HUMAN RESOURCES FOR HEALTH COORDINATION MECHANISM: IMPLICATIONS ON STAFF ESTABLISHMENT AND POLICY IN THE MINISTRY OF HEALTH, KENYA

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MAY 2014
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This project is my original work and has not been submitted for a degree in any other university.

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DEDICATION
In memory of my late father, Judson Nyaboga, September, 2007 and my sister, Emily Moraa, December, 2007 – You shall not be forgotten. Special thanks to my Husband Mark Otieno for his steadfast support.
ACKNOWLEDGEMENT

I acknowledge the almighty God for the strength and grace provided while undertaking this course and project work.

I am indebted to my supervisor Dr. Stephen Muathe who spent his time guiding me as I developed this document. Without his input, this project would not have been what it is today. May God grant him long life to continue supporting many more students.

I am equally obliged to acknowledge the advice and guidance I constantly received particularly from Dr. Felix Kiruthu, Professor David Minja and Mr. Weldon Ngeno. My gratitude also goes to Ms. Norah Simiyu, for assisting me with all the administrative processes at Kenyatta University making it possible for me to submit the final proposal and project with less difficulty.

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Lastly, my special thanks go to respondents in the Ministry of Health, Kenya who provided information that formed part of this project. Without them, this report would not have seen the light of the day. God bless you abundantly.
ABSTRACT

Human Resource for Health (HRH) is considered as a critical ingredient of any health system. Despite this, there exist critical HRH challenges in Kenya as demonstrated by the gaps in the staff establishment and HRH policy. HRH coordination mechanisms are continually becoming recognized globally as a strategic system in contributing to scaling up human resources for health staffing establishment and policy. It is against this that the study on the implications of the HRH coordination mechanism on staff establishment and policy in the Ministry of Health, in Kenya was conducted. This study was motivated by recent industrial unrest experienced in the health sector in Kenya coupled with a critical shortage of health workers in the Ministry of Health especially in the hard to reach areas. Specifically the study sought to establish the effect of HRH coordination structures and capacity building on policy and staff establishment. It also sought to establish the contribution of HRH coordination actors and the leadership of the HRH coordination on staff establishment and policy. A conceptual framework was used. Functionalism and contingency theory guided the study. Descriptive research design was applied. Stratified and purposive sampling was used to select the study respondents. Primary and secondary data collection methods were applied. Data collected was tabulated, coded and analyzed for purpose of clarity, using Statistical Package for Social Scientist (SPSS). Descriptive statistics including means, standard deviations, frequency counts, percentages was used to analyze the data. Data was presented using tables, and pie charts to make them reader friendly. Literature on the framework of the HRH coordination mechanism, leadership, HRH actors and capacity building was reviewed. The study established that the HRH Coordination structure has an implication on policy and staff establishment in the Ministry of Health. The study further established that the HRH actors contribute both technically and financially on policy and staff establishment issues. Further the study also revealed that the HRH actors do participate in joint planning with the Ministry of Health. The findings of this study have provided useful recommendations on stakeholder coordination towards addressing HRH challenges at the National and County level. The study findings revealed that the leadership of the HRH coordination have an effect on staff establishment and policy together with capacity building interventions initiated by the HRH coordination mechanism. The study concluded that HRH coordination mechanism has an implication on policy and staff establishment. The study recommends for increased investment on capacity building to scale up HRH production and instituting proper systems to avoid duplication of capacity building efforts. Further it recommends the need to strengthen HRH leadership at all levels.
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<td>AMREF</td>
<td>African Medical and Research Foundation</td>
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<td>CCF</td>
<td>Country Coordination Framework</td>
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<td>CHAK</td>
<td>Christian Health Association of Kenya</td>
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<tr>
<td>DFID</td>
<td>Department for International Development</td>
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<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunization</td>
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<td>GHWA</td>
<td>Global Health Workforce Alliance</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus Infection/Syndrome</td>
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<td>HIV/AIDS</td>
<td>Immunodeficiency</td>
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<td>HRH</td>
<td>Human Resource for Health</td>
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<td>HRH ICC</td>
<td>Human Resource Inter-agency Coordination Committee</td>
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<td>HRD</td>
<td>Human Resource Development</td>
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<td>HRM</td>
<td>Human resource Management</td>
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<td>HoDS</td>
<td>Head of Departments</td>
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<td>HSCC</td>
<td>Health Sector Steering Committee</td>
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<td>ICC</td>
<td>Inter-agency Coordination Committee</td>
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<tr>
<td>KMPDDU</td>
<td>Kenya Medical Practitioners, Pharmacists and Dentist Union</td>
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<tr>
<td>JLI</td>
<td>Joint Learning Initiative</td>
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<td>JICC</td>
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NHRHSP  National Human Resource for Health Strategic Plan
MDGS  Millennium Development Goals
MOMS  Ministry of Medical Services
MOPHS  Ministry of Public Health and Sanitation
MOH  Ministry of Health
MSH  Management Science for Health
ICC  Inter-agency Coordination Committee
SWAP  Sector-wide approach
TWGs  Technical Working Groups
UNICEF  United Nations International Children Emergency Fund
USAID  United States Agency for International Development
WHO  World Health Organization
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OPERATIONAL DEFINITIONS OF TERMS

Actors: Actors has been used interchangeable with stakeholder in this study and refers to a group or an individual who has a role in the coordination framework.

Human resource for Health (HRH): HRH has been used to refer to human resources that work in health sector including technical and support.

According to World Health Organization (2006), the health workforce can be defined as “all people engaged in actions whose primary intent is to enhance health”. These human resources include clinical staff such as physicians, nurses, pharmacists and dentists, as well as management and support staff – those who do not deliver services directly but are essential to the performance of health systems, such as managers, ambulance drivers and accountants.

HRH Coordination Mechanism: Coordination mechanism has been used in this study to a consortium bringing together several actors contributing to HRH matters. It has been used to mean the same as the HRH inter-agency Coordination Mechanism (HRH ICC).
CHAPTER ONE: INTRODUCTION

1.1 Background of the study

Human Resource for Health (HRH) is an integral part of any health system. Functioning health systems are the key to effective service delivery in any country regardless of its level of development, within which it is important to mobilize competent and motivated health workers to become key drivers for primary health care. Kenya is categorized by the World Health Organization (WHO) as one of the 57 countries facing Human Resource for Health (HRH) challenges according to a World Health Report of 2006. In Kenya, human resources for health (HRH) crisis is characterized by a severe shortage of health workers, with an average of 1.3 health workers per 1,000 population, 43% below the WHO benchmark of 2.3 (Save the Children, 2011). The Save the Children Report further highlights that over the years, efforts to improve global health have sidelined the vital contribution that health workers make. As a result, clinics and hospitals are understaffed, especially in remote or rural areas.

Despite the multiple sectors and stakeholders involved in training, deploying and maintaining a health workforce offering high performance, the HRH unit in the Ministry of health is considered to be key in moving forward the HRH agenda (WHO, 2012). The worldwide crisis in the health workforce was already recognized in 2002 when the Joint Learning Initiative (JLI) on HRH was launched with the support of the Rockefeller Foundation. It brought together about 100 health professionals and experts from
academia, countries and international agencies to examine the issue. In 2004 when the JLI published its report, a clear picture on the existence of the crisis was globally acknowledged, although the extent and its exact nature were still being estimated (JLI 2004). The crisis was related to both a serious shortage in the numbers and an imbalance in the skills mix for health workers available in most countries.

According to Kirigia and Barry (2008), there are serious leadership and governance challenges that include weak public health leadership and management inadequate health-related legislations and their enforcement; limited community participation in planning, management and monitoring of health services; weak inter-sectoral action; horizontal and vertical inequities in health systems; inefficiency in resource allocation and use; and weak national health information and research systems. They further highlight that the extreme shortages of health has been exacerbated by inequities in workforce distribution and brain drain. Thus, the delivery of effective public health interventions to people in need is compromised particularly in remote rural areas.

Sub-Saharan countries in particular were estimated to need to increase their health workers by a factor of almost 3 for any hope of significantly progressing towards the millennium development goals (MDGs). These health worker requirements were necessary to support: for sub-Saharan Africa reduction by two thirds of the under-five mortality rate between 1990 and 2015; improvement of maternal health; and successful combat of HIV/AIDS, malaria and other diseases. In terms of responsive action, the
World Health Organization (WHO) in its 2006 report rated the HRH crisis as worsening (WHO, 2006). It noted that while impressive progress was being made in health science and technology, the system to deliver them to needy populations was lacking due to the absence of adequate health personnel capacity. Similarly to the above Joint Learning Initiative study, WHO identified this HRH challenge as posed by: numbers - a mismatch between the number of health workers needed at service points and those deployed, leading to staffing shortages and wasteful excesses.

