at local level. This paper has shown that this has been achieved to some extent in some settings and not so much in others. There is however little evidence to support that decentralization itself is directly responsible for some of the achievements, nor always responsible for all the shortfalls. What it has shown is that it amplifies issues concerning HRH that already exist. Conversely, it also creates an environment where known interventions and best practices can be implemented faster and more efficiently since they are being done at a smaller scale.

Countries responses to challenges have shown that decentralization can work with commitment from political leaders and good accountability structures. These structures should however be more inclusive with participation of health workers encouraged. What this literature review has identified is that though decentralized systems attempt to define accountability mechanisms, the role of the health care worker is merely as a performer, with the local authorities and communities acting as watchdogs. HCW's roles need to be more participatory, they are in the unique position of not only knowing the communities they serve but potentially having the best solutions to meet these communities' health problems.

Decentralization systems that give local authorities substantial autonomy in HRH management and fiscal matters can potentially address HRH matters, pertaining to health workers availability, responsiveness and competence. Working conditions can be improved, resources to support supervision and monitoring as well as investments in medical equipment and medication and not merely the payment of salaries and allowances. This consequently makes it easier for local authorities to attract and retain healthcare workers.

Health care worker's performance can be affected both positively and negatively by the decentralisation process. A balance needs to be reached between containing the problems that existed before the reform process and instituting HRH changes. This review suggests that good accountability structures, meeting motivation and hygiene factors and involvement of healthcare workers in decision making forms a good foundation for HRH functions to fully realize their intended outcomes.

## **5.1 Future Research**

This study though a literature review, may yield more focused and specific results if it is done in a qualitative manner. Responses through focus grouped discussions and in depth interviews from health care workers, managers and other stakeholders in Kenya would produce a much richer body of work.

## **5.2 Recommendations**

These recommendations have been made considering Kenya's challenges in the face of decentralization. Even within the country itself the different counties have unique HRH issues, but this has been taken into consideration and thus the recommendations presented can be implemented by all:

Kenya has Council of Governors quite similar to the one mentioned in the Philippines, but it does not specifically address health system issues. This forum should be used by Governors to set out standards that should be met by all Counties in the provision of Healthcare and furthermore in ensuring Human Resources for Health Matters are addressed. It should provide a platform for exchanging ideas, learning from those who are doing well and supporting those that may be left behind. It will serve the purpose of ensuring that equity can be attained across the entire country. Participation should include the County Executives for Health.

The Kenya Human Resources for Strategy plan has already set out very good strategies and interventions, to address the Human Resources for Health challenges within the Country. Counties should use this plan as a blue print to address their specific challenges. Not all health executives in the counties are health experts and as such, the use of this strategic tool would serve as a good guide.

A combination of good training, supervision, monitoring and feedback plan should be set. This has been proven to be one of the most effective ways of improving health care workers performance (52). Counties should ensure first and foremost that Sub county Health Management team members are well trained and motivated in Health Service Management issues. I propose two approaches: healthcare workers such as doctors/clinical officers/nurses who are interested in management matters, should be given posts that reflect this. Conversely healthcare workers who are more interested in

clinical matters should be encouraged to focus on that. This will clearly set apart Healthcare workers who are intrinsically motivated to perform management tasks, from those who are more inclined to perform better in clinical activities. The second approach would be to ensure that all existing managers who wish to continue with managerial duties should be well trained and continually updated. The Kenya school of Government has a good management training programs that counties can utilize. Further collaboration with Ngo's such as Management sciences for health that train managers can be instituted. Competent Sub County Health Managers would then be able to disseminate this training to other health workers, supervise, monitor and act on feedback received.

NGO's and Private provider's representatives should be represented in Sub County Health Management Teams. Currently only representatives of faith-based organizations are regularly represented in facility health boards. This should be a priority for all counties. These public private collaborations not only enhances accountability but also helps all stakeholders involved within sub county units to remain focused on issues concerning their communities.

Kenya through the Public Service Commission has already standardized healthcare workers salaries and allowances that should be paid by County Governments. However County governments are free to offer non-financial incentives to increase health worker motivation.

From personal experience as a Sub County Manager for Health one of my biggest challenges is to get healthcare workers to go work in remote areas. Counties should provide motorcycles for HCW's in hard to reach areas, mobile telephones and proper housing. Previously, regulations limited the type of housing that one could build, material was expensive and thus construction of staff houses could not be done easily at District Level. Regulations have now eased to include local materials such as earth blocks in the construction of durable and modern housing, at a fraction of the price. Counties should take advantage of these new opportunities and develop guidelines giving Sub County and Primary Care facilities freedom and financial support in constructing houses for their staff members. This can be achieved if counties strive to increase their expenditure on health. To be at par in the provision of health services with other middle-income countries, such as Costa Rica, Chile, China or Cuba, counties need to increase their

General health expenditure as a percentage of their general expenditure to at least 10%.

