Nursing Human Resources in Kenya: Case study
Nursing Human Resources in Kenya

Case Study

Developed by Chris Rakuom

for the International Centre for Human Resources in Nursing

International Council of Nurses

Florence Nightingale International Foundation
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About this Paper

This paper is one in a series of documents developed for the International Centre for Human Resources in Nursing (ICHRN). The series aims to explore nursing human resource issues and offer policy solutions.

Launched in 2006 by the International Council of Nurses (ICN) and the Florence Nightingale International Foundation, the Centre is dedicated to strengthening the nursing workforce globally through development, ongoing monitoring, and dissemination of comprehensive information and tools on nursing human resources policy, management, research and practice.

About the Author

Chris Rakuom is Chief Nursing Officer (CNO) in the Ministry of Medical Services in Kenya, a post he has held since 2006. Between 1980 and 1996 he worked in a variety of clinical posts in two district and three provincial hospitals in Kenya. In 1996 he moved to the Ministry of Health Headquarters, where he served in various capacities before taking up the CNO post. His clinical nursing education (RN, Dip. Midwifery and Dip. Intensive Care Nursing) was undertaken in Kenya; his BScN was from the American World University, and Certificates in Health Service Management from Birmingham University, UK, and Global Health Action, USA.

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Executive Summary

This report for the International Centre for Human Resources in Nursing (ICHRN) aims to outline the composition of the nursing workforce in Kenya, including recent trends and dynamics, and describes the involvement of stakeholders, both within and beyond Kenya, in the development of nursing and the nursing workforce.

Kenya’s case is unique. Over the past decade, it has been reported that there are over 7,000 unemployed nurses. Over 1,300 new nurses graduate annually from local colleges. At the same time, almost every functional health facility is understaffed with over 500 of Kenya’s 2,122 (2007) dispensaries throughout the country did not have a single nurse. In addition, an average of 500 nurses have been retiring annually at age 55 and between 300-400 nurses migrate abroad annually.

Key factors responsible for shortage of nurses at service delivery points include fast-expanding health care delivery network that also experiences inadequate recruitment and maldistribution of staff. Contributing to the shortage are an aging nursing workforce, lack of proper workforce planning that includes skills analysis and distribution, and lack of up-to-date, accurate and comprehensive data sets to assist in remedying the workforce planning situation.

The response to these challenging trends in recruitment, training, and retention of staff has involved a range of policy developments including Vision 2030 (a national economic blueprint), and the Kenya Essential Package for Health (KEPH) that defines health delivery modes, and which will contribute to healthy living among various population groups in the country.

The health reform agenda in Kenya is noted with specific reference to decentralisation and the recent re-structuring of the Ministry of Health (MoH). As well, through the new Strategic Plan for Nursing, a new Scheme of Service for Nurses is being developed to enhance career progression, and to promote motivation and retention in the nursing workforce.

Recommendations of this Case Study echo the Ouagadougou Declaration (WHO 2008) Article V Item 4 that urges nations to “implement strategies to address the human resources for health needs and aimed at better planning, strengthening of the capacity of health training institutions, management, motivation and retention in order to enhance the coverage and quality of health care”. They include the need to initiate research on a range of workforce issues including skill-mix and task shifting, factors influencing recruitment and retention, and remuneration packages. Trends and policies on nursing recruitment, motivation and retention in line with Kenya’s specific health needs, especially in relation to the impact of HIV/AIDS, require urgent review.

1 Retirement age has been raised from 55 to 60 years beginning April 2009
Despite pioneering work by the Nursing Council of Kenya (NCK) in the development of data sets, for example, on recruitment and retention of students, migration and wastage, all nursing workforce databases require rigorous up-dating, especially those relating to nursing un- and under-employment, return to nursing, and migration. There is also an urgent need for the establishment of training programmes for nurse educators in order to address the serious shortages experienced in the Colleges of Nursing. Nurse education standards also require close scrutiny and strengthening. Finally, it is essential to gather accurate information on causes of death and to establish common occupational health risk factors among nurses.
Introduction

Kenya is one of the 57 countries with acute shortage of health care workers (WHO 2006a p.12).

Workforce imbalances are attributed to a range of factors, including inadequate human resources (HR); lack of human resource for health (HRH) planning; poor deployment practices, coupled with high attrition of health workforce; lack of adequate data; international and internal migration; the impact of HIV/AIDS; chronic under-investments in human resources for health; and policies imposed by international monetary institutions.2

There is little literature available to provide an in-depth understanding of dynamics and challenges of nursing in Kenya. This understanding is vital in making efforts to strengthen nursing and midwifery as envisaged in World Health Assembly resolution WHA 59.27 on *Strengthening Nursing and Midwifery* (WHO 2006c), the WHO *Nursing and Midwifery Services Strategic Direction 2002 – 2008* (WHO 2002), and the *Islamabad Declaration* (WHO 2007b). This understanding also underpins efforts to manage and improve nursing human resources in the country, especially scaling up the nursing workforce as envisaged in World Health Assembly resolution WHA 59.23 on *Rapid scaling-up of health workforce production* (WHO 2006b) and addressing migration of health workers as per resolution WHA 57.19 on *Challenge posed by the international migration of health personnel* (WHO 2004).

Specifically, this paper aims to explore the current key issues facing Kenya’s health system with regard to its nursing workforce, to determine, where possible, the causative factors, and to identify human resource solutions that are being or have been used to address the main challenges.

The specific objectives of this case study are:
• To provide a profile of the nursing population employed by the government in Kenya.
• To document attrition rates among nurses in the public sector and explore the main contributing factors.
• To explore the dynamics of internal and international migration of nurses in Kenya.
• To report on the maldistribution of nurses in Kenya and their under- and unemployment, and the strategies that are in place to address these key issues.
• To report on good practices in recruitment and retention of nurses.
• To provide a profile of nursing students in training in Kenya with reference to location and identify why students in Kenyan nursing colleges discontinue their studies.
• To review effectiveness of measures taken to improve human resources for health (HRH) financing.
• To present a summary of the national human resources (HR) plan.

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2 The World Bank, reacting to recent press reports, has categorically denied imposing any workforce recruitment embargo on Kenya. However, they have not yet denied that the Structural Adjustment Policies caused the Government to put in place policies that depleted the health workforce.
To report on the role and involvement of the government and non-governmental organisations, including faith-based health care organisations, professional association, nursing council and trade unions in HR policy development.

To document skill-mix of health care teams in urban and rural settings, the role of each member and the related HR plan.

Methods

The methods adopted for this study include in-depth review of the identified literature on nurses at both international and national levels, as well as review of other relevant literature on nursing and health sector human resources. The secondary data analysed was collected from materials selected purposively for the study as well as from other relevant literature on the subject of health workforce in general and health professionals in Kenya in particular. Most of the literature reviewed had a multiplicity of data that required quantitative analysis and interpretation. In some cases primary data is used to corroborate conflicting literature or to update dynamic data.

In this Case Study reference is made to the comprehensive study *Report on Human Resource Mapping and Verification Exercise* (MoH Kenya 2007a) and the 2004 report by the East, Central and Southern Africa Health Community on human resource challenges in relation to HIV/AIDS (ECSA-HC 2004). Other key references include reports on recent joint studies by the World Health Organization (WHO), the International Labour Organization (ILO), the International Organization on Migration (IOM), the Regional Network on Equity in Health in Southern Africa (EQUINET), the East African Community and ECSA-HC on health workers’ migration; policy-based studies such as the Kenyan Democratic Health Survey 2003 and Service Assessment Survey 2004; and Capacity Project field reports.

Although nursing is central to health care delivery (WHO 2006c), this study was not able to identify any literature specific to nursing HR in Kenya. Main sources of data for this study therefore remain the above reference materials, nursing database and the Ministry of Health *Health Information System* reports, the MoH Integrated Personnel Payroll Database (IPPD) as well as more general economic and policy literature on HRH.

All available data on intention to out-migrate as a proxy measure to international migration and supply and demand data were obtained from the Kenya Nurses Workforce Project database at the Nursing Council of Kenya. The Chief Nursing Officer’s (CNO) nursing workforce database provided information on nursing dynamics in the public sector such as shortage, maldistribution and age profile.³

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³ The Kenya Nursing Workforce Project belongs to the Government of Kenya but is supported by Emory University, CDC and PEPFAR. It is operated at both the National Council of Kenya and the CNO’s Office in the Ministry of Medical Services and is currently being expanded to include other health care workforce such as doctors and laboratory technologists and technicians.
Because documented studies conducted on HRH in Kenya do not focus specifically on nursing human resources, this Case Study therefore uses these various studies as its principal source of data by picking the relevant data on nursing.

The nursing workforce database provided a key source of primary data. As well, some rapid data collected directly from the field to provide some missing or corroborative information for this Case Study.

**Limitations**

This Case Study was limited to areas where data is already available or could be easily obtained. Although it contains some primary data, it is composed mainly of secondary data derived from existing study reports on HRH, health systems and health services in Kenya. This approach was used due to the breadth of its scope and because of limited resources, which could not allow detailed research work to provide comparative primary data in areas that required such studies, such as the private sector.

The available information on HRH, especially nursing, is scattered in many studies and reports on the Kenya health system. All these studies have a high concentration in the public sector, providing very scant information from the private sector. All the available data were collected and collated for different reasons at different time by different investigators. As a result, no standardised tool or format was used, making comparison and consolidation of the data difficult.

The available data are few, general and in some instances inconsistent and conflicting. Data on nursing migration outside the country are mainly inconsistent even on the nursing database at the NCK. In some areas data are completely missing. The nursing database is young; it is still developing and therefore has its own limitations too. However, information from these areas of inadequacies was not used in this study.

It is hoped that the limitations of the data identified during this research will inform future research efforts in this area, including efforts to widen the scope and strengthen the nursing database in Kenya.

**Assumptions**

The data presented in this Case Study are from other studies and are assumed correct for the purposes they are presented in their original form.
Section One: 
Health care delivery in Kenya

Background

Kenya is located on Africa’s eastern seaboard having a shoreline of 400 km with the Indian Ocean in the East. It is bordered by Tanzania, Uganda, Sudan, Ethiopia, and Somalia (see map below). It covers an area of 582,646 km$^2$ of which 11,230 km$^2$ is under water. About 80% of the land mass is arid or semi-arid with only 20% arable (MoH Kenya 2007d). For administrative purposes, it is divided into eight provinces. The total population is 36.5 million (2006) with an annual growth rate of 2.4% (2004). In 2006 the gross national income per capita was 1,470 PPP international dollars$^4$ (WHO 2009).

According to WHO, expenditure on health is 4.3 % of gross domestic product, of which government expenditure comprises 38.7%, and private expenditure 61.3%. Most of the private expenditure on health comes from out-of-pocket expenses (82.6%). The per capita expenditure on health, at the average exchange rate, was $US20 in 2003 (WHO 2006e).

Adult literacy is higher than the African average, at 73.6%. The total fertility rate (per woman) is 5.0, which is slightly less than the rate for the WHO African region of 5.3. Life expectancy at birth is 51 for men, and 52 for women (WHO 2006e).

Health care governance

The health sector has public and private sub-sectors, though it is publicly driven. The public sub-sector comprises the Ministry of Health$^5$ and the health institutions it manages; health institutions under local authorities or local government; and other quasi-government bodies. The Ministry of Health establishes policy directions and finances, provides and supervises health care delivery (NCAPD 2005 pp15-16). The private sub-sector comprises for-profit and not-for-profit health care institutions. The latter include faith-based (FB) health institutions and non-governmental organisations (NGOs) providing health care. Faith based health care is the larger part of the two branches of the private sub-sector.

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$^4$ The purchasing power parity (PPP) rate is defined as the number of units of a country’s currency that is required to buy the same amount of goods and services in the country as one US$ would buy in the USA (World Bank 2010).

$^5$ The Ministry of Health has been subdivided into two ministries from April 2008, i.e. Ministry of Medical Services and Ministry of Public Health and Sanitation. The operations of the two ministries are still in their formative stages (see Appendix 4). The reader is advised to read Ministry of Health, whenever it appears as Ministry of Medical Services and Ministry of Public Health and Sanitation, unless otherwise specified.
Health care structures are arranged in a pyramid in terms of volume and hierarchy. The base comprises rural health facilities (RHF) and community based health units. At the apex are few tertiary referral health facilities and the MoH policy organs at headquarters (Figure 2). Ownership of health facilities at national, provincial and district levels comprises a triad of central government, the local governments, and the private owners. See Appendix 1 Table A1 for details.