This widening recognition of the global HRH crisis led to the formation of the Global Health Workforce Alliance (GHWA) in 2006, as a partnership dedicated to identifying and coordinating solutions to the health workforce crisis (WHO, 2006). GHWA brought together a variety of actors, including national governments, civil society, finance institutions, workers, international agencies, academic institutions and professional associations and emerged as the forum for international exchange regarding action on HRH to date. Global efforts on HRH thus progressed simultaneously at GHWA and WHO.

GHWA on its part convened the first global forum on HRH in Kampala, Uganda in March 2008 (Global Health Workforce Alliance, 2008). During this forum the Kampala Declaration and Agenda for Global Action summarizing efforts needed at global and country levels to address health workforce challenges was developed and ratified as with commitment of members’ future response on HRH. The Declaration specifically called
on government leaders to provide the stewardship needed to resolve the health worker crisis by adopting a collaborative approach, which would involve relevant health sector stakeholders in each country; and advocating for more inter-sectoral engagement among private, public, faith-based and other nongovernmental actors.

As a result of the first GHWA’s call for joint global action on HRH, the WHO’s 63rd World Health Assembly in 2010 adopted the WHO voluntary Global Code of Practice on the International Recruitment of Health Personnel. The Code set out guiding principles and standards of best practice, whose intended results was reduction in the loss of health workers from some countries to others (World Health Organization, 2010). The second HRH global forum held in Bangkok, Thailand in January 2011 recognized significant advances in health workforce development that had taken place since the first conference (GHWA, 2011). Nevertheless, the second forum could identify major gaps that still remained for countries to address in their national HRH responses. Issues remained to do with the supply of health workers (those currently available and those being prepared to enter the health workforce); and in the availability of reliable and updated data to inform policy making, HRH planning, and management of the health workforce.

At the regional level, among the first countries to initiate national responses to this crisis was the Government of Malawi, which implemented a six-year Emergency Human Resource Program 2004 to 2009. This was designed primarily to address the health crisis
in Malawi, largely caused by the acute shortage of professional workers in the public health sector. The intervention was implemented through a sector wide approach (SWAp) and successfully accomplished its primary goal of increasing the number of professional health workers in public and key health services institutions (Department for International Development, 2010).

It is widely accepted that many different stakeholders have a role to play in HRH governance, including the ministries of health, education and finance, public service commissions, local and national governments, professional associations, unions and academic institutions. The unique contribution of each group makes its participation an important factor in HRH planning and implementation. However, the presence of such a wide range of stakeholders requires mechanisms for policy dialogue in order to ensure coordinated action. To this end, the Ministry of Health in Kenya is best placed to provide leadership, for which it needs to have an appropriate mandate and the capacity to take up the challenges.

1.1.1 Ministry of Health

In an attempt to coordinate HRH in Kenya, the Ministry launched the first National Human Resource for Health Strategic Plan (NHRHSP) in 2009 whose main goal was to support the implementation of the National Health Sector Strategic Plan II (NHSSP II) goal of reversing the decline of key health indicators by providing a framework to guide and direct interventions, investments and decision making in the planning, management
and development of Human Resources (Ministry of Health, 2009). Further to this they launched the HRH Inter-agency Coordinating Committee (ICC) in July 2010 whose major goal was to coordinate partner’s contribution and support to addressing HRH and overseeing the implementation of the HRH Strategic Plan.

Much of the attention in HRH globally and including in Kenya has focused on addressing inadequacy of health worker numbers, motivation and retention of health workers. Campbell and Stilwell (2008), point out the many examples have been identified where Development Partners and their implementing agencies actively support the development of HRH and the expansion of the health workforce. Coordination of these initiatives is welcomed to promote alignment to country leadership. With the wider macro-economic issues related to public service employees, there is an argument for broader stakeholder participation from the GoK and the health sector. Securing the participation of these stakeholders alongside the existing agencies who engage on HRH will enable broader consensus, engagement and actions, and can improve understanding among stakeholders of the requirements for more flexible fiscal space for HRH development.

Findings of a performance needs assessment conducted in Kenya by Capacity Kenya Project in 2011, revealed some seemingly contradictory information. For example, although most health workers surveyed reported having a clear job expectation, a smaller percentage reported having a written job description. Qualitative data indicate that health workers were less clear about their roles, a situation that is further exacerbated by staff
shortages, which was also cited as a barrier to performance. Regarding supervision, a high percentage of respondents reported receiving informal supervision often, and that supervision is of “good” quality. However, qualitative findings indicate that health workers suffer from burnout due to, among other factors, staff shortages and lack of supervisory support, which in some instances has led to health workers taking on multiple roles or duties and leading sometimes to health workers taking less time with patients or even taking short cuts (Capacity Kenya Project, 2011).

The HRH coordination mechanism has been in existence in Kenya since 2010. One of their major roles as per the Terms of Reference was to oversee and spearhead the Implementation of the National HRH Strategy 2009-2012 and other policy reforms in the sector. The Report of the end of term evaluation of the National HRH Strategic Plan (MoH, 2013) highlighted that though challenges still exist there was a lot of achievement in the implementation of this First National HRH Strategic Plan.

The industrial unrest by health workers experienced in Kenya in December 2011 was an indication of worsening HRH crises. A taskforce was established as part of a return to work formula and to look into grievances of the health workers. The Musyimi Taskforce report, 2012 highlights that overall, Kenya has 16 doctors per 100,000 population and 153 nurses per 100,000 populations. This is below the WHO recommended staffing levels of 100 doctors and 356 nurses per 100,000 population. Furthermore only a third of these are in the public service while two thirds are in the private sector. Effectively
therefore a third of the doctors cater for 57% of outpatient visit and 64% of admissions serviced by the public sector (Household health expenditure survey report, (2007). This demonstrates that the Kenya’s health system faces high under staffing and exhibit mal-distribution of health workers.

1.2 Statement of the Problem

There has been a significant visibility and focus on HRH in Kenya since the launch of the first NHRHSP in 2009 as a strategy of addressing shortage and mal-distribution of health workers. However, the HRH Situation continues to worsen despite the significant investment in strengthening the HRH coordination mechanism, with a critical challenge in attraction and retention of health workers in Northern Kenya according to a comprehensive Northern Kenya HRH assessment conducted by the USAID-funded Capacity Kenya Project in 2012 (Capacity Kenya Project, 2012). Chaknova et.al, (2009) in their study titled Health workforce attrition in the public sector in Kenya, focused on the factors influencing health worker attrition. Their findings revealed the main reason for health worker attrition at each level of facility, when looking at all cadres combined, was retirement (accounting for 48% to 58% of total attrition at the average facility), and followed by resignation and death. Resignation accounted on average for 40% of HRH attrition in provincial hospitals, 35% of attrition in district hospitals and 25% of attrition in health centres. The HRH Coordination mechanism established in 2010 was one attempt at addressing staff establishment and policy issues in the Ministry of Health. An evaluation of the first national HRH Strategic plan 2009-2012 (MOH, 2013), reveals that
though there has been a lot of achievement there are still critical HRH challenges that
remain to be addressed.

1.3 Objectives of the Study

The objective of the study was to investigate the implications of the HRH coordination
mechanism on staff establishment and policy in the Ministry of Health, Kenya.

The study however sought specifically to:

1. Establish the effect of HRH coordination structures on HRH staff establishment
   and policy for HRH in the Ministry of Health in Kenya;
2. Investigate the role of HRH coordination actors on staff establishment and policy
   in the Ministry of Health in Kenya;
3. Determine the contribution of leadership of the HRH coordination on staff
   establishment and policy in the Ministry of Health in Kenya;
4. Examine the effect of capacity building in the HRH coordination framework on
   staff establishment and policy in the Ministry of Health in Kenya.

1.4 Research Questions

The research study was guided by the following questions:

1. What is the effect of HRH coordination structures, on the staff establishment and
   policy in the Ministry of Health in Kenya?
2. What is the role of HRH actors in addressing staff establishment and policy in the
   Ministry of Health in Kenya?
3. What is contribution of the leadership of the HRH coordination on staff establishment and policy in the Ministry of Health in Kenya?

4. What is the effect of capacity building by the HRH Coordination on staff establishment and policy in the Ministry of Health in Nairobi, Kenya?