## References

1. Kenya National Bureau of Statistics. Population and Housing Census 2009 volume 1a, volume 1b, volume 1c, volume 2. Kenya: KNBS; 2009.
2. Kenya National Bureau of Statistics. Kenya Facts and Figures. KNBS; 2015.
3. The World Bank Group .Kenya .A Bigger Better Economy [internet]. World Bank Group; 2015; 2015/18/08. Available from: <http://www.worldbank.org/en/news/feature/2014/09/30/Kenya-a-bigger-better-economy>.
4. Ministry of Health. National Guidelines for the Implementation Of Primary Health Care in Kenya. Kenya: Government of Kenya; 1986.
5. World Health Organization. World Health Statistics 2015. Luxembourg: World Health Organization; 2015.
6. Republic of Kenya. Health Sector Strategic and Investment Plan. Ministry of Medical Services and Ministry of Public Health and Sanitation; 2013.
7. Green A. An Introduction to Health Planning in Developing Countries. Oxford: Oxford University Press; 1999.
8. Otieno MO. An assessment of Decision Space and District Health Care Sector Performance Following Decentralisation In Kenya. KIT Development Policy&Practice/Vrije Universiteit Amsterdam; 2009.
9. The world bank group. Decentralization and Sub National Regional economics[ Internet]. WorldBankGroup;2001[2015/08/18]. Available from: <http://www1.worldbank.org/publicsector/decentralization/what.htm>.
10. Alande JO. The Role of Human Resource Management in Devolution of Countries in Kenya: A case study of Mombasa County. International Journal of Social Sciences & Entrepreneurship. 2013; 1(3): 568-582
11. Conversation with a Sub County Health Manager(2015).
12. Franco L, Bennett S, Kanfer R. Health sector reform and public sector health worker motivation: a conceptual framework. Social Science & Medicine. 2002; 54(8).
13. Dieleman M, Gerretsen B, Wilt G. Human resource management interventions to improve health workers' performance in low and middle income countries: a realist review. Health Res Policy Sys. 2009; 7(1):7.
14. Bossert T. Analyzing the decentralization of health systems in developing countries: decision space, innovation and performance. Social Science & Medicine. 1998;47(10):1513-1527.
15. Republic of Kenya. The Constitution of Kenya: National Council for Law Reporting; Revised 2010.
16. Devolution and The Health System In Kenya. Nairobi; 2012.
17. KPMG Services Limited. Devolution of Health Services in Kenya. South Africa: KPMG Services Limited; 2013.21p.
18. Hope K. Devolved Government and Local Governance in Kenya. African and Asian Studies. 2014;13(3):338-58.
19. Republic of Kenya. Kenya Health Policy. Ministry of Health; 2014.
20. Republic of Kenya. Health Sector Strategic and Investment Plan. Ministry of Medical Services and Ministry of Public Health and Sanitation;2012.

21. Oyugi BO. Potential impact of Devolution on Motivation and Job satisfaction of Healthcare Workers in Kenya: Lessons from early implementation in Kenya and experiences of other Sub-Saharan African Countries. *The Journal Of Global Health Care Systems*. *The Journal Of Global Health Care Systems*; 2015;5(1).
22. Lodenstein E, Dao D. Devolution and human resources in primary healthcare in rural Mali. *Hum Resour Health*. 2011;9(1):15.
23. Kolehmainen-Aitken, R.-L. Decentralization's impact on the health workforce: Perspectives of managers, workers and national leaders. *Hum Resour Health* **2**, 5 (2004).
24. Kolehmainen-Aitken R-L: Decentralization and human resources: implications and impact. *Human Resource Development Journal* 1998, 2(1):1-1
25. Buchan J: Health sector reform and human resources: lessons from the United Kingdom. *Health Policy and Planning* 2000, 15(3):319-325.
26. Munga M, Songstad N, Blystad A, Mæstad O. The decentralisation-centralisation dilemma: recruitment and distribution of health workers in remote districts of Tanzania. *BMC Int Health Hum Rights*. 2009;9(1):9.
27. Liu X, Martineau T, Chen L, Zhan S, Tang S. Does decentralisation improve human resource management in the health sector? A case study from China. *Soc Sci Med*. 2006;63(7):1836–45.
28. Frumence G, Nyamhanga T, Mwangi M, Hurtig A-K. Challenges to the implementation of health sector decentralization in Tanzania: experiences from Kongwa district council. *Glob Health Action*. 2013;6.
29. Kibet L. Crisis looms as 200 doctors resign [internet]. Nairobi: The Standard; 2014; 31/07/2015. Available from: <http://www.standardmedia.co.ke/health/article/20001068/crisis-looms-as-200-doctors-resign>
30. Okewo E. County Chiefs read riot act to health workers [internet]. Nairobi: Daily Nation; 2014; 31/07/2015. Available from: <http://www.nation.co.ke/counties/Nairobi/Governors-warn-health-workers/-/1954174/2350618/-/rghg59z/-/index.html>
31. Okwany R. Shortage of health workers cripples Coast hospital services [internet]. Nairobi: Daily Nation; 2013; 31/07/2015. Available from: <http://www.nation.co.ke/counties/Mombasa/shortage-of-health-workers-cripples-hospital/-/1954178/1962470/-/4y1pbs/-/index.html>
32. Conversation with Kenyan healthworker; A Meru County Records Officer (2015).
33. Conversation with a Nursing Manager in Meru County, Kenya (2015).
34. Zinnen V, Paul E, Mwisongo A, Nyato D, Robert A. Motivation of human resources for health: a case study at rural district level in Tanzania. *Int J Health Plann Manage*. 2012;27(4):327–47.
35. Kyaddondo D, Whyte S R. Working in a decentralized system: a threat to health workers' respect and survival in Uganda. *Int J Health Plann Manage*. 2003(18): 329-342
36. Wang Y, Collins C, Tang S, Martineau T. Health systems decentralization and human resources management in low and middle income countries. *Public Admin Dev*. wiley; 2002;22(5):439–53.
37. Nyassy D. Doctors shortage hits Coast Hospitals [internet]. Nairobi: Daily Nation; 2012; 31/07/2015. Available from: <http://www.nation.co.ke/counties/Doctor-shortage-hits-Coast-hospitals/-/1107872/1447240/-/j5miae/-/index.html>