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6 Rural health facilities (RHF) comprise health centres and dispensaries.
7 There are two large general national public referral hospitals, two specialised national public referral hospitals and three smaller private hospitals that provide some national referral functions.
Health care management structures are similarly arranged, i.e. the national, provincial, district, and the health facility. The provincial level supervises health services within the province. Each province (except Nairobi) has a provincial referral hospital serving the district hospitals within the province. The district level supervises district health services that include district and sub-district hospitals, health centres, dispensaries and community-based health care services. The national hospitals comprise national referral centres for advanced health care.8

Medical doctors play leading roles in heading health care delivery systems at all levels. The Director of Medical Services is the technical head of health care services; the Provincial Medical Officers and the District Medical Officers of Health are the technical and administrative heads at their respective levels,9 while the medical superintendents are the administrative heads at hospital level. They all work through teams such as the Provincial Health Management Teams, the District Health Management Teams, and the Hospital Management Teams.10

Nursing governance follows the same pattern. The Chief Nursing Officer, based at the Ministry of Medical Services headquarters, is the head of nursing services in the country. There are Provincial Nursing Officers,11 District Public Health Nurses, and Nursing Officers in charge of health facilities. They are all members of the management teams at their respective levels. Efforts to fully implement the position of Divisional Nursing Officers at the Division level, for effective supervision of community-based nursing services, continue to be undermined by shortage of registered nurses in the country.

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8 For many years referral services have not been functioning as they should. The current hospital reform agenda is making good attempts to streamline these services.
9 The current restructuring of the Government following the formation of the Government of Grand Coalition has restructured this arrangement. There is now the Provincial Director of Medical Services and the Provincial Director of Public Health created from the former PMO. Functions and responsibilities remain the same but are divided between the two new offices.
10 The District Health Management Team comprises the District Medical Officers of Health, District Public Health Nurses, Health Administrative Officer, District Public Health Officers and District Clinical officers. The co-opted members are the district nutritionist, a pharmacist, and others.
11 Following the division of the MoMS the PNO has also been separated into the PNO for MoMS and the Provincial Public Health Nurse for MoPHS
Kenya Essential Package for Health

The goal of health policy is to deliver health care and improve the health status of the people. Attention is given to the MDGs, WHO health priorities, and the national health agenda (MoH Kenya 1994). To realise this goal the National Health Sector Strategic Plan II 2005-10 (NHSSP II) provides the national health priorities in packages under the “Kenya Essential Package for Health” (KEPH) (MoH Kenya 2005).

KEPH defines health services in six levels as shown in Figure 3 below. It also defines health service consumers in six cohorts explained in Appendix 3.

Figure 3: Service delivery structure

Source: Kenya Service Provision Assessment Survey 2004 (NCAPD 2005)

Level 1 health services are community-based health services, critical for the re-introduction and sustenance of the new concepts of primary health care. Service providers are Community Based Health Workers (CBHWs) supported and supervised by Community Health Extension Workers (CHEWs). Level 1 provides preventive and promotive primary health care, strengthening timely referral. It requires 7,600 community health units and 15,200 nurses and 380,000 CHWs to be fully established throughout the country (see Appendix 2).

Level 2 health services are health care services provided at the dispensaries and clinics. These are the lowest facility-based health services, forming the interface between the

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12 CBHWs are unskilled voluntary community members selected and given short courses on common health problems.

13 CHEWs are skilled health workers employed and deployed to supervise, support and train CBHWs. They are preferably nurses but could be public health technicians or clinical officers. The role nurses play in community health is very crucial with the re-introduction of primary health care. Nursing strategy for PHC includes school health, occupational health and safety, home-based care, community midwifery, and family health (MoH Kenya 2007).
community and the physical health systems. Services at Level 2 are ambulatory with limited maternal delivery services.

*Level 3 health services* are provided at health centres, nursing homes and maternity homes, comprising first in-patient services including maternal delivery.

*Level 4 health services* are provided at district and sub-district hospitals. They are the beginning of a well-defined curative referral health care system, providing the second stage of in-patient services with the first level of some specialised medical attention.

*Level 5 health services* are health care services provided at provincial or regional referral hospitals, basically forming secondary specialised and broad spectrum curative health care system.

*Level 6 health services* are health services provided at national referral hospitals, basically making up a highly specialised tertiary health care system. Some patients treated at this level may be referred from other countries (MoH Kenya 2008a).14

The context defining primary health care in Kenya is health services in Levels 1, 2 and 3 health facilities. Comparatively, secondary health care is defined in the context of health services in Levels 5 and 6 health facilities. Level 4 health facilities are basically intermediate, sometimes referred to as Primary Hospital Care.

**Health facilities**

The Ministry of Health’s *Norms and Standards for Health Service Delivery* (MoH Kenya 2006) uses population-based parameters to define norms for establishing various types and levels of health facilities as shown in Table 1.

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14 It has been envisaged that standards of operation for each level would be developed to guide grading of health facilities for quality improvement in health care. To date these standards are yet to be fully developed.
Table 1: A summary of health facility norms

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<thead>
<tr>
<th>Facility Level</th>
<th>Type of Facility</th>
<th>Population Catchments</th>
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<tbody>
<tr>
<td>Level 1</td>
<td>Community Health Units</td>
<td>5,000</td>
</tr>
<tr>
<td>Level 2</td>
<td>Dispensaries</td>
<td>10,000 to 15,000</td>
</tr>
<tr>
<td>Level 3</td>
<td>Health Centres</td>
<td>30,000 to 40,000</td>
</tr>
<tr>
<td>Level 4</td>
<td>District (Primary) Hospital</td>
<td>100,000 to 200,000</td>
</tr>
<tr>
<td>Level 5</td>
<td>Provincial or Regional Referral Hospital</td>
<td>Up to 1,000,000</td>
</tr>
<tr>
<td>Level 6</td>
<td>National Referral Hospital</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

Source: Norms and Standards for Health Service Delivery (MoH Kenya 2006).

However, the Kenya Service Provision Assessment Survey 2004 (NCAPD 2005) shows that the average population coverage per health facility significantly exceeds these norms. The report also indicates that government and faith-based organisations (FBO) health facilities experience higher workload compared to private-for-profit health facilities (NCAPD 2005 p.30).

More health facilities will be required to meet the aspirations in the NHSSP II. With the current population estimated to be 38 million (MoMS Kenya 2008), the estimated needs are 7,600 community health units, 3,800 dispensaries, 1,267 health centres, 380 primary hospitals and 38 secondary hospitals (MoH Kenya 2006 p.6). This will have significant staffing implications for nurses, as discussed elaborately in the next chapters.

Therefore, the need for additional services still exists despite a significant increase in the number of health facilities between 2004 and 2007. The 2007 Report on the faith-based health services vis-à-vis the Government health services reported an increase 15.1% in faith based services to 920 over this period (MoH Kenya 2007c). The Ministry of Medical Services’ Facts and Figures (MoMS Kenya 2008) shows that by the end of 2007 there were 2,778 health facilities in the MoH, a significant growth of 31.2% from 2004 (MoH Kenya 2007a), in part resulting from the opening of health facilities sponsored by the Constituency Development Fund (CDF)\(^\text{15}\). Details on the growth of health facilities under local governments is not available, but scant evidence available show that Local Authority Transfer Funds\(^\text{16}\) have also been invested in constructing health facilities countrywide.

\(^{15}\) CDF (Constituency Development Funds) are exchequer funds voted by parliament for development promotion in each constituency. In 2006/07 fiscal year much of the money in all constituencies countrywide were used mainly to construct health facilities. A total of 1000 new dispensaries were constructed.

\(^{16}\) Local Authority Transfer Funds are also exchequer funds for development programmes within a given Local Authority.
Section Two:
An overview of nursing in Kenya

Structure

There are three nursing institutions in Kenya:

- The Department of Nursing (DoN) in the Ministry of Health provides overall leadership and general policy directions;
- the Nursing Council of Kenya (NCK) provides regulatory functions under the Nurses Act Cap 257 (1983) of the Laws of Kenya; and
- professional associations are concerned with the welfare of nurses.

Both NCK and the associations have participated in major health policy consultative forums alongside DoN.

There are two professional associations for nurses. The National Nurses Association of Kenya (NNAK) is the largest and the oldest (formed in 1948) and is affiliated to the International Council of Nurses (ICN). The Kenya Progressive Nurses Association (KPNA), originally Kenya Enrolled Nurses Association, has been operating for over 20 years. Both associations represent the interest of nurses and have been negotiating terms and conditions of work for nurses with the government. They organise continuing education activities for nurses. NNAK has also taken part in vital political consultative forums such as national constitutional conventions.

Strategy for strengthening nursing and midwifery

Strengthening nursing and midwifery in Kenya is fundamental, arising from World Health Assembly Resolution WHA 59.27 of 2006. The draft Nursing Sub-Sector Policy Framework towards Vision 2030 articulates an aim to achieve high quality nursing and midwifery services which are accessible and acceptable to populations and are being delivered by empowered nurses (MoH Kenya 2007b).

With the introduction of Performance Based Management in the civil service, nursing drafted its first Strategic Plan and started its reforms agenda in 2008. The Strategic Plan describes four dimensions of nursing.

1. *Nursing is a service.*\(^\text{17}\) As a service people seek it and nurses provide it. It should be available, accessible, qualitative and acceptable.\(^\text{18}\)

\(^\text{17}\) In Kenya, nursing services means nursing and midwifery services.
2. **Nursing is a discipline.**\(^{19}\) As a discipline it has its philosophy, values, and work culture. Nursing in Kenya is historically based on a medical model. Efforts are being made to change to a more proactive model.

3. **Nursing is a career.** As a career it is a body of knowledge that can be studied.\(^{20}\) It also has its own career ladder along which its members progress.\(^{21}\)

4. **Nursing is an organisation.** As an organisation it has a vision, mission, goals, philosophy, principles, culture and objectives guiding its operations and against which its performance as an institution is measured.\(^{22}\) It has a self-governance system and works with other health institutions/disciplines for better health care (MoH Kenya 2007b).

The Strategic Plan has the following five thematic areas of focus:

1. **Improving the numerical strength in nursing workforce.** This involves developing reasonable staffing norms (Appendix 2); establishing staffing gaps; putting efforts to train and recruit adequate nurses; managing workforce migration; and promoting retention and equitable distribution across regions and health facility types.\(^{23}\) The focus is on improving access to quality nursing services.

2. **Enhancing intellectual development in nursing.** The main focus is on improving skills, knowledge and competencies by developing and scaling up competent nursing practices\(^{24}\). This includes conducting periodic training needs assessment; re-designing syllabi and curricula to conform to prevailing health care priorities; and reviewing training tools and methodologies to align them with current health care needs and challenges locally, regionally and globally. It also includes promoting and strengthening higher nursing education that goes beyond basic diploma programmes to graduate and post-graduate studies; and enhancing nursing research.

3. Structurally **positioning nursing** within the health systems to strengthen its governance and operations including nurses’ involvement in policy formulation, interpretation and evaluation at highest possible levels in the health sector. This includes developing strong nursing leadership structures and modes that enhance motivation of nurses and efficiency and effectiveness in nursing operations. Specific activities include but not limited to

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\(^{18}\) The service reform agenda is focusing on improving quality, accessibility and acceptability of nursing services. Efforts are being made to move away from the medical model by initiating practical implementation of the concepts in Virginia Henderson’s model, Dorothea Orem’s Model, Watson’s Model and others on circumstantial basis. The initial step is moving towards strengthening application of nursing process and recruitment plans are being developed to improve the number of nurses in the civil service.

\(^{19}\) Nursing discipline is a combination of nursing and midwifery.

\(^{20}\) Nursing research remains weak but efforts are being made to strengthen it and translate research findings into policy and practice.

\(^{21}\) At present the Scheme of Service for Nurses is being reviewed to provide more opportunities for academic development and career progression, to motivate nurses and facilitate their retention.

\(^{22}\) Constituency developments are also being considered. Two new post-basic diploma trainings have been commenced in paediatric nursing and peri-operative nursing, besides those that have been running. There are considerations to enhance post-graduate studies, introduce specialisation and strengthen nursing leadership.

\(^{23}\) The Nursing Workforce Database is the principal tool for operationalising this agenda.

\(^{24}\) The Nursing Database is essential in mapping available skills and skills utilisation.
reviewing scheme of service for nurses and reviewing laws, rules and regulations that govern nursing operations.

4. Ensuring adequate supply of essential health commodities and equipment to provide adequate tools of trade and promote commitment of nurses, facilitating delivery of quality nursing services. Action area is on strengthening nurse-managers’ involvement in commodity procurement and management to ensure continuous availability and quality.

5. Ensuring proper and adequate support systems within the wider health systems framework. The subject matter here is strengthening collaboration with and support by other health care workers and managers. Areas of focus include but not limited to human resources management, financial managements, procurement and supplies management systems, efficient transport systems, and improved operation systems including favourable work environment. This included promoting and facilitating effective communication and cordial working relations among health workers (including relations between various nursing groups) and health care providers and management groups (MoH Kenya 2007b).