1.5 Research Premise

1. There is an effect of HRH coordination structures on staff establishment and policy at the Ministry of Health, Kenya;

2. The HRH Coordination actors have a role on staff establishment and policy in the Ministry of Health, Kenya;

3. The leadership of the HRH coordination mechanism has a contribution on staff establishment and policy in the Ministry of Health in Kenya;

4. There is an effect of capacity building in HRH Coordination framework on staff establishment in the Ministry of Health in Kenya.

1.6 Significance of the study

This research has made a significant contribution to the Ministry of Health in Kenya as they have been implementing the HRH coordination mechanism since 2010. The research has provided valuable information on how the mechanism has contributed to staff establishment and policy in the Ministry of Health, Kenya.
Health is now a devolved function as per the Constitution of Kenya 2010 and as County Governments develop systems for management of the HRH function, this study has provided relevant information on the HRH Coordination mechanism and offers critical input on how best to develop a similar mechanism at the County level.

Globally this study provided critical information on the functionality of the HRH coordination mechanism in Kenya in as far as addressing the staff establishment and related policy issues including staffing norms and standards. The GHWA that has been supporting countries to implement the HRH coordination frameworks will also find the findings useful.

The findings of the study are critical in raising the visibility of the HRH Coordination mechanism in Kenya and would encourage and reinforce interest of stakeholders in HRH coordination as a framework for strengthening HRH. The findings have provided information on Kenya’s efforts towards meeting the Millennium Development Goal - 4. To reduces child mortality rates; 5. To improves maternal health; and 6. To combat HIV/AIDS, malaria, and other diseases, which are highly dependent on the different initiatives being invested in and their contribution to staff establishment and a supportive policy environment. Additionally this study has provided useful information on the progress towards implementation of the Vision 2030 model for Kenya. One of the key outputs expected for health in the vision 2030 is a comprehensive Human Resource Strategy of which the Human Resource for Health Coordination is a part of it. The study
revealed that the HRH coordination mechanism has been overseeing implementation of such strategies.

This study has also added to the exiting knowledge and highlighted areas of further research in different aspects of HRH.

1.7 Scope and Limitations of the Study

This study was limited to the Ministry of Health, Kenya. The study looked into the implications of the HRH Coordination mechanism in addressing staff establishment and policy in the Ministry of Health in Kenya. It involved collecting data from the staff working in the HR Departments and Heads of Department (HODs) in the Ministry health, Kenya. On policy, this study was limited to policies relating to staff establishment and HRH management.

Staff resistance to provide information was one of the key limitations of the study. To mitigate this, the researcher provided adequate time for the respondents to fill their questionnaires and make systematic follow ups. Approval was also sought collect data from the Ministry of Health in Kenya to leverage this challenge.

Data required for this study was scattered in different departments. To mitigate this limitation, the researcher applied a variety of data collection tools to obtain data from both primary and secondary sources.
CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction
This chapter presents a review of literature related to the study topic, the conceptual and theoretical framework.

2.2 Review of Past Studies

2.2.1 Human Resource for Health Coordination Mechanism in Kenya
Effective coordination of the Health sector activities is recognized as a key imperative in strengthening health care delivery systems and provision of quality health services. In order to improve health performance targets and achieve the health-related MDGs, partnership and coordination among all stakeholders has become inevitable. According to the GHWA, 2010 facilitating country actions to address the HRH crisis means building the capacity of priority countries to assess, formulate, manage and implement the appropriate policies and interventions in their own communities. It also entails assisting them to ensure that a sustainable, motivated and skilled cohort of health workers is available to meet health care needs and working with partners to ensure that funding and technical expertise is available for programmes. Given the diverse nature of country-level stakeholders involved in HRH, coordination is essential for addressing the crisis locally.

The health sector stakeholders in Kenya adopted a sector-wide approach (SWAP) to guide the coordination of health activities and programmes with a view to maximizing utilization of scarce resources amongst partners. Stakeholders resolved to adopt sector
wide approaches in implementing programmes to realize the objectives of the second
Health Sector Strategy Plans. This coordination framework consists of a Joint Inter-
agency Coordinating Committee (JICC); a Health Sector Coordinating Committee
(HSCC), Health Sector Steering Committee (HSSC); an Inter-agency Coordinating
Committee (ICC); and the county and District Health Stakeholder Committees (PHSF &
DHSF), (Ministry of Health, 2011) MOH, 2011). Each of these structures has a distinct
mandate in realizing the goals of Health Sector Goals and Vision 2030. The Inter-agency
Coordination Committee on Human Resources for Health (HRH ICC) is one of the 17
technical and support systems ICCs formed to facilitate the implementation of these
overarching objectives. Launched on February, 17 2010, the HRH ICC is expected to
spearhead a wide range of HR reforms that will enable the effectiveness and efficiency of
service delivery across the entire health sector. The framework for the HRH coordination
mechanism is shown in figure 2.1 below.
2.3.2 Human Resource for Health Actors

The Global Health Workforce alliance, 2010 highlights that, it is essential that national governments and all stakeholders at local, regional and global levels work together for
the successful implementation of the coordination mechanism. The highest level of the various government ministries involved in HRH should provide the political leadership and commitment to the CCF process. Given the gravity of the HRH crisis and varying roles of stakeholders in resolving the crisis, leadership and close monitoring will be required by ministers, permanent secretaries and general directors of all concerned government entities. This will ensure that their specific contributions, commitment and participation are provided in a timely manner to strengthen the HRH committee. National constituency stakeholders (such as health professional associations, training institutions, NGOs, FBOs, academia, research institutions, bilateral and multilateral partners, trade unions and the private sector) should similarly support the functionality of the HRH committee through active participation and regular attendance at meetings (Ibid, 2010).

Local capacity and the relative strengths of each stakeholder should be fully exploited in finding solutions to bottleneck and obstacles to improve the HRH crisis. Constituency stakeholders should examine their roles, policies and strategies to assess the impact of their programmes and how they can better contribute to resolving HRH issues in their country (GHWA, 2010). In Kenya, the HRH ICC mechanism has drawn actors from a number of key institutions that have a role in HRH. Apart from the Kenya Government as lead for the HRH Coordination mechanism, through its Health Ministries, the other Implementing Partners include; African Medical and Research Foundation; Christian Health Association of Kenya; Global Alliance for Vaccines and Immunization; International Centre for AIDS Care and Treatment Programmes; Karibuni Onus; Kenya
Medical Training Centre; Mercy Project; Medicines Sans Frontieres; Management Sciences for Health; Save the Children; Terre des Hommes Swiss; Tunza; United Nations International Children Emergency Fund; the USAID projects, Population and Health Integrated Assistance and Capacity Kenya; and WHO (MOH, 2012).

The constituency of representatives from this organization is one of the key issues the HRH coordination is trying to handle besides ensuring active members participation to the HRH coordination agreed priorities (MOH, 2012). The evaluation report for the NHRHSP 2009-2012 also highlights a challenge in receiving timely information and data from stakeholders for decision making.

2.2.3 Leadership of Human Resource for Health Coordination Mechanism

Effective management and leadership are critical aspects of well-performing health organizations and programs. Even the availability of technically competent health professionals, adequate facilities and supplies, and well-designed programs does not assure high performance in delivery of family planning or other health services (Management Science for Health, 2008). The critical role played by leadership in providing stewardship to the HRH dimensions of the human resource (HR) crisis in health have been reported in stark terms in publications and studies by the Joint Learning Initiative (JLI) (2005) and the World Health Organization (WHO, 2006) among others. Nzomo et.al (2009) highlighted that missing at all levels of the health system is a critical mass of proactive, respected, and professionally trained human resource managers and
specialists who have the authority and expertise to command attention, and champion a comprehensive response. Ideally, a cadre of managers should be trained at the central, provincial, and district levels. The study findings indicated a critical need for capacity building in human resource management in the sector. The respondents identified HR challenges in their organizations that severely limit their capacity to meet the health needs of their populations. In broad categories, these challenges are: understaffing, lack of staff skills, lack of staff satisfaction, poor working conditions, and staff grievances. These are complex issues that, if neglected, contribute directly to lower standards of performance, increased staff turnover, and higher levels of staff vacancies. In a fully resources system, professional HR managers would be trained and prepared to address these challenges (Ibid).