38. Njuguna, J., Mwangi, P. & Kamau, N. Incentives among Health Workers in a Remote Kenyan District: Implications for Proposed County Health System. *Journal of Health Care for the Poor and Underserved* **25**,204214 (2014).
39. The Standard. Solve health sector impasse on Devolution[internet] . Nairobi: The Standard; 2015; 31/07/2015. Available from: <http://www.standardmedia.co.ke/article/2000162607/solve-health-sector-impasse-on-devolution>
40. Luboga S, Hagopian A, Ndiku J, Bancroft E, Mcquide P. Satisfaction, Motivation; and intent to stay among Ugandan physicians: a survey from 18 national hospitals. *International Journal of Health Planning and Management*. *International Journal of Health Planning and Management*; 2011 Apr 2;26:2–17.
41. Geyer N, Naude S, et al. Legislative issues impacting on the practice of the South African nurse practitioner. *Journal of America Academic Nurse Practice*. 2002 **14**(1): 11–15.
42. Ojaka, D., Olango, S. & Jarvis, J. Factors affecting motivation and retention of primary health care workers in three disparate regions in Kenya. *Hum Resour Health* **12**, 33 (2014).
43. Saide MA, Stewart DE. Decentralization and human resource management in the health sector: a case study (1996-1998) from Nampula province, Mozambique. *Int J Health Plann Manage*. 2001 Jan 1;16(2):1
44. Hertzberg F, Mausner B, Synderman B. *The motivation to work*. New York: Wiley; 1959.
45. Feilden R, Nielsen OF. *Immunization and health reform: making reforms work for immunization*. Geneva: World Health Organization; 1998. WHO/GPV/EIP Draft Report #3.
46. Tinto V. Full state of the Nation address by President Uhuru Kenyatta [internet]. Nairobi: news24kenya ; 2015; 31/07/2015. Available from: <http://m.news24.com/Kenya/MyNews24/County-employees-threaten-to-strike-over-salary-delays-20150202>
47. Wajir Times. Wajir hospitals in shutdown as County health workers strike[internet]. Wajir: Wajir Times;2015;31/07/2015. Available from: <http://www.wajirtimes.com/news/wajir-hospitals-in-shutdown-as-county-health-workers-strike/>
48. The World Bank. *East Asia Decentralizes. Making Local Government Work*. Washington: The World Bank; 2005.
49. Grundy J, Healy V, Gorgolon L, Sandig E. Overview of devolution of health services in the Phillipines. *the International and Electronic Journal of Ruraland Remote Health Research, Education, Practice and Policy*. *the International and Electronic Journal of Ruraland Remote Health Research, Education, Practice and Policy*; 2003 Jun 1;3.
50. Galing K. *The Phillipine Case Bank on Innovation and Exemplary practices in Local Governance*. Pook Foundation; 2001.
51. Dieleman M, Shaw D, Zwanikken P. Improving the implementation of health workforce policies through governance: a review of case studies. *Hum Resour Health*. 2011;9(1):10.
52. Rowe, A., Savigny, D., Lanata, C. & Victora, C. How can we achieve and maintain high-quality performance of health workers in low-resource settings?*The Lancet* **366**, 10261035 (2005).



53. Ochiel JD. Highlights of the County allocation Revenue act[internet]. Nairobi: Laws of Kenya; 2015/08/09. Available from: [http:// www.kenyalaw.org/kenyalawblog/highlights-of-the-country-allocation-of-revenue-act-2013/](http://www.kenyalaw.org/kenyalawblog/highlights-of-the-country-allocation-of-revenue-act-2013/).
54. World Health Organization. Global Health Observatory Data Repository[internet]. Geneva: WHO ; 2015. Available from: <http://www.apps.who.int/gho/data/node.main.75>
55. Commission on Revenue Allocation. County Budgets 2013-2014: Nairobi: CRA; 2013/08/12.