Nursing cadres

1. Registered nurses
Registered nurses in Kenya are of varying types, varying training levels and qualification:

- General registered nurses trained for three years at diploma level to provide care and managerial functions in a hospital setting. This programme has been limited to only two diploma training schools but there are plans to expand it to more schools.
- General registered nurses may further train for one year each to be registered midwives then to be registered community health nurse (post-basic). They may also train for the same period to be registered intensive care nurses, registered ophthalmic nurses, registered paediatric nurses, registered peri-operative care nurses, registered mental health care nurses, and registered anaesthetic nurses.
- Registered community health nurses (basic) were introduced in 1987 to provide comprehensive nursing services that encompass general nursing, midwifery and community based health care services. They are generalist nurses trained for three and a half years but can undergo further specialised courses mentioned above to enhance their practice skills in those areas of nursing.\(^{25}\)
- Registered community health nurses (graduate) programme was introduced in 1992 to produce generalist nurses at degree level. These nurses are trained for four years and can undertake specialised skills in all branches of nursing including community health and midwifery at master’s level for three years.

\(^{25}\) They can also train as intensive care nurses, ophthalmic nurses, paediatric nurses, peri-operative care nurses, mental health care nurses, anaesthetic nurses, etc. with exception to midwifery and community health nursing. A RCHN has basic competencies in general nursing, midwifery and public health / community health nursing.
Enrolled nurses

Nurses at enrolled level are certificate holders trained for two and a half years. They are practical nurses working at operational levels in hospitals, health centres, dispensaries and communities. For many years they have worked in and managed dispensaries. But in recent times registered community health nurses are being posted to take charge of nursing services in health centres and, in some cases, dispensaries. Certificate cadre include general enrolled nurses, enrolled midwives, enrolled health visitors, enrolled community health nurse and enrolled mental health nurse.

Changing roles in service delivery and skill mix

Roles played by nurses continue to change over time. Up to the early 1980s nurses did not establish IV drips or administer IV drugs. Today nurses fix drips as part of their normal routine duties in lower health facilities or in emergency situations. Those with special training such as intensive care (critical care) nurses undertake complex procedures that have previously been the preserve of doctors such as administering IV drugs, intubation and endotracheal suction. Midwives are today being trained to perform manual vacuum aspiration (MVA) procedures, manual removal of placenta and other life saving skills. In dispensaries and at community level nurses perform restricted prescription functions as one of their principal duties.

Today nurses prescribe ARVs (antiretroviral drugs) in health centres and dispensaries after being trained in comprehensive HIV/AIDS care and treatment services (NASCOP). Midwives conduct deliveries at all levels of health care and have limited legal prescription roles on limited drugs. More roles will continue to change and new responsibilities added, as nursing education is enhanced bringing in improved skills, new competencies and specialisation.

From the legal standpoint the Nurses Act is permissive, not restrictive in nature. What nurses can and cannot do is not prescribed in Law but is determined by the NCK from time to time on the basis of health care needs at particular settings and on the basis of competencies, skills, and experience. Issues of professional malpractice or impropriety are addressed through the legal system.

Nursing shortages

The health workers' shortage has serious repercussions for health care delivery, and impedes attainment of the Millennium Development Goals, especially in low and medium income

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26 Direct involvement of nursing in community health care is just emerging in Kenya under (KEPH) to strengthen PHC activities that essentially are family health (home-based care, community midwifery, palliative care, and other care given to members of the family at home), school health, and occupational health and safety (MoH 2007b). This is despite commencing Community Enrolled Nurses course in 1966. Nursing practice in Kenya has always remained hospital-based.

27 Pharmacy and Poisons Act, Cap 244 of the Laws of Kenya, Section 31 (1) permits a midwife practicing domiciliary midwifery to supply or dispense Part 1 poisons (drugs), provided such a midwife complies with the regulations made under the Nurses Act Cap 257 of the Laws of Kenya.
countries (Stilwell & Evans 2006 p.14). There is no agreed-upon universal definition of nursing shortages (Buchan & Calman 2006 p.32), however, HRH shortage is defined by WHO in terms of the number of health professionals (doctors, nurses and midwives) per 1,000 population in relation to skilled attendance at birth and measles coverage of 80%. In this respect WHO has established a threshold index of 2.5 health workers per 1,000 population; and countries with lower indices are defined as being in critical shortage of HRH (WHO 2006a p.11).

Kenya is one of the 57 countries with acute manpower shortages in health care identified in the World Health Report (WHO 2006a). These 57 countries are all low- and medium-income countries, and 36 are in the sub-Saharan Africa (SSA). There is a shortfall of 2.4 million health workers in these 57 countries, from a global total shortfall of 4.3 million health workers. SSA alone has a shortage of 0.8 million health workers (WHO 2006a p.11).

There are approximately 29,000 nurses in active practice in both public and private health sectors in Kenya. This translates to a ratio of 1 nurse per 1,345 population as compared to a WHO recommendation of a minimum of 2.5 nurses per 1000 population.

By mid 2009 there were cumulative estimates of 53,500 nurses registered in various registers maintained by the NCK since 1960, of which 25,200 are registered nurses and 28,300 are enrolled nurses. Most nurses have their names in more than one of the registers (see Appendix 1 Table A7). However, the majority of these nurses are not active. Some have migrated out of the country, retired, are performing non-health functions or have since passed away. The database is being updated to establish the actual number of nurses who are actively practicing in the country.

In Kenya, The Norms and Standards for Health Service Delivery (MoH Kenya 2006) defines staffing needs as the relationship between annual workload and the standard workload for the staff cadre at the defined level of care. Workload is defined as volume of work involved in delivering health services that can be accomplished during the course of one year by a competent and motivated health worker working to acceptable professional standards (MoH Kenya 2006 p.10).

Since the 1980s the Ministry of Health has used staffing norms related to bed capacity to assess workforce needs in health facilities. For example, in-patient areas have been staffed using official or available bed space as the benchmark at a ratio of one nurse to six in-patients beds per shift. This gives an average of four nursing contact hours per 24 hour-period. However, most of the time hospital wards are congested beyond the official bed capacity, lowering the available nursing time per patient considerably.  

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28 In the WHO context health worker here implies nurses, midwives and doctors/physicians.
29 The number of nurses in the private sector is lower and can only be estimated due to lack of adequate data. Only the Ministry of Health can be certain on its active nursing workforce. With the database improving its information base the data in the private sector will soon be accurately available.
30 Unpublished analysis by the National Hospital Insurance Fund (2005), in which this author participated.
Staffing in health centres and dispensaries has been standardised using a rule of the thumb. The staffing norm for health centres has been 12 nurses and one clinical officer, in sub-health centres it has been eight nurses and one clinical officer, and dispensaries two nurses. This norm has been overtaken by the dynamics in population density and disease burden in the catchments area; caseload alterations; and types and intensity of services offered.

Given the emerging trends in workload, staffing norms have since been revised (Appendix 2) taking into consideration trends in population rise; increasing poverty; rising disease burden; additional technical and professional responsibilities that have emerged over time at different levels of health care; the need for quality nursing care; and the need to balance cost of labour with quality of care. The aim is to increase nurse/patient contact hours to an average of six hours daily for in-patients, and ambulatory nurse-patient contact time ranging between 5 to 45 minutes, depending on client health need.

In summary, findings in 2004 indicate that:

- There is acute manpower shortage in all health facilities.
- Though district hospitals staffing is better than the established norms, available nurses do not match the existing (excessive) workload.
- There is one nurse in almost half the dispensaries, and nearly half the health centres are staffed by less than three nurses.
- 425 dispensaries met the standard staffing norm but 143 dispensaries had no nurse (MoH Kenya 2007a).

Recently, FBO health services have been badly affected by shortage of nurses. Despite the shortage in the public sector the Government has deployed 51 doctors and 377 nurses in some FBO health facilities to keep them operational. The Public Expenditure Review 2007 indicates that additional 6,241 “staff” is required by the FBO health services to provide optimum care (MoH Kenya 2008c).

Based on the Ministry of Health’s health facility norms (Appendix 2) the country requires a total of 96,322 nurses, bringing the shortfall to 66,782 nurses (Table 2 below)

### Table 2: National demand for nurses, 2008

<table>
<thead>
<tr>
<th></th>
<th>Nurses required</th>
<th>Nurses in post</th>
<th>Nurses' shortfall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health</td>
<td>49,838</td>
<td>19,885</td>
<td>-29,953</td>
</tr>
<tr>
<td>Faith based organisation</td>
<td>7,860</td>
<td>1,629</td>
<td>-6,231</td>
</tr>
<tr>
<td>Other (derived)</td>
<td>38,624</td>
<td>8,026</td>
<td>-30,598</td>
</tr>
<tr>
<td><strong>National demand</strong></td>
<td><strong>96,322</strong></td>
<td><strong>29,540</strong></td>
<td><strong>65,782</strong></td>
</tr>
</tbody>
</table>

31 This staffing norm has since been reviewed as shown in Appendix 2.
32 Information on this table is calculated from data arising from various sources.
33 For this table the MoH includes National Referral Hospitals and Kenya Medical Training Centre, which are semi-autonomous health facilities under the Ministry.
Factors influencing demand for nurses

- HIV and AIDS has resulted in increased workloads, caused congestion in hospitals and created demand for more extra nurses (MoH Kenya 2002). This increase in workload is not only for hospital care but also for delivery of additional programmes, such as prevention of mother-to-child transmission, voluntary counselling and testing, anti-retroviral therapy, condom distribution, and others. These have emerged as vital strategies for managing HIV/AIDS treatment and prevention, and all require staffing. At the same time, HIV/AIDS has affected and infected health workers, causing deaths among health workers, increased attrition, and discouraging entry into the profession.

- In 2007/08 financial year, 360 new dispensaries were opened. In 2008/09 another 389 dispensaries were opened totalling 749 dispensaries under CDF. As a result, nursing staff demand has increased by 2,996 just within two years. Unfortunately, the legal instruments establishing CDF do not allow these funds to be used to hire human resources.

- Between 1988 and 2000, districts increased from 41 to 71. During this period 30 new district hospitals were established. Many of these hospitals are still developing new infrastructure such as wards, maternity units, operating theatres, etc. Older, larger hospitals are also expanding creating new specialised health care units such as ICU, Newborn Units, etc. These programmes require more nurses and equipment.

- Administrative districts again increased from 71 in 2006 to 149 in 2008/09, resulting in the establishment of an additional 78 district hospitals in the new districts. More nursing staff will be required to work in these district hospitals. This new demand is estimated to be between 7,000 and 12,000 nurses in the next five to ten years.

- The new community health initiative through KEPH has led to the creation of positions for nurses at the community level to serve as Divisional Nursing Officers and Community Health Extension Workers (CHEWs). 15,200 additional nurses are required as CHEWs and another 1,200 as divisional nursing officers, totalling 16,400 new nursing positions for community-based health care.
Section Three:
Education, training and supply of nurses in Kenya

Education and training programmes

The Code of Regulations for public servants in Kenya indicates that “training is intended to equip public officers with knowledge, skills and attitudes that will enable them to deliver quality services” (GoK 2006a Section P 1 p.3). Training of health workers is carried out in three major categories – certificate, diploma and degree programmes. Nurses have all the training levels.

- **Certificate (enrolled) nurses** programmes have been in existence since 1939 (Ndirangu 1982 p. 44). They began as nurse orderly training during World War II. It later comprised separate structured courses in general nursing, midwifery, and health visitors. In 1966 the three courses were combined into enrolled community health nursing. Up to 1996 all nurses’ training schools throughout the country, except two schools based in Nairobi, offered certificates for this course. Certificate programmes last two and a half years.

- In order to improve quality of care and enhance nurses’ empowerment, the need to expand diploma programmes and terminate the certificate course was recognised in 1997. In 2000 the decision was made to complete phased implementation by 2005. However, to date three schools still conduct certificate programme and the matter is under review at government policy levels.

- The **basic diploma** programme was established in 1952 for registered nurses (Ndirangu 1982 p.58). Midwifery and Health Visiting were post-basic diploma programmes. In 1997 registered community health nursing (combining the three programmes) was commenced. Currently all schools of nursing except three conduct registered community health nursing courses. Diploma programmes last between three to three and a half years.

- A **registered diploma** nurse may undergo basic degree training in registered community health nursing or registered nursing in recognised universities locally or abroad. However, the development of upgrading programmes for diploma holders to graduate nurses has been slow. Some local universities have been prescribing full course work for such students while others award credits for prior learning and work experience acquired over time (NCK 2007).

- **Basic degree** programmes for school leavers began in the mid-1980s and have developed slowly into the mid-1990s. Momentum has been gathered from the turn of the century with eight universities offering basic degree programmes in nursing today. Post-graduate studies are still at their early developmental stages with only three universities offering

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34 Data on upgrading diplomas to degree are far from incomplete because a large number of graduates do not seek further registration, or update their personal records at the Nurses’ Council of Kenya.
limited opportunities at Master’s degree level. Figure 4 below provides a summary of skills upgrading trends from 2000 to 2007 in five areas, i.e. certificate to diploma upgrading programme, diploma to degree upgrading programme, post-basic certificates, post-basic diplomas, and post-basic degrees. Basic degree nursing programmes last four academic years while post-graduate studies in nursing last three academic years.