Human Resource leadership has been recognized as critical in improving results in health. O’Neil (2008) highlights that the lack strategic HR leadership (managing people as a strategic resource) poses a significant challenge for most ministries of health because HR management policies and practices are not in professional hands. Governments lack the ability to adapt to rapid changes such as labor migration, the impact of HIV/AIDS, structural adjustments and hiring freezes. O’Neil further notes that countries need visionary leaders to advocate that funding for HR solutions go hand-in-hand with funding for health programs. Millions of dollars, for example, have been invested to ensure the availability of AIDS and tuberculosis drugs, but hardly any funding has been committed to ensure that there is a sustainable work-force to administer these drugs.
Leaders in the health sector have a critical role in change management. According to Gilson and Daire (2011) managers who lead change make their own decisions how local level needs within the policy and resource framework that guide them rather than simply administering instructions received from their bureaucratic and political principals. Similarly, Save the Children, (2011) highlights the critical role of leadership in addressing HRH. They assert that ministries of health require clear political leadership, with health ministers who are committed to addressing health workforce needs in a sustainable and sequenced way that prioritizes the unmet needs of the poorest children and their families.

2.2.4 Capacity Building

According to Ndumbe, P. (2009), the reversal of the worrying health and development indices of the African continent cannot be achieved without appropriate HRH and development. Training institutions have an important role to play in the production of all cadres of HRH in adequate numbers and quality. The role of training institutions in capacity building is highlighted to as an imperative.

Capacity among HRH stakeholders varies immensely, as does their level of engagement in collaborative dialogue (GHWA, 2010). To better identify gaps in capacity, partners in HRH should undertake a situation analysis of all stakeholders to determine the various capacity building needs that will impact the comprehensive, costed, evidence-based HRH plan. In many countries, strategic planning and advocacy are two recurring capacity gaps.
that could be considered as starting points for future work. All stakeholders should be encouraged to contribute, facilitate and participate in the process of capacity building needed to transform health systems so that they can better meet the range of existing health challenges.

According to Save the Children (2011), in many low-income countries, the low levels and poor quality of education contribute to critical shortages of health workers. In the poorest countries only a small proportion of children attain the levels of education needed to qualify for formal training as a nurse or doctor, and there are usually too few medical training institutions, with those that do exist often under resourced. For example, whereas in Europe 173,000 doctors are trained each year, in Africa this number is just 5,100 (Action for Global Health, 2010). Many countries lack the capacity either to train enough people to become health workers, or to provide effective in-service training so qualified workers can develop and improve their skills.

The second Global Forum for HRH Conference (2011) noted that there are multiple sources of financing for health worker education and the impacts of different financing sources need to be evaluated for quality and quantity. Different financing modalities have important implications for equity. There are large disparities in the health workforce in many countries, with under representation of women, rural backgrounds or ethnic minorities. This is the case in both public and private education and training sectors. There is a need to develop policies and programs that harness private financing while also
ensuring access to opportunities by all segments of the population. There are powerful ways to increase participation by poor households including targeted subsidies or scholarships and similar approaches. Government financing of medical education needs to deal with the urban-rural aspect. Public policy should focus on ensuring adequate investment (by public and private sectors) in the rural areas. This is likely to be one of the most effective means to promote rural deployment and retention.

During the 2012 industrial unrest by doctors led by their union, Kenya Medical Practitioners, Pharmacists and Dentist Union (KMPPDU), one of their key grievances was the weak capacity building initiatives and failure to pay registrars who are mostly subjected to take up more intense work load as part of their practical sessions. The Musyimi Taskforce Report (2012) highlights that the Ministry’s training budget was underfunded and the shortages of specialist personnel have been worsened by budgetary provision. The report further highlights that disease profiles have been inconsistently matched with human resource development with respect to specialist required to utilize new infrastructure.

2.2.5 Staff Establishment and Policy

The WHO report of 2006 recognizes that health workers are critical for any health system and ranks Kenya as one of the 57 countries facing critical challenges in HRH. The 2004-2005 Human Resource Mapping and Verification Exercise found that staffing levels do not meet the prevailing MOH staffing norms. Almost half of the dispensaries (47 percent)
have only one community nurse plus one or two support staff, while 3 percent has only support staff, which is not qualified to administer drugs. This is despite the fact that Kenya has a policy document defining its Staff establishment for health workers in Kenya is elaborated in the norms and standards policy document that has elaborated staffing requirement for each level of health care (Ministry of Health, 2006).

Despite the existence of norms and standards, the Kenya Health Sector Integrity Study Report, (2011) revealed a general shortage of healthcare providers in line with the established international (WHO) standards for efficient and equitable delivery of health care services aimed at meeting community needs. Some departments in the health facilities had as few as one qualified staff or even none. Further, Chankova et.al. (2006), in their study, ‘rising to the challenges of human resources for health in Kenya’; Developing empirical evidence for policy making note that like many other sub-Saharan African countries Kenya’s geographical distribution of skilled HRH is heavily skewed to the urban areas. This clearly demonstrates that despite existence of certain policies on staff establishment very little has been done to implement them.

Ensuring staff establishment is adhered to require a lot more effort. According to Immure Adana, one of the major challenges to developing sustainable health systems in sub-Saharan Africa is lack of human resources. In Kenya, a shrinking public health workforce, staffing levels of 50% at most facilities and mal-distribution of existing staff contribute to the fact that thousands of people living with AIDS, especially in rural areas,
do not have access to medication. These staff shortages resulted from migration, a long freeze on civil service employment, and a high rate of attrition due to the impact of AIDS and poor working conditions—a common scenario (Adano, 2008).

Globally and nationally staffing requirements for health workers have been determined and policy documents to guide the same in place. The situation was even worse for technical staff particularly in provincial hospitals where their services are based on the available technology for referral services. The decency was more pronounced in the provincial health facilities which were largely affected by lack of adequate technical staff. The rural health facilities were decent in almost all the cadres of staff (Transparency International, 2011).

According to the Musyimi Taskforce Report of 2012, it highlights that Kenya has 16 doctors per 100,000 population and 53 nurses per 100,000 population compared with the WHO minimum staffing levels of 100 doctors and 356 nurses per 100,000 populations. Effectively, therefore 1/3 of the doctors cater for 57% of the outpatient visits and 64% of all admissions in the country. The report goes ahead to state, in addition, the Kenya health system exhibits mal-distribution of health workers. Although minimum norms are clearly described they are rarely used.

2.2.6 Summary of Literature Review

From the literature review, the conclusion is that there are several factors that influence the ability of the HRH coordination mechanism in addressing policy and staff
establishment. Some of this key issues include; the structures and systems of the HRH coordination mechanism which basically shape the HRH coordination mechanism and how it delivers its mandate which has an implication on policy and health workers. Secondly the literature informs of the critical role of leadership in ensuring the HRH coordination is able to deliver its mandate as stipulated. It further reveals the weakness of leadership in sub-Saharan Africa including Kenya and how it has affected the health systems as indicated by O’Neil in 2008. The HRH actors are key stakeholders and the main driver of the HRH coordination system. Their constituency and active participation is critical to ensuring the HRH coordination mechanism is able to address HRH polices and shortages of health workers in Kenya according to MOH 2013.

Notably the literature reviewed highlights that HRH has been globally recognized as an important ingredient in the health system. The staffing requirements for each level of health care have been elaborated in the Norms and Standards policy documents that guide the health sector. Despite these efforts, Adano (2008), points out that the staff shortages still exist and the staffing requirements have not been met especially in the rural areas. Transparency International (2011) also notes that the critical staffing shortages remains a challenge as indicated in their Kenya Health Sector Integrity Study Report.

From the empirical review, leadership remains a critical challenge within the health sector as well as staff shortages.
2.3 Conceptual Framework and Theoretical Framework

2.3.1 Conceptual Framework
The research applied a conceptual framework as indicated in figure 2.2 below.

Figure 2: Conceptual Framework

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Dependent Variable</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRH Coordination</td>
<td>Staff Establishment and Policy</td>
</tr>
<tr>
<td>Structures</td>
<td></td>
</tr>
<tr>
<td>Organizational Structures</td>
<td></td>
</tr>
<tr>
<td>HRH Actors</td>
<td></td>
</tr>
<tr>
<td>Members and their role</td>
<td></td>
</tr>
<tr>
<td>Leadership of the HRH</td>
<td></td>
</tr>
<tr>
<td>coordination structures</td>
<td></td>
</tr>
<tr>
<td>Capacity Building</td>
<td></td>
</tr>
</tbody>
</table>

Source: HRH Coordination Framework, 2010

The conceptual framework is a diagrammatic research tool intended to assist the researcher to develop awareness and understanding of the situation under scrutiny and to communicate this. A conceptual framework is used in research to outline possible courses
of action or to present a preferred approach to an idea or thought. It can be defined as a set of broad ideas and principles taken from relevant fields of enquiry and used to structure a subsequent presentation. The interconnection of these blocks completes the framework for certain expected outcomes. An independent variable is one that is presumed to affect or determine a dependent variable. It can be changed as required, and its values do not represent a problem requiring explanation in an analysis, but are taken simply as given.