**Figure 4: Post-graduate skills upgrading trends, 2000-2007**

![Graph showing skills upgrading trends from 2000 to 2007](image)

Source: NCK database (December 2008)

**Education and training facilities**

Increasing production of health workers depends on existing production capacity in the county and the potential to expand. Figure 5 provides profile of education and training institutions in Kenya for nurses by ownership and by cadre, highlighting the important role played by faith-based and private institutions.
There is potential to establish new schools of nursing in Kenya. There are more hospitals with capacity to facilitate training partnership with new schools. New universities are emerging with potential for college-based degree programmes in nursing and there is strong political goodwill to expand nurses’ production. What is in short are supply are resources to facilitate expansion.

One key impediment is insufficient faculty staff. The teacher/student ratio recommended by the NCK is 1:10. Table 3 below shows the actual situation.

Table 3: Faculty staff in nursing colleges

<table>
<thead>
<tr>
<th>Training Institutions</th>
<th>No.</th>
<th>Student Population</th>
<th>Faculty Staff</th>
<th>Teacher/Student Ratio</th>
<th>Faculty Shortfall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certificate</td>
<td>3</td>
<td>330</td>
<td>6</td>
<td>1:17</td>
<td>14</td>
</tr>
<tr>
<td>Diploma</td>
<td>40</td>
<td>9660</td>
<td>244</td>
<td>1:27</td>
<td>604</td>
</tr>
<tr>
<td>Basic Degree</td>
<td>7</td>
<td>700</td>
<td>40</td>
<td>1:15</td>
<td>23</td>
</tr>
<tr>
<td>Post-Graduate</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>53</td>
<td><strong>10,690</strong></td>
<td><strong>290</strong></td>
<td><strong>1:25</strong></td>
<td><strong>641</strong></td>
</tr>
</tbody>
</table>

Source: NCK database (December 2008)

The supply of nurses

Local education and training institutions are the main source of Kenya’s supply of nurses. Foreign supply is negligible. Data held by the NCK indicates that between 2000 and 2005 only 106 registered nurses and 245 enrolled nurses trained abroad came to practice in Kenya (NCK

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35 One more university opened a graduate nursing programme in 2009 bringing the total to 8.
database 2008). Data on nurses trained outside Kenya is well maintained at the NCK but data on nurses returning home is missing. Also missing are data on nurses returning to nursing from other sectors.

Figure 6 below shows local supply of nurses from 1998 to 2006. A total of 10,865 nurses were produced while only 5,134 (47.2%) nurses were absorbed in the civil services. It is not certain that the balance 5,731 (52.8%) has been absorbed in the smaller private sector or has migrated out of the country. Recruitment data in the private sector is missing. It is generally deemed that they are unemployed. Despite the surplus the actual need still outstrips the unemployed.

**Figure 6: Nurses absorption into the public sector, 1998-2006**

![Graph showing nurses absorption into the public sector, 1998-2006](image)

Sources: NCK database (December 2008) and MoH Kenya Health Human Resource recruitment data

However, experience during recruitment exercises in the public sector show that many nurses are unemployed or are simply in temporary underpaying holding jobs that may or may not be health related (see unemployment on p. 37).

**Nursing students’ profile**

Of the 53 nurses training institutions spread across the country, Kenya Medical Training College has a network of 23 constituent mid-level colleges in all the eight provinces with 6,000 student nurses out of the 10,865-student population.

An analysis conducted for this Case Study on 4,145 student nurses randomly selected in the nursing database is shown in Appendix 1 Table A3. Figure 7 shows their age profile, with the vast majority of the students between 20 and 24 years old. While the youngest student is 18
years old, the oldest is 42 years old. The mean age for both first and second year students is the same, 22.4 years, and for third year students it is 23.3 years.

**Figure 7: Age profile of student nurses, 2008**

[Image: Pie chart showing age distribution of student nurses with percentages for different age groups: 1% < 10 years, 1% 10-14 years, 1% 15-19 years, 2% 20-24 years, 5% 25-29 years, 20% 30-34 years, 20% 35-39 years, 20% 40-44 years, 6% 45+ years.]

Source: NCK database (December 2008)

**Continuing education**

According to the Code of Regulations for public servants, “all public servants should have at least five [5] days (or 40 work hours) training in a year while newly recruited or transferred officers must be inducted within three months of joining the new organisations” (GoK 2006a, Section P, p. 1). However, the Nursing Council requires that all nurses undergo at least 20 hours of CE each year as a prerequisite to retention on the rolls or registers, which it maintains in accordance to the Nurses Act Cap 257 (1983) Section 11 sub-Section 4.

The *Kenya Service Provision Assessment Survey 2004* found that 76% of health facilities had staff who had received up-date training in the preceding 12 months. Hospitals were leading at 85%. NGO health facilities were better in updating their staff (84%) than public facilities (NCAPD 2005 p.41). Rapid assessment on continuing education activities carried out for this study in Central Province indicates that 85.2% of health facilities have continuing education programme with regular activities for nurses.
Section Four:
Current workforce profile

Nursing workforce distribution

- Health Worker Ratios
  The Report on Human Resource Mapping and Verification Exercise (MoH Kenya 2007a) shows that in 2004 the MoH had 2,156 health facilities served by a workforce of 35,643 staff including nurses, doctors, clinical officers and public health officers. Nurses comprised 45.3% of the total workforce. The ratio of doctors to nurses was 1:13. A more recent analysis of the MoH payroll (August 2008) on nurses for this Case Study shows that there are 17,540 nurses in the MoH making the existing ratio of doctors to nurses at 1:11.

- National and Regional Distribution
  The Report on Human Resource Mapping and Verification Exercise (MoH Kenya 2007a) showed that Nyanza and North Eastern provinces had the lowest staffing ratios. While the emergency recruitment programme has significantly improved the Nyanza situation, the North Eastern Province shortage remains more or less unresolved. The emergency recruitment in the province was small and not well structured. This has not demonstrated any significant impact in alleviating nurses' shortage. Besides, the province appears to have some unique situation that requires further investigation. It is still too early to demonstrate the impact of this improvement in nursing workforce on health indicators in Nyanza.

  The Report provides both national and provincial health workers staffing ratios per 100,000 population in 2004 as shown in Appendix 1 Table A6. Figure 8 shows the comparative data in the number of nurses in public sector per 100,000 population by Province in November 2008. Appendix 1 Table A4 compares the status in 2005 and 2008 by provinces (MoH Nursing Database December 2008).

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36 Public health officers provide environmental and sanitation services in the community but attached to health centres and dispensaries.
37 Emergency hiring was put in place in 2004 and 2007 where development partners (Danish Government through the Clinton Foundation, Global Fund for HMT, PEPFAR and Capacity Project) complemented the Government efforts to hire additional health workers. Focus was on HIV and malaria high prevalence areas with acute shortage of staff.
38 Attempts have been made by an international organisation to do what was done in Nyanza. However, this programme was not well planned in that there were few nurses, there was no contractual arrangement between the Government and the organization which made eventual absorption of these nurses into the mainstream public sector difficult at the end of the programme.
39 See Table A5 Appendix 1 for a comparison of the situation between December 2005 and June 2008.
Figure 8: Nurse distribution by province in the public sector

Source: MoMS Kenya nursing database (November 2008)

- Distribution in Primary and Secondary Care Facilities
  The Report on Human Resource Mapping and Verification Exercise (MoH Kenya 2007a) defines dispensaries and health centres as ‘primary health care’ and hospitals as ‘secondary health care’. For the purpose of this paper, staff distribution is defined using this definition rather than a rural/urban dimension. In general in Kenya the term RHFs means health centres and dispensaries.

The Report shows that in 2004, public hospitals comprised only 6.2% of total public health facilities yet they had 62.8% of the public sector health workers. Similarly, the Kenya Service Provision Assessment Survey (NCAPD 2005 p.30) reported that hospitals are better staffed with more qualified staff than lower level facilities. The trend remains the same today where the Nursing Database shows the nurses distribution per facility type in August 2008 were hospitals (71.6%), health centres (13.2%) and dispensaries (15.2%).

Age profile of nursing workforce

The Report on Human Resource Mapping and Verification Exercise (MoH Kenya 2007a) compares age patterns of health workforce categories in 2004. It shows that nurses are relatively older than physicians. At the same time enrolled nurses were older than registered

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40 Defining the terms rural and urban for the purpose of discussing staff distribution is rather ambiguous. While nurses in district hospitals may consider themselves to be working in urban setting, doctors working in the same district hospitals may consider themselves to be working in rural settings. This is because the types of infrastructure and the environment as perceived by some groups dictate individuals’ perceptions and definitions of their dwelling environment (Arudo et al. 2007).
nurses. It appears that the upper professionals are younger than the lower professionals, partly because migration is higher among better educated and experienced professional.

Generally, the nursing population in the MoH is aging. Nurses’ return analysis in 2005 (Appendix 1 Table A5) shows that only 25.5% were below 35 years; the average age of nurses was 38.9 years; and 35.9% would retire within ten years at age 55 years. Comparable data for physicians is not readily available.

Although, 3,644 nurses were recruited to the MoH between 2005 and 2008, the age distribution of nurses has remained relatively unchanged over this period as demonstrated in Figure 9 below. Probably this indicates that relatively older nurses were recruited despite being potential retirees within the next few years and despite having younger nurses graduating from colleges at the average age of 24 years.

**Figure 9: Nurses’ age profile, 2008**

![Pie chart showing the age distribution of nurses in 2008.](image)

Source: MoMS Kenya nursing database (November 2008)

**Nursing attrition**

A report written in 2004, *Challenges Facing the Kenya Health Workforce in the Era of HIV/AIDS* by ECSA-HC (2004), found that between 1996 and 1999 the MoH workforce fell by 4,810 (from 50,504 to 45,694), and by 2,784 (from 45,694 to 42,910) between 1999 and 2001. Clinicians were reduced from 2,417 to 1,719 (by 28.9%) and nurses from 11,262 to 10,483 (by 6.9%) (ECSA-HC 2004 pp11-13).

This report also states that during the period between 1996 and 2001, the Ministry of Health recorded 486 (6.4%) deaths of health workers. Nyanya province had the highest deaths at 141 (29%). 45% of the deaths were due to HIV/AIDS related diseases such as tuberculosis, pneumonia, chronic diarrhoea, and immuno-suppression. Deaths of nurses were 200 (41.8%)
and clinicians 56 (11.5%). More than half of the nurses were between 30 years and 44 years of age (ECSA-HC 2004 p.11).

Payroll analysis for this Case Study on nurses who left service between March 2004 and February 2008 shows exit of 1006 nurses. Figures 10 and 11 show trends in nurse attrition by cadre and causes during the four years period as extracted from the MoH payroll data. Figure 11 shows common causes of attrition. Mandatory retirement accounts for 60% followed by deaths at 24% and resignation at 8%. A striking feature in this analysis is that the majority (37%) of the nurses who died were aged between 35 and 44 years.

**Figure 10: Trends in attrition, Mar 2004 – Feb 2008**

Source: MoH Kenya payroll data April 2008

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41 Information available did not capture all the nurses who left service during the mentioned period. However the data available is regarded as sufficient to give information on attrition trends.

42 It is noted that the rise in figures on attrition is basically due to improving data collection on the payroll over the period due to IPPD. The actual trend may be higher than this and shall be known at the data improvement stability phase.
Figure 11: Nurses’ attrition by cadre & causes, March 2004 – Feb. 2008

Source: MoH Kenya payroll data (2004 to 2008)

Student attrition (2003 to 2007)

Data in the NCK database show that between 1975 and 2004 (29 years) a total of 712 nursing students were discontinued from training. 64.3% were enrolled nurse students and 90.7% were females. The overwhelming majority of discontinuances were pregnancy related (79.4%). Other reasons included misconduct (14.9%), poor performance (0.8%), ill-health (0.7%), and crime related (0.7%).

Unemployment

Literally unemployment means a state of being unemployed or a state of being without a paying job

Dovlo expressed that the Kenya health workforce is bedevilled with ghost workers, estimated in 2004 at 5,000 in the MoH payroll (Dovlo 2005). The ghost workers caused false high figures of health workforce, inhibited recruitment of new workers and caused waste of scarce financial resources. Volqvartz, as reported by Kingma (2007), says that although half of the nursing

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43 The study found that annual attrition among students is so low that to get adequate data the study had to stretch back to 1975 to get a population of 712 students for analysis.
44 Ghost workers are people who are in the payroll but absent in the workplace.
positions in Kenya are not filled, 7,000 nurses trained in the country remain unemployed, yet the country needs to double its hospital nursing workforce to attain its MDG targets.

Unemployment was unknown for nurses in Kenya before 1998 when employment for nurses was stopped. The introduction of *Structural Adjustment Programme* related policies in the late 1980s on the labour market in low-income countries (and in Kenya early 1990s) resulted in unemployed health workers in Kenya from as early as 1996.

Retrenchment of public servants through the *Voluntary Early Retirement*, locally referred to as *the golden handshake*, was introduced between 1994 and 1996; recruitment of new health workers was suspended in 1996 (for nurses in 1998); and *civil service restructuring* programme was implemented in 2000. The effects of these three programmes were:

- Nurses who left service through normal attrition were sometimes not replaced;
- The suspension of recruitment resulted in unemployment for nurses; and
- Sporadic ad hoc recruitment has never solved the paradox of unemployment co-existing with a shortage of nurses. 4,794 nurses were recruited into the public sector between 2004 and 2007. By 2006 there were still 5,731 (52.8%) of the nurses trained since 1998 considered unemployed.

The NCK captures data on student nurses and new graduates but not on unemployed nurses. The National Nurses Association of Kenya and the Ministries of Labour and Health also do not maintain data on unemployed health workers. While the MoH has data on recruited health staff in the Ministry, there are no consolidated data for private sector health employees at a central place. This is because the private health sector is fragmented and diverse in ownership, structure and operations. Because of this scenario complete status of unemployed nurses remains only deductive.

**Underemployment**

Underemployment of nurses is believed to exist in Kenya and is probably high in the wake of the current high unemployment of nurses. There are uncorroborated complaints that some employers underpay nurses. There are also complaints of nurses performing non-nursing duties in some health institutions. However, there are no reliable documented data to claim or disclaim these complaints. Due to time constraints and limited resources rapid assessment of this phenomenon could not be undertaken for the purposes of this monograph.
Section Five: Nurse migration

Although international migration has existed for decades, there has been significant growth since the late 1990s and it has now attracted global attention. Outside Africa for example, it is reported that in 2002 alone, Barbados lost 15% of its nursing workforce, Trinidad and Tobago 20%, and Jamaica 22% through migration (Salmon 2006 p.19). In Sri Lanka the 7,000 vacant nurses’ positions in 2004 are expected to double by 2010.

In Africa this phenomenon has demonstrated serious devastation. In South Africa the loss of two specialised anaesthetists to international recruitment caused closure of spinal injury centre serving many countries in the region (Dovlo 2007). In Malawi many nurses lost to UK nearly grounded maternal services. In both Ghana and Kenya many positions for nurses and doctors remained unfilled. The resultant effects of migration, as postulated in Zimbabwe, are increased workload for the few remaining health workers, long waiting time for patients, and probably more deaths than naturally ought to be (Stilwell & Evans 2006).

There are multiple factors responsible for this phenomenon, but top of the global agenda is health workers’ migration from low- and medium- to high-income countries. Stilwell and Evans postulate that the aging population, technological advancement, and changing consumer demands in developed countries will continue to increase demand for more health workers above the “indigenous supply”. Given the available wealth in these countries, they will continue to pull more HRH from developing countries. In contrast, developing countries continue to have fast increasing populations, poor resources, and high burden of disease (Stilwell & Evans 2006 p.16). Other causes of HRH shortage are inadequate supply of health workers; lack of resources to scale up supply; and health sector reforms restricting employment of new staff (ECSA-HC 2004 p.24, Buchan & Calman 2006 pp32-33).

Trends in internal migration

In the late 1980s and early 1990s migration of health workers in Kenya was predominantly internal: from the public to the private sector. During this period Kenyan economy was in decline. Resources were scarce; allocation of resources to public health facilities was dwindling in real terms; deficient and defective tools and equipment characterised the state of public sector health facilities.

The destination of health workers was mainly to faith-based (FB) health institutions and private practice, as FB health care facilities offered better remuneration package and were better equipped, private practice was lucrative and popular with clients from the richer segments of the population. Private practice for nurses commenced in mid 1980s, attracting many nurses from the public sector.
Findings of the survey recently conducted in Kenya (the first one of this kind) for IOM/ILO/WHO (Arudo et al. 2007) on health workers migration in Kenya provide data on the general population internal migration, although the census data does not tease out health workforce trends. The study reports show rural and urban HR trends in Table 4 below.

**Table 4: Internal migration of health workers**

<table>
<thead>
<tr>
<th>Location of facility</th>
<th>From rural</th>
<th>From Urban</th>
<th>Sector</th>
<th>From Private</th>
<th>From Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>To Rural</td>
<td>4 (22.2%)</td>
<td>9 (14.5%)</td>
<td>To Public</td>
<td>-</td>
<td>7 (53.8%)</td>
</tr>
<tr>
<td>To Urban</td>
<td>14 (77.8%)</td>
<td>53 (85.5%)</td>
<td>To Private</td>
<td>67 (100.0%)</td>
<td>6 (46.2%)</td>
</tr>
<tr>
<td>Total</td>
<td>18 (100.0%)</td>
<td>62 (100.0%)</td>
<td>Total</td>
<td>67 (100.0%)</td>
<td>13 (100.0%)</td>
</tr>
</tbody>
</table>

**Internal migration of nurses (Left), June 2006 – May 2007**

<table>
<thead>
<tr>
<th>Location of facility</th>
<th>To rural</th>
<th>To Urban</th>
<th>Sector</th>
<th>To Private</th>
<th>To Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>To Rural</td>
<td>-</td>
<td>-</td>
<td>To Public</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>To Urban</td>
<td>2</td>
<td>8</td>
<td>To Private</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>8</td>
<td>Total</td>
<td>1</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: Arudo et al. (2007).

Improving terms and conditions of work by Government are reversing staff movement. Internal migration is beginning to occur from the private sector (especially FB health facilities) to the public sector. The 2007 report, *Faith Based Services vis-à-vis the Government Health Services* (MoH Kenya 2007c), shows causes of staff shortage in FB health services are poor salary, poor job security, and overwork. Emerging migration of nurses from FB health facilities to government is due to better job security, better pay, better education opportunities, and better working environment in the government health sector.

**Trends in external migration: 2000 to 2007**

Nurses are part of a global health professional workforce that is in high demand in many countries. While shortage of nurses continues to increase locally nurses migrating in to Kenya are far less than those migrating outwards. Nurses trained outside Kenya come to practice in the country. Some of these nurses are expatriates working with international NGOs, while others are Kenyans trained in neighbouring countries.

Whereas internal migration is traceable and quantifiable, the nature of external migration is complex making it difficult to quantify. Mwanika and Dulo (2008 p.7) report that most professionals never show intention to emigrate. They simply desert work, resign, or take leave without indicating their destination.

Many locally trained nurses seek employment outside the country each year. This phenomenon was analysed by Clemens and Pettersson (2007) in ‘*New Data on African Health Professionals Abroad,* showing that in 2000 there were 2,372 Kenya nurses abroad. The destination countries of these nurses are shown in Figure 12.
Nurses’ migration is also analysed using data in the source country. It is however difficult to ascertain the actual number as there is absence of data capturing as nurses leave the country. The method used is analysis of the number of nurses seeking verification of certificates for registration abroad, necessitated by the common international practice that compel nurses seeking employment in countries where they were not trained to apply for registration with the regulatory authority in the destination country first. To obtain registration the nurses are required to be cleared by the regulatory authority in the source country where they were trained.

The NCK receives clearance request every year for such nurses as shown in Figure 13.
Figure 13: Certificate verification by cadre and year.

Source: NCK database (December 2008)
Section Six:
Responding to the nursing shortage

The cost of labour may be as high as, or more than, 75% of the total cost of health care delivery (Buchan & O'May 2007). One factor that may cause direct and indirect rise in labour cost is high staff turnover. Direct costs include the cost of recruiting and training new staff. Indirect costs include underperformance and inefficiency during the early periods the employee is in the new assignment. Staff retention, skill mix and task shifting are considered as essential strategies for cost reduction and cost containment (Zurn et al. 2006 p.42).

Recruiting and retaining the right nurses is essential (Zurn et al. 2006 p.43) for containing labour cost, reducing errors, and maintaining efficiency. Sources of supply of nurses include new graduates, international migrants, inter-provincial migrants, and nurses returning from other occupations to nursing (Cleverly et al. 2006).

Recruitment

The recruitment process in the public sector is an elaborate exercise that sometimes takes as long as nine months. All civil servants in Kenya are employees of the Public Service Commission. Respective ministries only have limited recruitment and attrition powers though they are principal planners and consumers of their own human resources. In the case of the MoH, the recruitment process involves the Ministry of Health, Ministry of State for Public Service (formerly Directorate of Personnel Management), Ministry of Planning, Ministry of Finance (Treasury) and the Public Service Commission.

The role of Treasury in recruitment and retention of health workers was a subject of discussion during the 1st Global Forum on Human Resource for Health in Kampala (2008). The former Minister for Finance in the Government of the Republic of Ghana demonstrated that the exercise involves both the World Bank and the International Monetary Fund at the background. The Ministry of Finance has to convince the two international financial institutions on how it would raise enough funds for additional recruitment of staff or implementing any salary increase.

Up to 1996 all mid-level college graduates from public health sector training institutions were recruited into public service immediately on completing training. The private sector was also able to absorb those trained in private training institutions.
Authorised staff establishment for nurses in the Ministry of Health is 17,558 posts against 15,335 nurses in post on the MoH payroll resulting in vacancies of 1,684. Recruitment supported by development partners under contractual arrangement has brought in an additional 2,045 nurses that have helped in bridging the gap.

Advocacy for the recruitment of more nurses has been advanced since 2002 culminating in emergency recruitment from 2004 onwards, involving the Government and development partners’ collaboration. It is now generally accepted in principle that any aide to health care programme should include staff recruitment provisions.

The emergency recruitments (Figure 14 below) have introduced contractual arrangements with a focus on the understaffed districts with high HIV/AIDS burden in Nyanza, Coast, Eastern and North Eastern Provinces. Other disease burdens being considered include malaria, tuberculosis and immunisation coverage below set targets. All the recruited nurses are contracted to work in the districts for a period of time before relocating.

Figure 14: Nurses recruited 2004-2007 by supporting agency

Source: MoH Kenya HR Department

Workforce planning

The purpose of workforce planning (WFP) is to ensure that the right people with the right skills are in the right place at the right time. While there are various models of WFP, the concepts in

Note that with establishment the Grand Coalition Government in April 2008 the MoH has been split into the Ministry of Medical Service and the Ministry of Public Health and Sanitation. Consequently the staffs have been divided between the two new ministries.

Out of 2,333 nurses recruited through development partners support only 2045 nurses remain in services; 288 have resigned for “greener pastures”.

45

46
WFP include analysing attrition trends and current workforce status; identifying future needs on competencies or skills; comparing current and future needs with projected workforce supply; identifying skills or competency gaps; developing action plans that address the gaps; and considerations on organisation’s vision, mission, objectives, priorities and performance targets (US Dept of the Interior 2001).

Effective workforce planning is a prerequisite for sustaining improvement in human resource performance. While WFP helps in early warning on human resource shortage and mechanisms for interventions, it cannot predict the future with certainty and prevent staff shortages. However, it provides managers with frameworks for making HR decisions with regard to an organisation’s strategic plan, mission, budgetary resources, and desired competencies (Buchan 2006 p.11).

Human resource planning using the nursing database is in progress in Kenya for nurses. It is intended that the database, supported with other studies, will provide report on staffing gaps in terms of numbers, skills, attrition rates and possible causes, etc. This information will be used to plan existing and future HR interventions.

HRH and nursing specific strategic plans have been developed to guide HR related interventions that help improve health care interventions critical for the MDGs attainment. During the budgetary process for the year 2009/10 the nursing WFP was used in its draft form to convince treasury to allocate funds for recruitment. Consequently funds have been allocated to recruit 4,200 nurses for rural health services and 700 nurses for hospital health services.

**Retention strategies**

Backman (2000) outlines the following seven points necessary for improving staff retention:

1. Showing employees that they are of value and are valued;
2. Treating employees with respect;
3. Treating employees as professionals;
4. Involving front-line employees/staff in planning and decision making;
5. Creating and supporting opportunities for professional growth and development;
6. Addressing job security for employees; and
7. Paying attention to employees’ workplace concerns, such as workload, work tools, burnout, and their effects on patients.

Backman also identifies six factors that are essential for staff motivation and retention:

1. Policies targeting personal characteristics of nurses such as personal ambitions and needs that go with age, gender or educational thirst, social amenities and career development;
2. Monetary incentives that include all forms of remunerations;

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47 Rural health services in this context mean health centres, dispensaries and community health units.
3. Non-monetary incentives such as work autonomy, encouraging career development and adapting working time and shift work;
4. Reducing violence in the work place;
5. Leadership that focuses on staff job satisfaction; and
6. Policy on contextual factors, e.g. job market, family support and location of workplace (Backman 2000).