The independent variables in the study were; i) Structures and systems of HRH Coordination - this refers to the organizational structures for operating; ii) HRH actors - the different organizations and members that make up the HRH coordination and their role and how it influence the staff establishment; iii) Leadership of the HRH coordination - this variable focuses on the type of leadership, competencies and how they influence the staff establishment and policy; and iv) Capacity building - this variable focuses on training, both in-service and pres-service, short-term, on the job and their influence on the staff establishment.

A dependent variable is what measured in the experiment and what is affected during the experiment, it responds to the independent variable. The dependent variable in the study will be staff establishment and policy. One of the functions of the HRH Coordination mechanism is addressing the staff establishment and policy; this is clearly linked to the overall goals Health sector.
2.3.2 Theoretical Review
HRH Coordination is underpinned by a number of philosophy based sociological theories. The two theories with relevant philosophy to this study and the HRH coordination are those concerning structural-functionalism and contingency theory.

2.3.2.1 Functionalist Theory
The functionalist perspective attempts to explain social institutions as collective means to meet individual and social needs. The functionalist perspective attempts to explain social institutions as collective means to meet individual and social needs. It is sometimes called structural-functionalism because it often focuses on the ways social structures (e.g., social institutions) meet social needs. Functionalism draws its inspiration from the ideas of Emile Durkheim. Durkheim was concerned with the question of how societies maintain internal stability and survive over time. He sought to explain social stability through the concept of solidarity, and differentiated between the mechanical solidarity of primitive societies and the organic solidarity of complex modern societies (Boundless Study Guide, 2013).

According to Durkheim, more primitive or traditional societies were held together by mechanical solidarity; members of society lived in relatively small and undifferentiated groups, where they shared strong family ties and performed similar daily tasks. Such societies were held together by shared values and common symbols. By contrast, he observed that, in modern societies, traditional family bonds are weaker; modern societies
also exhibit a complex division of labor, where members perform very different daily tasks (Ibid).

Durkheim argued that modern industrial society would destroy the traditional mechanical solidarity that held primitive societies together. Modern societies however, do not fall apart. Instead, modern societies rely on organic solidarity; because of the extensive division of labor, members of society are forced to interact and exchange with one another to provide the things they need. The functionalist perspective continues to try and explain how societies maintained the stability and internal cohesion necessary to ensure their continued existence over time. In the functionalist perspective, societies are thought to function like organisms, with various social institutions working together like organs to maintain and reproduce them. The various parts of society are assumed to work together naturally and automatically to maintain overall social equilibrium. Because social institutions are functionally integrated to form a stable system, a change in one institution will precipitate a change in other institutions. Dysfunctional institutions, which do not contribute to the overall maintenance of a society, will cease to exist (Ibid).

The HRH Coordination mechanism in Kenya was established for a certain purpose and in its operations it has established other units called technical working groups to facilitate its agenda. The successful functioning of the HRH ICC to address policy and staff establishment is dependent on how the different elements function within this system including the HRH actors, the systems and structures and the leadership.
Contingency theory suggests that management principles and practices are dependent on situational appropriateness. Luthans (1976) notes that “the traditional approaches to management were not necessarily wrong, but today they are no longer adequate. The needed breakthrough for management theory and practice can be found in a contingency approach”. Different situations are unique and require a managerial response that is based on specific considerations and variables. The appropriate use of a management concept or theory is thus contingent or dependent on a set of variables that allow the user to fit the theory to the situation and particular problems. It also allows for management theory to be applied to an intercultural context where customs and culture must be taken into consideration (Shetty 1974). Basic theme of the Contingency Theory is that organizations have to deal with different situations in different ways. There is no single beast way of management applicable to all situations. In order to be effective, the internal functioning of an organization should co-relate to the demands of external environment.

The contingency theory is applicable to this study as the HRH coordination mechanism in its mandate to address policy and shortages of health workers has been influenced by the changing external factors and from time to time changed its structures and systems, transformed the leadership and developed tools to look into the emerging trends in capacity building and shortage of health workers.
According to Weill, et.al (1989), the main features of the contingency theory include; management is essentially situational. Consequently the techniques of management are contingent on the situation. If it properly conforms to the demands of the environment, the technique is effective and fruitful. In other words the diversity and complexity of the external situation with which the organization interacts alone should determine which measure or technique is to be chosen to be effective. Secondly, management should adopt its approach and strategy in tune to the requirements of each particular situation. Management policies and practices that spontaneously are responsive to environmental changes alone would be effective. To meet this, the organization should design its structure, leadership style, and control systems should all be oriented to the situation prevailing.

Further, Weill, et.al (1989) argues that since management effectiveness and success are directly related to its ability to cope up with the environment and to the changes overtaking therein, it should sharpen its diagnostic skills to be proactive and to anticipate and comprehend environmental changes. In short the successful manager should recognize that there is no one best way or thumb rule to manage. They must not consider particular management principles and techniques as applicable to all time and all needs. There is no solution of universal applicability, as two situations may not be identical.
CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This chapter discusses the methodology for the study and highlights the research design, target population, sampling techniques, data collection instruments and data analysis and presentation.

3.2 Research design

This study adopted a descriptive design. A descriptive research determines and reports the way things are and attempts to describe such things as possible behavior, attitudes, values and characteristics (Mugenda & Mugenda, 2003). A case study research approach was adopted. Case approach helps to narrow down a very broad field or population into an easily researchable one, and seeks to describe a unit in details, in context and holistically (Kombo & Tromp, 2006). The study hence considered case study approach suitable since data was gathered from a single source that is the Ministry of Health in Nairobi, Kenya and used to represent, the effectiveness of HRH coordination mechanisms addressing the staff establishment in Kenya.

3.3 Study Site

The study was conducted at the Ministry of Health located at Afya House, Cathedral Road in Nairobi Kenya.
3.4 Population

The population for this study was all the staff in the HR department. Heads of Departments (HoDs) and heads of semi-autonomous units in the Ministry of Health in Kenya. This is because the HRH coordination mechanism is done by the HR department. There are a total of 68 staff at the HR department and a total of 62 HoDs and Heads of semi-autonomous Government Agencies attached to the Ministry of Health (MOH, 2013).

3.5 Sampling Design

Stratified sampling was applied to ensure all departments were represented in the sample. However, purposive sampling was used to identify the specific respondents. Table 3.1 below shows a breakdown of the application of the stratified samples.

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Sample Ratio</th>
<th>Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR officers</td>
<td>68</td>
<td>0.5</td>
<td>34</td>
</tr>
<tr>
<td>HODs and Heads of Semi-autonomous Government Institutions linked to the ministry of Health</td>
<td>62</td>
<td>0.5</td>
<td>31</td>
</tr>
</tbody>
</table>

Table 3.1: Stratified Sampling Procedures
3.6 Data Collection Procedures

Primary data was collected for this study using a questionnaire with both closed and open-ended questions. This ensured data collection from many respondents within a short time and respondents are free to give relevant information because they are assured of their anonymity (Mugenda and Mugenda, 2003). Secondary data on the other hand was collected through review of both empirical and theoretical data from libraries journals, dissertations, magazines and the internet. An approval letter from the University to collect the data was obtained and presented to the Ministry of Science and Technology for further approval. A copy of the approval was then presented to the Director of HR in the Ministry of Health seeking authority to proceed. Once authorization was provided, drop and pick method was used. The questionnaires were picked after a week.

3.7 Validity and Reliability

A pilot study is a small scale preliminary study conducted before the main research in order to measure the validity and reliability of the data collection instrument. According to Kombo & Tromp (2006), validity is the ability of an instrument to measure what it is expected to measure while reliability is the ability of the instrument to give consistent results. A sample size of five was chosen, to form the pilot study. Cronbach’s α measure of internal consistency was employed analyzing the results of the pilot study after which some items from the Likert scales were edited.
3.8 Data analysis and presentation

Once the data was obtained it was tabulated and analyzed for purpose of clarity with the help of statistical package for social scientist (SPSS). Data collected was tabulated and analyzed for purpose of clarity, using statistical package for social scientist (SPSS). Descriptive statistics was applied to quantitative data to obtain measures of central tendency and measures of dispersion. Data presentation was done using frequency tables, pie charts, percentages and bar graphs.