Accordingly, financial and non-financial incentives that organisations use to attract, retain and motivate staff are increasingly being considered (ICN et al. 2008). Some of the retention strategies that have been tried in some countries include allowing health workers to engage in private practice while working in the public sector; and raising salaries and improving working conditions. In some countries drastic measures that border on human rights violations, such as retaining certificates of qualified nurses, have also been practiced. In some countries communities are allowed to recruit their own health workforce, while in others bilateral specialist exchange programmes between countries are encouraged (WHO 2006d).

Other important elements of retention schemes include contracts for a defined period of time, clarity for all parties; topping-up employees’ salaries; providing accommodation and/or means of transport for employees, especially when employed in rural areas; means of communication for employees (television, telephone, computer and internet); education (allowance) for children; loans for construction of a house or purchase a car; and post-graduate education.

In the Kenyan context the following strategies are being undertaken:
- **Salary increases**
  The government is currently making efforts to harmonise salaries and wages for civil servants to market rates through the *Pay Policy Review for the Public Servants Board* (GoK 2006b). Table 5 below shows salary improvement for health workers between 2000 and 2008.

*Table 5: Salary for nurses 2000 to June 2008 (KShs)*

<table>
<thead>
<tr>
<th>Health care Cadres</th>
<th>Basic Entry in 2000 (KShs)</th>
<th>Basic Entry in 2008 (KShs)</th>
<th>Salary Increase (KShs)</th>
<th>Increase Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>9,925</td>
<td>30,472</td>
<td>20,547</td>
<td>207.0%</td>
</tr>
<tr>
<td>Registered (diploma)</td>
<td>7,090</td>
<td>13,452</td>
<td>6,362</td>
<td>89.7%</td>
</tr>
<tr>
<td>Registered (graduate)</td>
<td>9,925</td>
<td>22,519</td>
<td>12,594</td>
<td>126.9%</td>
</tr>
<tr>
<td>Enrolled</td>
<td>5,340</td>
<td>11,518</td>
<td>6,178</td>
<td>115.7%</td>
</tr>
</tbody>
</table>

Source: MoH Kenya records

- **Training opportunities**
  Study opportunities are on the increase. University education is expanding and intensifying. In 1996 only two universities offered degree programmes for nurses in Kenya, today there are eight. Three of them also offer post-graduate studies for nurses. Nurses also have the option of undertaking other programmes such as Master in Public Health, which is being offered by four universities. Nurses retain their jobs and salaries while undergoing studies.
• Post-training bonding.
All post-basic trainees in government employment are bonded for three years from the time of completing the course, to ensure that the investments on staff development are returned to the people. However, those undergoing basic training are not bonded.

• Career progression
At the time of writing (2009) nursing career structures in Kenya are undergoing review. A new scheme of service is being developed to provide more opportunities of promotion, academic development and professional recognition. A two track progression system that provides for a nurse-managers’ track and nurse-practitioners’ (clinicians) track within the civil service is proposed with the aim of motivating nurses and facilitating retention.

The nurse-clinicians track is being designed to provide for post-basic training specialisation in nursing and to promote implementation of Advanced Nursing Practice. It has two sets of specialisation – hospital-based nursing and midwifery; and community-based nursing and midwifery. Each set has several units of specialisation.48 For effective service delivery the two sets are linked by discharge planning and two way referral system across the six levels of health care.

The nurse-educators’ track is not developed within the civil service but independently within training institutions which are either private or semi-autonomous public institutions. It is being suggested that more posts be created along those three career pathways to provide additional opportunities for recruitment, promotion and retention.

• Recruitment of unemployed nurses
At the time of writing (2009) a five-year nurses recruitment plan is being developed to facilitate absorption of unemployed nurses as well as new graduates. This plan, if approved by the Government, will be used to mobilise resources from various internal and external sources towards the recruitment of nurses into the public sector during the next five years.

Skill mix
Skill mix is defined as the mix of posts in the establishment; the mix of employees in the post; the combination of skills available at a specific time; or the combination of activities that comprise each role, rather than the combination of different job titles (Buchan and O’May 2007 p. 1). Equivalent terms are staff mix, skill substitution, grade mix, personnel (staff) mix, re-profiling, and multi-skilling (Buchan & Calman 2005). It can be applied within occupational groups (e.g. nurses), or across different groups (e.g. nurses and doctors), or between different occupational groups.

48 Examples of hospital-based nursing and midwifery specializations include medical/surgical nursing, paediatric nursing, mental health nursing, critical care nursing, trauma nursing (accident and emergency), and midwifery. Examples of community health specializations include community midwifery, community IMCI, community mental health nursing, school health nursing, family health nursing including home-based care, and occupational health and safety.
sectors of health systems, e.g. skilled and unskilled HR (Buchan & O'May 2007). For example, staff mix may mean the ratio of RNs to other personnel such as 40% RNs, 40% ENs, and 20% others (Marquis & Huston 2000).

Table 6 below shows the staffing mix in the MoH health facilities in 2004 (MoH Kenya 2007a).

**Table 6: National staffs mix by facility types (2004)**

<table>
<thead>
<tr>
<th>Health Facility Type</th>
<th>No.</th>
<th>Total</th>
<th>RNs</th>
<th>ENs</th>
<th>Clinical Officers</th>
<th>Doctors/physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispensaries</td>
<td>1,536</td>
<td>2,646</td>
<td>230</td>
<td>2,416</td>
<td>82</td>
<td>3</td>
</tr>
<tr>
<td>Health Centres</td>
<td>440</td>
<td>2,295</td>
<td>393</td>
<td>1,902</td>
<td>381</td>
<td>9</td>
</tr>
<tr>
<td>District Hospitals</td>
<td>132</td>
<td>8,172</td>
<td>2,049</td>
<td>6,123</td>
<td>1,427</td>
<td>547</td>
</tr>
<tr>
<td>Provincial Hospitals</td>
<td>7</td>
<td>2,099</td>
<td>528</td>
<td>1,571</td>
<td>210</td>
<td>306</td>
</tr>
<tr>
<td>Others</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>2,115</td>
<td>15,212</td>
<td>3,200</td>
<td>12,012</td>
<td>2,100</td>
<td>865</td>
</tr>
</tbody>
</table>


Table 7 shows the seven skill mix driving forces, as identified by Buchan and Dal Poz (2002). It adapts the framework to outline the issues and responses in the Kenyan context.

**Table 7: Skill mix drivers, issues and responses in Kenya**

<table>
<thead>
<tr>
<th>Drivers</th>
<th>Issues</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills shortage</td>
<td>Shortages of nurses at primary, secondary and tertiary levels of health care.</td>
<td>Recruitment of community health workers for Level 1 health care activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recruitment of 4794 nurses during period between 2000 and 2007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plans to recruit 1160 nurses in 2008.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Development of recruitment plan for the next 5 years (2009/10 – 2014/15)</td>
</tr>
<tr>
<td></td>
<td>Shortage of clinicians (doctors and clinical officers)</td>
<td>Prescriptive role for nurses in health care levels 1 &amp; 2.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Circumstantial prescriptive roles of nurses at Level 3.</td>
</tr>
<tr>
<td></td>
<td>Need to scale up ARV access and distribution</td>
<td>Training nurses to prescribe antiretroviral drugs at primary levels</td>
</tr>
<tr>
<td></td>
<td>Shortage of nurses with skills in paediatric care in the public sector</td>
<td>Post-basic training of registered nurses in paediatric nursing.</td>
</tr>
<tr>
<td></td>
<td>Shortage of nurses with skills in peri-operative nursing in the public sector</td>
<td>Post-basic training for registered nurses in peri-operative nursing</td>
</tr>
<tr>
<td></td>
<td>Shortage of nurses with emergency medical care skills</td>
<td>Consideration is being made to train nurses with skills in emergency medical care</td>
</tr>
<tr>
<td><strong>Shortage of doctors (especially gynaecologist) to scale up MVA as a PAC strategy of reducing maternal mortality</strong></td>
<td>Training of nurses and clinical officers in MVA procedure to scale up post-abortion care. Policy changes on nurses’ scope of practice to include conducting MVA procedure and including the same in nurses’ syllabus.</td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td></td>
</tr>
<tr>
<td>Need for highly skilled clinical nurses.</td>
<td>Intensive nursing course has been in place since 1972, producing nurses that perform roles that are ordinarily preformed by doctors in clinical settings.</td>
<td></td>
</tr>
<tr>
<td><strong>Cost containment</strong></td>
<td>Nurse-managers’ roles redefined to include role in management and fee and included in their training in administration/management.</td>
<td></td>
</tr>
<tr>
<td>Improve collection and better use of user fee (cost-sharing funds)</td>
<td>Train nurse-managers’ roles in budgeting and budgetary controls</td>
<td></td>
</tr>
<tr>
<td>Reduce overall cost of health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Quality improvement</strong></td>
<td>Train nurse-midwives on Active Management of 3rd Stage of Labour and all allow them to prescribe and administer oxytocins</td>
<td></td>
</tr>
<tr>
<td>Improve quality of care of mothers in labour and post-delivery.</td>
<td>Train nurse-midwives of Life Saving Skills that include manual removal of retained placenta and allow them to carry out the procedures.</td>
<td></td>
</tr>
<tr>
<td>Improve quality of care of mothers after incomplete abortion</td>
<td>Train nurses on PAC and allow nurse to carry out MVA procedure.</td>
<td></td>
</tr>
<tr>
<td>Improve quality of nursing care</td>
<td>Retrain nurses on nursing process, discharge planning, and continuity of care</td>
<td></td>
</tr>
<tr>
<td><strong>Technological Innovations: New medical Interventions</strong></td>
<td>Training of nurses on new injection technology that ensures and promotes injection safety.</td>
<td></td>
</tr>
<tr>
<td>Introductions of reuse-prevention syringes for injection safety strategy</td>
<td>Training of nurses in Norplant insertion and including this skill in family planning training curriculum for nurses.</td>
<td></td>
</tr>
<tr>
<td>Introduction of Norplant insertion technology</td>
<td>Training of nurse-midwives on MVA technology and procedure.</td>
<td></td>
</tr>
<tr>
<td>Introduction of MVA in maternal care in 1990s in Kenya</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>New health sector programmes or initiatives</strong></td>
<td>Changing traditional role of nurses’ that are facility-based functions to community-based functions.</td>
<td></td>
</tr>
<tr>
<td>Emphasis on preventive health care and community health initiatives</td>
<td>Divisional Nursing Officers positions created at the community level. Positions for nurses as Community Health Extension workers created. Positions of Community Health Workers established in the health system.</td>
<td></td>
</tr>
<tr>
<td>Establish and enhance primary health care at the community level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving skilled attendance during child birth</td>
<td>Recalling retired nurse-midwives and changing their roles into community midwives</td>
<td></td>
</tr>
</tbody>
</table>

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*MVA – Manual Vacuum Aspiration  
PAC – Post-abortion Care*
### Task-shifting

According to WHO, task shifting is a process of delegation that involves transferring tasks (where appropriate) to less specialised health workers (WHO 2007). There are two features in this model of task shifting – tasks are transferred from one cadre of health care worker to an existing lower-cadre with lower labour cost; or tasks are transferred to a new cadre developed to meet specific health care goals (Bluestone 2006). Basically, task shifting is a tool for skill mixing (see Table A6 Appendix 4). Its goal is to get the right workers with the right skills in the right places doing the right things, at the right time (Bluestone 2006).

At the time of writing (2009) a committee has been established to look into issues surrounding the implementation of task shifting in Kenya. Given the past experience with traditional birth attendants nurses are generally sceptical about task shifting. The committee was established after it became apparent that the country needs to develop its own specific task shifting policy.

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49 This is largely an opinion of the author which may be subjective, but is based on experience gained while interacting with health workers in the country.
Conclusion

This study has attempted to analyse the nursing human resource capacity in relation to health policy and health care needs of the Kenyan people. Volqvartz, as quoted in Kingma (2007), reported that although half of nursing positions in Kenya are not filled 7,000 nurses trained in the country remain unemployed, yet the country needs to double its hospital-nursing workforce to attain its MDG targets.

Dovlo (2005) as quoted by Kingma (2007) on the other hand reported that Kenya HRH has ghost workers estimated at 5,000 in the MoH payroll that block the recruitment of a genuine health workforce thereby causing avoidable health workers shortage. The Report on Human Resource Mapping and Verification Exercise reported the same phenomenon. The need to upgrade the databases on nursing human resources is clearly urgent.

A number of studies need to be carried out to shed more light on some critical areas in HR dynamics in nursing. These studies include:

- Analysis of trends in recruitment of nursing workforce including profiles of those recruited during the last 10 years;
- Nursing retention strategies in practice and their impacts;
- Analysis of skills-mix and task shifting and current practices among nurses, including skills distribution and their relationship with common health conditions;
- Assessing the situation of unemployment and underemployment as part of nursing workforce dynamics;
- Analysis of financial allocations and expenditure on nurses as a potential major factor behind nurses recruitment and retention;
- Determining causes of death and establishing common occupational health risk factors among nurses as part of the dynamic factors in staff attrition;
- Identifying staffing trends in heard-to-reach areas to identify factors behind internal regional migration, maldistribution and attrition unique to those regions;
- Studying the impact of HIV/AIDS on nurses including prevalence rate, attrition, and social burden; and
- Nursing databases need to be improved to capture information on those returning from working abroad and returning to nursing from non-nursing occupations.

In addition to the above recommendations:

- More investment should be put into nursing through training and routine recruitment of additional nurses to address the national deficit in relation to implementing and strengthening the community health strategy and improving quality of hospital services. Thus remuneration for health workers needs to be improved further to facilitate retention of nurses in the country and in specific regions.
- There is need to recruit younger nurses directly from college into service to address problems being caused by an aging nursing workforce.
• The country requires a training programme for nurse educators to produce nurse trainers and prevent future deterioration of nursing education.
• Retirement age has been raised to 60 years for civil servants. This will help retain experienced nurses in service. However, a programme needs to be developed that uses retired nurses on contractual basis to arrest the shortage crisis.
• Policies on health financing and HR for health recruitment should be reviewed at local and global levels to facilitate HR recruitment, motivation and retention in low-income poorly staffed countries like Kenya.
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<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AOP</td>
<td>Annual Operation Plan</td>
</tr>
<tr>
<td>ARV</td>
<td>antiretroviral drugs</td>
</tr>
<tr>
<td>CBHWs</td>
<td>Community Based Health Workers</td>
</tr>
<tr>
<td>CDF</td>
<td>Constituency Development Fund</td>
</tr>
<tr>
<td>CHEWs</td>
<td>Community Health Extension Workers</td>
</tr>
<tr>
<td>CNO</td>
<td>Chief Nursing Officer</td>
</tr>
<tr>
<td>DoN</td>
<td>Department of Nursing</td>
</tr>
<tr>
<td>ECSA-HC</td>
<td>East, Central and Southern Africa Health Community</td>
</tr>
<tr>
<td>FB</td>
<td>faith based</td>
</tr>
<tr>
<td>FBO</td>
<td>faith based organisations</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>HR</td>
<td>human resources</td>
</tr>
<tr>
<td>HRH</td>
<td>human resources in health</td>
</tr>
<tr>
<td>ICHRN</td>
<td>International Centre for Human Resources in Nursing</td>
</tr>
<tr>
<td>ICN</td>
<td>International Council of Nurses</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organisation</td>
</tr>
<tr>
<td>IOM</td>
<td>International Organisation on Migration</td>
</tr>
<tr>
<td>IPPD</td>
<td>Integrated Personnel Payroll Data</td>
</tr>
<tr>
<td>KEPH</td>
<td>Kenya Essential Package for Health</td>
</tr>
<tr>
<td>KPPA</td>
<td>Kenya Progressive Nurses Association</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MoMS</td>
<td>Ministry of Medical Services</td>
</tr>
<tr>
<td>MoPHS</td>
<td>Ministry of Public Health and Sanitation</td>
</tr>
<tr>
<td>MVA</td>
<td>manual vacuum aspiration</td>
</tr>
<tr>
<td>NHSSP II</td>
<td>National Health Sector Strategic Plan II</td>
</tr>
<tr>
<td>NNAK</td>
<td>National Nurses Association of Kenya</td>
</tr>
<tr>
<td>NCK</td>
<td>Nursing Council of Kenya</td>
</tr>
<tr>
<td>NGOs</td>
<td>non-governmental organisations</td>
</tr>
<tr>
<td>NHIF</td>
<td>National Hospital Insurance Fund</td>
</tr>
<tr>
<td>PAC</td>
<td>post-abortion care</td>
</tr>
<tr>
<td>PHC</td>
<td>primary health care</td>
</tr>
<tr>
<td>PNO</td>
<td>Provincial Nursing Officer</td>
</tr>
<tr>
<td>RHF</td>
<td>rural health facilities</td>
</tr>
<tr>
<td>SSA</td>
<td>sub-Saharan Africa</td>
</tr>
<tr>
<td>WFP</td>
<td>workforce planning</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
## Appendices

### Appendix 1 Additional Tables

### Table A1: Public and FBO Health Facilities

<table>
<thead>
<tr>
<th>Institution Type</th>
<th>Public Health Facilities</th>
<th>Faith-Based Health Services</th>
<th>Overall Total</th>
<th>Total health facilities expected</th>
<th>Facility Shortfall</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>CHAK</td>
<td>KEC-CS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals</td>
<td>191</td>
<td>25</td>
<td>45</td>
<td>70</td>
<td>217</td>
</tr>
<tr>
<td>Health Centres</td>
<td>465</td>
<td>48</td>
<td>92</td>
<td>140</td>
<td>600</td>
</tr>
<tr>
<td>Dispensaries</td>
<td>2,122</td>
<td>324</td>
<td>282</td>
<td>606</td>
<td>2,236</td>
</tr>
<tr>
<td>Community Based Health Care Programmes</td>
<td>-</td>
<td>58</td>
<td>46</td>
<td>104</td>
<td>104</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,778</strong></td>
<td><strong>455</strong></td>
<td><strong>465</strong></td>
<td><strong>920</strong></td>
<td><strong>3,157</strong></td>
</tr>
</tbody>
</table>

Source: Faith Based Health Services vis-à-vis the Government Health Services (MoH Kenya 2007c).

### Table A2: Distribution of MoH Health Facilities by Provinces

<table>
<thead>
<tr>
<th>Province</th>
<th>Hospitals</th>
<th>Health Centres</th>
<th>Dispensaries</th>
<th>Total Facilities</th>
<th>Health Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nairobi Province</td>
<td>6</td>
<td>53</td>
<td>10</td>
<td>69</td>
<td>2.5%</td>
</tr>
<tr>
<td>Central Province</td>
<td>18</td>
<td>58</td>
<td>250</td>
<td>326</td>
<td>11.7%</td>
</tr>
<tr>
<td>Coast Province</td>
<td>16</td>
<td>31</td>
<td>211</td>
<td>258</td>
<td>9.3%</td>
</tr>
<tr>
<td>Eastern Province</td>
<td>32</td>
<td>69</td>
<td>427</td>
<td>528</td>
<td>19.0%</td>
</tr>
<tr>
<td>North Eastern Province</td>
<td>12</td>
<td>5</td>
<td>97</td>
<td>114</td>
<td>4.1%</td>
</tr>
<tr>
<td>Nyanza Province</td>
<td>38</td>
<td>70</td>
<td>291</td>
<td>399</td>
<td>14.4%</td>
</tr>
<tr>
<td>Rift Valley Province</td>
<td>47</td>
<td>119</td>
<td>678</td>
<td>844</td>
<td>30.4%</td>
</tr>
<tr>
<td>Western Province</td>
<td>22</td>
<td>60</td>
<td>158</td>
<td>240</td>
<td>8.6%</td>
</tr>
<tr>
<td><strong>Total Health Facilities</strong></td>
<td><strong>191</strong></td>
<td><strong>465</strong></td>
<td><strong>2,122</strong></td>
<td><strong>2,778</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: Facts and Figures (Ministry of Medical Services Kenya 2008).

### Table A3: Distribution of Students by Region (intake 2005 to 2008)

<table>
<thead>
<tr>
<th>Province</th>
<th>3rd Years</th>
<th>2nd Years</th>
<th>1st Years</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nairobi</td>
<td>270</td>
<td>279</td>
<td>69</td>
<td>618</td>
<td>15.0%</td>
</tr>
<tr>
<td>Central</td>
<td>249</td>
<td>281</td>
<td>78</td>
<td>608</td>
<td>14.8%</td>
</tr>
<tr>
<td>Coast</td>
<td>71</td>
<td>82</td>
<td>18</td>
<td>171</td>
<td>4.2%</td>
</tr>
<tr>
<td>Eastern</td>
<td>343</td>
<td>380</td>
<td>62</td>
<td>785</td>
<td>19.1%</td>
</tr>
<tr>
<td>North Eastern</td>
<td>30</td>
<td>42</td>
<td>1</td>
<td>73</td>
<td>1.8%</td>
</tr>
<tr>
<td>Nyanza</td>
<td>258</td>
<td>331</td>
<td>73</td>
<td>662</td>
<td>16.1%</td>
</tr>
<tr>
<td>Rift Valley</td>
<td>356</td>
<td>402</td>
<td>139</td>
<td>897</td>
<td>21.8%</td>
</tr>
<tr>
<td>Western</td>
<td>134</td>
<td>121</td>
<td>40</td>
<td>295</td>
<td>7.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,711</strong></td>
<td><strong>1,918</strong></td>
<td><strong>480</strong></td>
<td><strong>4,109</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Source: Nursing Council of Kenya

50 CHAK = Christian Health Association of Kenya by the Protestants
51 KEC-CS = Kenya Episcopal Conference – Catholic Secretariat
### Table A4: Nursing Workforce Distribution by provinces (Provisional 2008)

<table>
<thead>
<tr>
<th>Province</th>
<th>Nurses (Dec. 2005)</th>
<th>Nurses (June 2008)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Central Province</td>
<td>2,621</td>
<td>18.4%</td>
<td>1,937</td>
</tr>
<tr>
<td>Coast Province</td>
<td>1,439</td>
<td>10.1%</td>
<td>1,414</td>
</tr>
<tr>
<td>Eastern Province</td>
<td>2,092</td>
<td>14.7%</td>
<td>2,189</td>
</tr>
<tr>
<td>Nairobi Province</td>
<td>889</td>
<td>6.2%</td>
<td>1,661</td>
</tr>
<tr>
<td>North Eastern Province</td>
<td>300</td>
<td>2.1%</td>
<td>379</td>
</tr>
<tr>
<td>Nyanza Province</td>
<td>1,823</td>
<td>12.8%</td>
<td>2,352</td>
</tr>
<tr>
<td>Rift Valley</td>
<td>3,357</td>
<td>23.6%</td>
<td>3,265</td>
</tr>
<tr>
<td>Western Province</td>
<td>1,727</td>
<td>12.1%</td>
<td>1,469</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14,248</strong></td>
<td><strong>100%</strong></td>
<td><strong>14,666</strong></td>
</tr>
</tbody>
</table>

Source: MoH Kenya nursing database and staff returns

### Table A5: Nursing staff distribution by regions and by age

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>Registered Nurses (RNs)</th>
<th>Enrolled Nurses (ENs)</th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Below 35</td>
<td>35-44</td>
<td>45-55</td>
<td>Below 35</td>
</tr>
<tr>
<td>National Level</td>
<td>0</td>
<td>14</td>
<td>38</td>
<td>2</td>
</tr>
<tr>
<td>Central Province</td>
<td>129</td>
<td>208</td>
<td>216</td>
<td>246</td>
</tr>
<tr>
<td>Nyanza Province</td>
<td>140</td>
<td>122</td>
<td>116</td>
<td>321</td>
</tr>
<tr>
<td>Rift Valley Province</td>
<td>377</td>
<td>271</td>
<td>193</td>
<td>739</td>
</tr>
<tr>
<td>Eastern Province</td>
<td>137</td>
<td>179</td>
<td>109</td>
<td>264</td>
</tr>
<tr>
<td>Nairobi Province</td>
<td>113</td>
<td>130</td>
<td>52</td>
<td>166</td>
</tr>
<tr>
<td>Western Province</td>
<td>100</td>
<td>111</td>
<td>95</td>
<td>250</td>
</tr>
<tr>
<td>North Eastern Province</td>
<td>106</td>
<td>12</td>
<td>3</td>
<td>122</td>
</tr>
<tr>
<td>Coast Province</td>
<td>219</td>
<td>149</td>
<td>71</td>
<td>215</td>
</tr>
<tr>
<td><strong>Total by Age Groups</strong></td>
<td><strong>1,321</strong></td>
<td><strong>1,196</strong></td>
<td><strong>893</strong></td>
<td><strong>2,323</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(%) Age Distribution</th>
<th>Cadre</th>
<th>Below 35</th>
<th>35-44</th>
<th>45-55</th>
<th>Below 35</th>
<th>35-44</th>
<th>45-55 plus</th>
<th>RNs</th>
<th>ENs</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>All nurses</td>
<td>9.24%</td>
<td>8.36%</td>
<td>6.24%</td>
<td>16.24%</td>
<td>30.30%</td>
<td>29.61%</td>
<td>23.8%</td>
<td>76.2%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Table A6: Distribution of doctors, clinical officers and nurses (per 100,000 population) by Province