3.9 Ethical Considerations

Confidentiality was strictly observed in the study by locking all questionnaires in a private place. Informed consent was also sort from all respondents. The objectives of the study were clarified to all respondents to ensure they were aware of the purpose of the study. Honesty in reporting of results ensured that the report was as per the data collected. Integrity and accountability were upheld. The study also exercised transparency with the respondents and my supervisor.
CHAPTER FOUR: DATA ANALYSIS AND INTERPRETATION

4.1 Introduction
This chapter presents the findings of the research study per objective and an interpretation of the same. The section begins with an analysis of background characteristics of the respondents.

4.2 Demographic Characteristics

4.2.1 Response Rate
Response rate for questionnaires was 93%. It was difficult to obtain 100% response rates as some targeted staff had already been transferred to the county level at the time of undertaking the data collection.

4.2.2 Characteristics of Respondents
Respondents were drawn from the HR department and HODs from the different departments in the Ministry of Health. Key characteristics of the respondents that were analyzed include; age, gender and years worked at the Ministry of health.

Gender
Majority of the respondents were male (61%) while (39%) were female as shown in figure 4.1 in the next page.
Majority of the respondents had postgraduate qualification (55%) and only about 5% had form four qualification as shown in figure 4.2 below.

Figure 4.2: Level of Education of Respondents

<table>
<thead>
<tr>
<th>Level of Education of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form Four</td>
</tr>
<tr>
<td>Diploma</td>
</tr>
<tr>
<td>Degree</td>
</tr>
<tr>
<td>Postgraduate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Series1</th>
<th>Postgraduate</th>
<th>Degree</th>
<th>Diploma</th>
<th>Form Four</th>
</tr>
</thead>
<tbody>
<tr>
<td>55%</td>
<td>18%</td>
<td>21%</td>
<td>5%</td>
<td></td>
</tr>
</tbody>
</table>
Respondent’s Years of Service at the Ministry of Health

Majority of respondents had worked in the Ministry of health for 5 years and below as shown in figure 4.3 below. This represented staff from the HR department who majority of them are posted to the Ministry for a number of years from the directorate of personnel management. Majority of those with over 10 years working experience in the Ministry represented respondents that were mainly drawn from the other technical line departments in the Ministry of Health.

Figure 4.3: Years Worked by Respondents at the Ministry of Health

Age Distribution

Majority of the respondents that took part in the study were between 36 and 50 years. Only 2% of the respondents were between 20-25 years of age.
4.3 Effect of HRH Coordination Structures

The study sought to establish the effect of HRH coordination structures on policy and staff establishment in the Ministry of Health in Kenya. Majority of the respondents agreed to a great extent that the HRH coordination structures influenced policy and staff establishment. A total of thirty respondents agreed to a great extent that the structures had an implication on policy and staff establishment while nineteen of them agreed to some extent as shown in figure 4.5 below.
Figure 4.5: Perception of Respondents on Effect of HRH Coordination Structures

HRH Coordination Structures and Implications on Staff Establishment and Policy

- 30 respondents indicated Great Extent
- 19 respondents indicated Some Extent
- 12 respondents indicated Little Extent
- 7 respondents indicated No effect
- 3 respondents indicated Don't Know

Further, respondents' view was sought to understand the extent of prioritization of the staff establishment and policy agenda by the HRH Coordination mechanism as shown in figure 4.6 in the next page.
The data presented above shows that majority of the respondents agreed that the HRH coordination structures prioritized staff establishment and policy issues in the Ministry of Health. Majority (50%) of the respondents agreed to some extent the HRH coordination mechanism prioritized policy and staff establishment issues while 38% agreed to a great extent.

4.4 Role of HRH Actors

The study also sought to investigate the role of HRH actors in addressing staff establishment and policy in the Ministry of Health, Kenya. Majority of the respondents (32) agreed to a great extent that the HRH actors contribute to staff establishment and policy in the Ministry of health as shown in figure 4.7 below.
Figure 4.7 Respondents Perceptions on the contribution of HRH Actors towards staff establishment and policy

Further, majority of the participants (51%) perceived that the HRH actors did not undertake joint planning with the Ministry of Health as shown in figure 4.8 in the next page. Only 38% of the respondents agreed to a great extent that joint planning is undertaken.
4.5 Contribution of Leadership of the HRH Coordination

The study also sought to determine the contribution of leadership of the HRH coordination on staff establishment and policy in the Ministry of Health in Kenya. The findings are shown in figure 4.9 in the next page.
Thirty five respondents identified leadership of the HRH coordination mechanism to be having an implication on policy and staff establishment to a great extent while 8 agreed to some extent as show in the chart above (figure 4.9).

Further 80% of the respondents agreed that the HRH coordination leaders had the required competencies. However only 43% of the responses perceived that there was a clear work plan against which leaders are evaluated as shown in table 4.2 in the next page.
<table>
<thead>
<tr>
<th>Component</th>
<th>Rate of Responses in %</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRH Leadership has appropriate competencies to lead the HRH coordination framework</td>
<td>80%</td>
</tr>
<tr>
<td>The HRH coordination framework has a clear work plan against which the leaders are evaluated</td>
<td>43%</td>
</tr>
</tbody>
</table>

**Table 4.2 Contribution of Leadership of the HRH Coordination Mechanism**

### 4.6 Effect of Capacity building on Staff Establishment and Policy

The study also sought to examine the effect of capacity building on Staff Establishment and Policy. Of the sixty one (61) respondents, thirty (30) of them agreed to a great extent that the HRH coordination mechanism had provided opportunities for enhancing in-service and pre-service capacity building, while ten (10) perceived the contribution was minimal (little effect) as shown in figure 4.10 in the next page.
Further, majority of the respondents (35) perceived that HRH coordination mechanism has not established a comprehensive plan.

4.7 Discussions

4.7.1 The Effect of HRH Coordination Structures

The findings from the study established there is an effect of the HRH coordination structures on staff establishment and policy in the Ministry of health. These findings are further supported by an assessment that was conducted by the Capacity Plus project, 2013 which confirm that in Kenya, the HRH Inter-agency Coordinating Committee (HRH ICC) helped establish and continues to address workforce challenges and expand advocacy efforts with completion of a national overarching strategic plan on HR, increased development partner focus and investment in HRH; increased budgetary
allocations to HRH, which led to hiring additional health workers and improved terms and conditions of health workers. Further the study also highlighted greater collaboration in curricula, strengthening faculty and expanding investments to improve quality and output by convening health training institutions.

The coordination structures also organized for the 1st National HRH conference held in December 2011 whose major aim was to raise advocacy level on the HRH challenges facing the country priority agenda being the shortage of health workers. The conference which was a first of its kind attracted both national and international attention.

4.7.2 The Role of HRH Actors
On the role of HRH actors on staff establishment and policy, findings reveal that HRH actors have contributed technically and financially in addressing staff establishment and policy in the Ministry of Health. The contribution of HRH actors has been through hiring of staff for instance the USAID-funded Capacity Kenya Project has hired 1077 health workers over the last five years under the rapid hire program. The HRH coordination actors have also supported development of policies and setting up implementation structures.

Further the evaluation report of the first National NHRHSP, 2009-2012, recognized that role of the HRH coordinating framework. It highlights that the HRH coordination mechanism had assisted to mobilize thinking on HRH as a high priority issue in Kenya health. Further it had tangibly directed the practical interventions being made in HRH to
align with what respondents considered the country’s highest priorities: productivity of existing health workers; increasing staffing numbers and deploying staff to improve equity of services; and working to raise the competence of health workers.

Notably, HRH policies were developed in collaboration with partners through the HRH coordination mechanism according to the Capacity Kenya 2013 technical brief including; the revision of the norms and standards, 2013 which was done with the support from the World Health organization. This policy outlines minimum staffing requirements at each level of health care. Further leadership and management competencies developed with support from the USAID-funded Leadership and Management (LMS) Project implemented by Management Science for Health (MSH). This policy outlines competencies for leaders and managers at different levels of health care. The HRH actors have also contributed significantly to the development of the 2nd National HRH strategic Plan 2013-2017 which has been developed with support from WHO.