<table>
<thead>
<tr>
<th>Province</th>
<th>Kenya</th>
<th>Central</th>
<th>Coast</th>
<th>Eastern</th>
<th>North</th>
<th>Nyanza</th>
<th>Rift Valley</th>
<th>Western</th>
<th>Nairobi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Clinical Officer</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>6</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Nurses</td>
<td>49</td>
<td>73</td>
<td>50</td>
<td>56</td>
<td>28</td>
<td>40</td>
<td>49</td>
<td>45</td>
<td>34</td>
</tr>
</tbody>
</table>

Source: Human Resource Mapping and Verification Exercises (MoH Kenya 2007a)

Table A7: Registered maintained by NCK and number of nurses (June 2009)

<table>
<thead>
<tr>
<th>Category/Type of Register</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurses</td>
<td></td>
</tr>
<tr>
<td>1. Kenya Registered Community Health Nurses</td>
<td>13,220</td>
</tr>
<tr>
<td>2. Kenya Registered Nurses</td>
<td>11,960</td>
</tr>
<tr>
<td>3. Kenya Registered Midwives</td>
<td>6,741</td>
</tr>
<tr>
<td>4. Bachelor of Science in Nursing</td>
<td>780</td>
</tr>
<tr>
<td>5. Kenya Registered Anaesthetic Nurses</td>
<td>10</td>
</tr>
<tr>
<td>6. KRCCN</td>
<td>44</td>
</tr>
<tr>
<td>7. Kenya Registered Psychiatric Nurses</td>
<td>714</td>
</tr>
<tr>
<td>8. Kenya Registered Peri-operative Nurses</td>
<td>44</td>
</tr>
<tr>
<td>9. Kenya Registered Ophthalmology Nurses</td>
<td>44</td>
</tr>
<tr>
<td>10. Kenya Registered Paediatric Nurses</td>
<td>145</td>
</tr>
<tr>
<td>Enrolled Nurses</td>
<td></td>
</tr>
<tr>
<td>1. Kenya Enrolled Nurses</td>
<td>10,207</td>
</tr>
<tr>
<td>2. Kenya Enrolled Midwives</td>
<td>7,975</td>
</tr>
<tr>
<td>3. Kenya Enrolled Community Health Nurses</td>
<td>23,110</td>
</tr>
<tr>
<td>4. Kenya Enrolled Psychiatric Nurses</td>
<td>960</td>
</tr>
<tr>
<td>Total</td>
<td>75,951</td>
</tr>
</tbody>
</table>

Source: NCK Database (2009)

Note: The names of some of the nurses appear in two or three registers. The NCK is currently working on this to ascertain the actual number of nurses who have been trained in Kenya.
## Appendix 2

### NURSING STAFFING NORMS

**Community-Based Health Services (Level 1)**
- Divisional Supervision: 2 nurses
- Home Based Care Unit: 2 nurses + 50 CHWs
- School Health Care Unit: 2 nurses
- Dispensaries (level 2 facilities): 4 nurses (minimum)
- Health Centres (level 3 facilities): 16 nurses (minimum)

Hospitals (levels 4, 5, & 6) based on nurse/patients ratio per shift:

<table>
<thead>
<tr>
<th>Ward Type</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgical Wards</td>
<td>1:4</td>
</tr>
<tr>
<td>General Medical Wards</td>
<td>1:5</td>
</tr>
<tr>
<td>Paediatric Wards</td>
<td>1:5</td>
</tr>
<tr>
<td>Gynaecology Wards</td>
<td>1:5</td>
</tr>
<tr>
<td>Eye Ward</td>
<td>1:7 (min. 3 people per ward per shift)</td>
</tr>
<tr>
<td>Mental Health Ward</td>
<td>1:7 (min. 3 people per ward per shift)</td>
</tr>
<tr>
<td>Other Wards</td>
<td>1:6</td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>2:1</td>
</tr>
<tr>
<td>High Dependence Unit</td>
<td>1:2</td>
</tr>
</tbody>
</table>

**Operating Theatre**

- Receiving area: 1 nurse per shift (minimum)
- Operating Room: 3 nurses per shift (minimum)
- Recovery Ward: 1:1

**Maternity Unit:**

- Antenatal: 1:4
- Labour Room: 1:1
- Postnatal (SVD): 1:7
- Postnatal (C/S): 1:4
- Newborn unit: 1:3

**Out-patient Units**

- Triage Section: 2 nurse per day (minimum)
- Counselling room: 1 nurse for every 4 patients.
- Consultation Room: 1 nurse (minimum)
- Other sections: 30 patients per nurse

**Emergency Unit**

- Triage Section: 2 nurse per shift (minimum)
- Emergency Room: 2 nurses per room per shift (minimum)
- Observation Ward: 1:2
Appendix 3

KEPH BASED TRAINING NEEDS FOR NURSES

The following text is on six cohorts receiving health care services from the Kenya health care system to which nursing is part. It is an extract from the Nursing Policy Framework 2008 (draft) illustrating the other aspect of KEPH mentioned in Chapter 1.

1. *Mothers and the new-born* where the objectives are: mothers are kept healthy during pregnancy; mothers are able to have normal labour attended by skilled attendant; and newborns are protected against immunizable disease.

2. *Children 2 weeks old up to 5 years* where the objectives are: children receive protection against immunizable diseases; children are able to survive common childhood illnesses; and a health lifestyle is adopted among children.

3. *Older children aged 6 to 12 years* where the objectives for cohort 2 continue.

4. *Youth and the adolescent age 13 to 24 years* where the focus is education and counselling on adolescent sexuality and lifestyles that prevent early marriage, early pregnancy, HIV and STI spread, and prevention of drug and substance abuse.

5. *Adults aged 25 to 59 years* where the objectives are: adults are practicing a healthy lifestyle; adults are screened against non-communicable diseases; and adults are able to survive common health conditions affecting them.

6. *The elderly 60 years and above* where the objectives are: elderly persons are practising a healthy lifestyle; the elderly are screened against non-communicable diseases; the elderly are able to access drugs for degenerative diseases; and elderly persons are able to survive common health conditions affecting them.

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52 Nursing Policy Framework is a long term strategy which is part of the nursing strategic plan.
Appendix 4

HEALTH REFORM CHALLENGES

Health reform agenda focuses on four broad objectives:
1. health financing mechanisms that are acceptable and affordable;
2. best ways of allocating resource to maximise cost-effectiveness;
3. improving ways in which services are being delivered to the people; and
4. facilitating fairness in access to health care by all population groups (Jowett 2000 pp 258-25).

The course of health care is highly influenced by socio-economic and national political factors. National health policies are predominantly political decisions made at the highest levels of government. Therefore political policies remain in the frontline, dictating directions health care systems need to take. Designers of health systems, nursing being one, must therefore be cognisant of political priorities in health. The following text explains how politics and external economic forces have altered the Kenya health systems landscape.

Before independence there were social segregation policies in health care. There were hospitals designated for whites, Indians and Native Africans. Native Africans would pay a standing fee for outpatient visits and for in-patient care. The political direction after independence in 1963 changed all that.

1. After independence, focus was on eliminating social segregations and improving the health of indigenous population. Although everybody would access all health facilities irrespective of their colour, gender, age, religion or creed, only racial segregation was removed. Economic segregation remained to this day where the wealthy are able to access better health care than the poor. Majority of the poor still live in rural areas where there is poor access to health services; some of them cannot afford the cost of transport to distant health facilities; and some cannot afford to pay even the cost sharing in public health facilities.

2. After independence new health facilities were constructed (with some existing ones undergoing expansion) to increase access to health care. This trend of expanding health care services and health facilities still continues today as more hospitals, health centres and dispensaries are being constructed. The trend continues to increase demand for more health workers, particularly nurses.

3. Free medical services were introduced in 1965 under the African Socialism Policy on Sessional Paper No. 10. In this way the Government decided to finance and provide health care to the people. Demand for health care sharply increased; congestion in health facilities followed. The need for more health workers became apparent and training for health workers was expanded with more nursing schools being opened; other health cadre trainings being initiated; and a new medical school were started in 1971. Today there are
two medical schools and two more are soon opening their doors for admission. Nursing training institutions rose from less than 10 in 1963 to 53 in 2008.

The first training of Community Health Nurses was established in 1966 in Kisumu as a response to the need for strengthening rural-based health care (long before the Alma Ata Conference on Primary Health Care in 1978). At this time Rural Health Training Centres were established in each province to improve health workers knowledge and skills on rural health services, facilitate improved access to health care and intensify disease prevention and health promotion.

Up to 1972 provision of public health care services was two dimensional. There were the Central Government health services directly under the Ministry of Health, and the Local Government health services run by city council, town councils and county councils. Private health care was minimal concentrating only in urban areas, except the Faith Based Health Services which have always operated among the disadvantaged communities.

The County Councils operated mainly health centres and dispensaries in the rural areas where financial circulation was poor and levy collections were low. The introduction of free medical services in 1965 created an unbearable demand on the County Councils causing health services in rural areas to collapse. The Central Government became compelled to take over health services in the rural areas run by the County Councils in 1972. All health workers (the majority being nurses) were transferred from the Local Government employment terms to the Central Government employment terms. This became the second major health reform undertaking in Kenya.

After the 1978 Alma Ata Conference on primary health care (PHC) health reform agenda spread across the globe (more so in SSA) with five objectives: to promote community participation; to enhance health promotion; to facilitate equity; to facilitate use of appropriate technology; and to promote multi-sectoral collaboration (Jowett 2000 p. 260). All these agenda revolved around increasing access to health care, making health care affordable and improving quality of health care. Cost containment in health care emerged as an essential factor.

The oil crisis of 1973 and 1979 negatively affected world economy. Developing countries become most affected as the prices of agricultural commodities fell due to global economic recession. Raising external health financing support to developing countries caused pressure on international donor agencies to change course (Jowett 2000). The Structural Adjustment Programme was introduced in mid 1980s, causing three main social reform agendas in health care systems:

1. Review of health financing mechanisms that lead to the introduction of Cost Sharing (Facility Improvement Fund) in health care in 1989, as an instrument for cost recovery and as a source of fund for improving infrastructure in health care. To date the National Social Health Insurance Scheme designed in 2005 as an alternative health financing mechanism has not been approved for implementation in Kenya.
2. Civil service reform agenda was introduced. It created review of recruitment policies and practices, causing employment freeze on health workers in 1996 and nurses in 1998.

3. Review in health management and service delivery practices was initiated. It gave rise to the Kenya Health Policy Framework 1994. This Framework created the first National Health Sector Strategic Plan (NHSSP) 1999 – 2004 and the 2nd NHSSP II 2005 -2010. It is during the NHSSP II that AOPs and performance contracting were also introduced in health care. The entire health care delivery system is still struggling to comprehend and implement performance contracting effectively.

In most recent times the introduction of performance contracting in the Civil Service by the Government has created change in the way business is conducted in health sector. Annual Operation Plans (AOPs) have been introduce at national, regional and service delivery institution levels. Performance Contracting has also been introduced at ministerial, departmental, regional and service delivery institution levels. Performance appraisal system is being intensified at individual worker’s levels to cascade down performance contracting principals and mechanisms. These approaches are meant to introduce focused health care delivery and improve productivity.

Nurses are currently labouring to embrace this change in the way business is to being conducted in health care delivery. The nursing strategic plan has been a useful tool in implementing the performance contract. It serves as a source of information for annual planning. The Department of Nursing is at the centre of developing and implementing nursing reform agenda towards new health care dispensation.

Meanwhile politics continue to shape and reshape the way health services are being delivered to the people. After the general election of December 2007, a Grand Coalition Government was formed in April 2008. The Ministry of Health was split into two ministries – Ministry of Medical Services (MoMS) and Ministry of Public Health and Sanitation (MoPHS). Consequent to the division of the MoH nursing had to be reorganised to provide services in the two ministries with focus to community health nursing in the MoPHS and hospital-based nursing services in the MoMS. Again the Department of Nursing is at the centre of it.

Generally the responsibilities of these two ministries comprise curative and rehabilitation services for the Ministry of Medical Services; and preventive and health promotive services for the Ministry of Public Health and Sanitation. In the simplest terms the MoMS is responsible for hospital-based health care and the MoPHS is responsible for rural health services in health centres, dispensaries, and community health units. However, details of the assignment in the two ministries as given by the Government are shown in Table A8 below:

<table>
<thead>
<tr>
<th>Table A8: Functions and responsibilities of MoMS and MoPHS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Ministry of Medical Services</strong></td>
</tr>
<tr>
<td>- Medical Service Policy</td>
</tr>
<tr>
<td>- Curative Services</td>
</tr>
<tr>
<td>- HIV/AIDS and STI Infections treatment and management</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Maternity Services</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>Rural Medical Services</td>
</tr>
<tr>
<td>Clinics and hospitals</td>
</tr>
<tr>
<td>Registration of doctors and para-medicals</td>
</tr>
<tr>
<td>Nurses and Midwives</td>
</tr>
<tr>
<td>Clinical laboratory services</td>
</tr>
<tr>
<td>Kenya Medical Training College</td>
</tr>
</tbody>
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