The findings of the study further reveal that HRH actors do not undertake joint planning with the Ministry of Health. A Health Sector Integrity study conducted (Transparency International, 2011) revealed that the Ministry of Health’s strategic development plan is formulated to attract donor funding and not tailored to meet the needs of the community and further address capacity gaps in the sector. The Ministry of Health and donors do not participate in the development of annual action on plans of civil society organization on (CSO) to guide the harmonization of CSO interventions to the Health Sector Strategic
Plans leading to poorly coordinated and duplicated interventions. The findings of this study do corroborate the findings of the study undertaken to an extent, that there is a lack of a clear mechanism for evaluating the HRH coordination mechanism performance.

4.7.3 Contribution of the Leadership of the HRH coordination
On the contribution of leadership to staff establishment and policy, the findings reveal that the leaders have remained committed to prioritizing staff establishment and policy issues. Both the ministry of health and the other actors are jointly involved in the leadership of the coordination mechanism. Similarly, Save the Children, 2011 highlights the critical role of leadership in addressing HRH. They assert that ministries of health require clear political leadership, with health ministers who are committed to addressing health workforce needs in a sustainable and sequenced way that prioritizes the unmet needs of the poorest children and their families. The critical role played by leadership in providing stewardship to the HRH dimensions of the human resource (HR) crisis in health have been reported in stark terms in publications and studies by the Joint Learning Initiative (JLI) (2005) and the World Health Organization (WHO, 2006) among others.

According to the Capacity Kenya Technical brief of 2013, the leadership of the HRH coordination has been recognized for steering HRH reforms. The HRH coordination has provided leadership in coordination of critical sector HRH reform agenda, including establishment of the Kenya Institute of Health Systems Management (KIHSM). The institute is aimed at providing the necessary leadership and management capacity strengthening for health system managers at all levels. The coordination mechanism has
also provided support to MOH to map partners involved in hiring of contract health workers in the public sector to harmonize HR practices among them.

On the HRH coordination contribution to policy the technical brief recognizes that the coordination has been instrumental in coordinating sector strategies for transitioning into the decentralized health management system. To ensure a seamless transition, the HRH-ICC developed and launched the HRH Transition Work Plan 2011-2014, which outlines key HRH priorities to be initiated. The plan has been a key resource mobilization strategy involving several partners in implementing various components. The HRH-ICC also led the development of a change management framework, which the MOH disseminated to sub-national teams. These efforts have established the HRH-ICC as a recognized contributor to health sector reform (Ibid). This evidence does agree with the findings of the study that the leadership of the HRH coordination mechanism has been instrumental in driving a number of interventions towards addressing policy and staff establishment in the Ministry of Health in Kenya.

4.7.4 Effect of Capacity Building Interventions

On the effect of capacity building interventions by the HRH coordination on staff establishment and policy in the Ministry of health, findings reveal that the HRH coordination mechanism has invested in pre-service and in-service training. Nevertheless, it was noted that the HRH coordination mechanism is yet to develop a comprehensive plan for scaling HRH production.
A performance needs assessment of the Kenya Health Training System (2011) conducted by Ministry of Health and capacity Kenya support the findings of this study. It highlights that many actors are engaged in the training of health workers in Kenya including Ministries of Health (mainly through the Kenya Medical College training system), the Ministry of Higher Education Science and Technology (MOHEST) (through the public university system), the Ministry of Labor and Human Resource Development, the Ministry of Agriculture, private and faith-based universities and training colleges, regulatory bodies, placement sites, international bodies, and donor organizations. Moreover, the Ministries of Health are both producers, for example through the Kenya Medical Training College system, as well as major employers of health workers, among others. Coordination among these actors is critical to a well-functioning. The findings of this assessment do agree with the findings of this study that revealed though the HRH coordination has contributed to scaling up pre-serve and in-service capacity building opportunities there lacks a clear comprehensive plan for scaling up HRH production.

The WHO Country Coordination framework (CCF), 2010 notes that capacity among HRH stakeholders varies immensely, as does their level of engagement in collaborative dialogue. To better identify gaps in capacity, partners in HRH should undertake a situation analysis of all stakeholders to determine the various capacity building needs that will impact the comprehensive, costed, evidence-based HRH plan.
CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction
This chapter presents a brief summary of the findings of the study, conclusion and recommendations. It also highlights possible directions for future studies.

5.2 Summary of Findings
There has been significant investment in HRH coordination as mechanism to scale up HRH including addressing staff establishment and policy in the Ministry of Health. Despite the investment there continues to exist staffing shortages. It is against this background that this study sought to establish the implications of the HRH coordination mechanism on staff establishment and policy in the Ministry of Health. The findings of this study have revealed that the HRH coordination has an implication on staff establishment and policy.

Objective one of the study sought to establish the effect of HRH coordination structures on staff establishment and policy in the Ministry of Health in Kenya. The study revealed there is an effect of HRH coordination structures on staff establishment and policy at the Ministry of Health, Kenya. Majority of the respondents agreed that the HRH structures have an effect on staff establishment and policy. This is supported by the how the HRH coordination structures are organized to meet staff establishment and policy issues. A number of TWGs that have been established to address priority HRH issues one of
which is the HRH management TWG whose priority is policy and staff establishment issues.

Objective two of the study sought to investigate the role of HRH coordination actors on staff establishment and policy in the Ministry of Health in Kenya. The study revealed that the HRH Coordination actors have a role on staff establishment and policy in the Ministry of Health and have contributed technically and financially towards the same. However 51% of the respondents felt that the HRH actors do not undertake joint planning with the Ministry of Health.

Objective three of the study sought to determine the contribution of leadership of the HRH coordination on staff establishment and policy in the Ministry of Health in Kenya. The study revealed that the leadership of the HRH coordination mechanism has a contribution on staff establishment and policy in the Ministry of Health in Kenya; 43 of the 61 respondents agreed that the HRH leadership has an implication on staff establishment and policy in the Ministry of Health. Further 80% of the respondents agreed that the HRH leaders have the required competencies. However only 43% of respondents perceived that the HRH coordination mechanism has a clear work plan upon which the leaders are evaluated.

Objective four sought to look into the effect capacity building in the HRH coordination framework on staff establishment and policy in the Ministry of Health in Kenya. The
study revealed there is an effect of capacity building in HRH Coordination framework on staff establishment in the Ministry of Health in Kenya. While 61% of the respondents agreed that capacity building interventions initiated by the HRH coordination have had an effect on staff establishment and policy, 39% felt there has been minimal contribution. Further 57% of the respondents felt that the HRH coordination mechanism has not developed a comprehensive plan for scaling up HRH production.

5.3 Conclusion

Theoretical Conclusion

The study borrowed from two theories namely the functionalist theory and the contingency theory. The findings of the study agree with the two theories. According to the explanation of the functionalist theory, each part of a system has a specific function to serve. The role of the HRH coordination mechanism in addressing staff establishment and policy has been identified by the findings of this study to be one of critical roles undertaken by this mechanism. The study established that the HRH coordination mechanism through its technical working group's processes technical issues of related to staff establishment and policy. The structure of the HRH coordination mechanism together with the actor's financial and technical contribution all add to the functionality of the system.

The contingency theory on the other hand looks at successful management as act of adaptability. The HRH Coordination mechanism is developed within a framework of the
global Country Coordination Framework developed by WHO. The Ministry of health leadership successfully adapted the mechanism to what would work for the situation in Kenya. The terms of reference for the HRH coordination mechanism also provide for formation of adhoc committees to be able to handle emerging technical issues. The effectiveness of the leaders of the HRH coordination mechanism has been largely through adaptability and customization of structures that seek to achieve certain objectives.

The two theories; functionalist and contingency theory are adequate and valid in explaining the implication of the HRH Coordination mechanism on policy and staff establishment in the Ministry of Health, Kenya.

**Empirical Conclusion**

The HRH coordination approach has undeniably created a multi-stakeholder platform that provides an opportunity for open dialogue, which promotes consensus, commitment, and cooperation in addressing staff establishment and policy in the Ministry of health in Kenya towards meeting the second NHRHSP goals and *Kenya Vision 2030* according to the findings of this study.

HRH coordination mechanism has often been recognized as an important element of the health system that has an implication on HRH including staff establishment and policy issues. From the findings, 88% (50% of whom agreed to a great extent and 33% of whom agreed to some extent) of the respondents agreed that the HRH coordination structures have prioritized staff establishment and policy.
Similarly, the study also established that, HRH actors contribute to staff establishment and policy, financially and technically and further in their participation in joint planning.

The study also established that leadership contributed to staff establishment and policy, further 80% of the respondents agreed that the leaders of the HRH coordination had required competencies and that both the ministry of health and other actors were involved jointly in the leadership. 43% of the respondents though felt that there is no clear work plan against which the leaders are evaluated for their performance.

Finally the study established that the HRH coordination mechanism has provided in-service and pre-service capacity building opportunities for scaling up HRH production. The study therefore concludes that the HRH coordination mechanism has an implication on staff establishment and policy.

5.4 Recommendations
The critical role of HRH coordination mechanism has been flagged by the WHO since 2010 emphasizing the need for multi-stakeholder coordination in addressing HRH challenges (WHO, 2010). The 1st National HRH Strategic Plan 2009-2012 also highlighted the critical importance of scaling HRH coordination mechanisms to address strategic HRH challenges. Strengthening of the HRH coordination is a continuous process that requires the MOH leadership and commitment, as well as, stakeholder participation and support. The HRH coordination mechanisms serves as a sustainable
model; especially, at the decentralized levels of health system management. In line with the research findings and literature reviewed, three major recommendations are made.

Firstly, in order for the HRH Coordination mechanism to have a greater implication on policy and staff establishment there is a need to re-align capacity building efforts both pre-service and in-service to be in line with the needs of the health system. This will contribute to ensuring that staff are provided with capacity building opportunities that they can translate to required skills that can help fill in gaps of critical skill shortages in the Ministry of Health in Kenya. Further, capacity building efforts supported by partners have to be coordinated better to avoid duplication of efforts.

Secondly, there is also need to strengthen the leadership of the HRH coordination mechanism at all levels is critical - Strengthening the leadership is critical in ensuring that issues of staff motivation, attrition, remuneration and development are addressed in a more harmonious way. Effective HRH coordination requires trained and skilled leaders and managers. Further systems for evaluating performance of the leaders and managers need to be put in place.

Finally, there is also need to cascade the HRH coordination mechanism to the devolved system of health management - Health is now a devolved function according to the Constitution of Kenya 2010. Therefore management and development of health workers needs to be strategically defined at the County level, it is imperative that the county
governments devolved coordination mechanism that will harness the participation of other stakeholders in addressing policy and staff establishment issues.

5.5 Suggestions for Further Studies
The study only managed to address the implication of the HRH Coordination mechanism on policy and staff establishment in the Ministry of Health. However, there is need to conduct further research in the following areas:

Capacity building of HRH is a multi-stakeholder issue involving different arms of government, the private sector, regulatory bodies faith based and other development actors. Reviewed literature indicates there is a shortage of certain skills of health workers, it is necessary to conduct a study to establish the role of all the actors in scaling up the staff establishment in health sector.

According to the Constitution of Kenya 2010, health is a devolved function. As Counties work towards establishment of their own systems of HRH management, it is necessary to conduct a study on how HRH coordination mechanism has worked in other countries with a devolved system of health management. This will provide evidence based on how best to anchor the HRH coordination in the county structures of health.
REFERENCES


Save the Children. (2011). *No Child Out of Reach: Time to end the Health Worker Crisis.* UK: Save the Children.


APPENDICES

Appendix 1: Letter of Introduction

Dear Respondent,

I, Joyce Nyaboga, am a post graduate student at Kenyatta University undertaking an Executive Master of Public Policy and Administration. Pursuant to the pre-requisite course work, I am currently conducting a research project on **HUMAN RESOURCES FOR HEALTH COORDINATION MECHANISM: IT'S IMPLICATION ON STAFF ESTABLISHMENT AND POLICY IN THE MINISTRY OF HEALTH IN NAIROBI, KENYA**. The focus of my research is the Ministry of Health in Kenya and this will involve use of questionnaires administered to the staff working in the Ministry of Health. I kindly seek your authority to conduct the research at your Institution through questionnaires and use of any other relevant documents. I have enclosed an introductory letter from the University. Your assistance is highly valued. Thank you in advance.

Yours faithfully,

Joyce Nyaboga

EXECUTIVE MASTER OF PUBLIC POLICY AND ADMINISTRATION, STUDENT

KENYATTA UNIVERSITY
Appendix 2: Questionnaire

Kindly tick or fill in the spaces provided

Part A: Respondents Information

1. **Designation**

2. **Age of the respondent** (Please tick where applicable)

<table>
<thead>
<tr>
<th>Age (Years)</th>
<th>20 to 25</th>
<th>26 to 30</th>
<th>31 to 35</th>
<th>36 to 40</th>
<th>41 to 45</th>
<th>46 to 50</th>
<th>Above 50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
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</table>

3. **Gender**

Male [ ] Female [ ]

4. **What is your highest level of education?**

Postgraduate [ ] Degree [ ] Diploma [ ] Form four [ ]

5. **How long have you worked at the Ministry of Health?**

<table>
<thead>
<tr>
<th>Period - Years</th>
<th>Less than 5</th>
<th>6 - 10</th>
<th>11-15</th>
<th>16-20</th>
<th>21-25</th>
<th>26-30</th>
<th>Over 30</th>
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<tbody>
<tr>
<td>Response</td>
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65
PART B: EFFECT OF THE COORDINATION STRUCTURES

6. To what extent does the HRH coordination structures affect the staff establishment and policy for HRH in the Ministry of Health?

<table>
<thead>
<tr>
<th>Extent</th>
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<th>4</th>
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</thead>
<tbody>
<tr>
<td>Response</td>
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</table>

Where:

5 – Great Extent; 4 – Some Extent; 3 – Don’t Know; 2 – Little Extent; 1 – No Effect

7. What is your level of agreement with the following statements that relate to the effect of level of HRH Coordination structures on staff establishment and policy for HRH at Ministry of Health, Nairobi Kenya? Use a scale of 1-5 where 1 = strongly agree and 5 = strongly disagree.

<table>
<thead>
<tr>
<th>Effect of HRH Coordination structures on staff establishment</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tr>
<td>in the Ministry of Health in Kenya</td>
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<tr>
<td>The HRH Coordination structures are functional and operational</td>
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<tr>
<td>The HRH coordination structures are reviewed regularly to address the changing demands</td>
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<td>All stakeholders are sensitized and are aware of the structures of the HRH Coordination mechanism</td>
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PART C: HRH ACTORS

8. To what extent do the following apply to HRH actors? Please tick the most appropriate option using the provided scale of: 5 – Great Extent; 4 – Some

<table>
<thead>
<tr>
<th>Question</th>
<th>5</th>
<th>4</th>
<th>3</th>
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</thead>
<tbody>
<tr>
<td>To what extent do HRH actors undertake joint planning on Staff establishment and HRH policy with the Ministry of Health</td>
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<td>Do HRH actors contribute financially and technically to the implementation of staff establishment and HRH policy in the Ministry of Health</td>
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</table>

Extent; 3- Don’t Know; 2--Little Extent; 1--No Effect

PART D: LEADERSHIP

9. To what extent does leadership of the HRH Coordination mechanism affect the staff establishment and policy for HRH in the Ministry of Health in Kenya?

<table>
<thead>
<tr>
<th>Extent</th>
<th>5</th>
<th>4</th>
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<tr>
<td>Response</td>
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Where:

5 – Great Extent; 4 – Some Extent; 3- Don’t Know; 2--Little Extent; 1--No Effect

10. To what extent do you agree with the following statements that relate to leadership of the HRH coordination mechanism in the Ministry of Health in
Kenya? Use a scale of 1-5 where, 5 – Great Extent; 4 – Some Extent; 3 – Don’t Know; 2 – Little Extent; 1 – No Effect

<table>
<thead>
<tr>
<th>Leadership of the HRH ICC and the staff establishment and Policy</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>HRH Leadership has appropriate competencies to lead the HRH coordination framework</td>
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<td>Both the Ministry of Health and other actors are actively involved in leadership</td>
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<tr>
<td>The HRH coordination framework has a clear work plan against which the leaders are evaluated</td>
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</table>

PART E: CAPACITY BUILDING

11. What is the contribution of Capacity building in the HRH Coordination framework on staff establishment and policy in the Ministry of Health, Kenya?

<table>
<thead>
<tr>
<th>Extent</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
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<tr>
<td>Response</td>
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</tbody>
</table>

Where:

5 – Great Extent; 4 – Some Extent; 3 – Don’t Know; 2 – Little Extent; 1 – No Effect

12. What is your level of agreement with the following statements that relate to Capacity building and its effect in staff establishment and policy in the Ministry
of Health in Kenya? Use a scale of 1-5 where 5 – Great Extent; 4 – Some Extent; 3 – Don’t Know; 2 – Little Extent; 1 – No Effect

<table>
<thead>
<tr>
<th>Capacity Building of HRH Interventions</th>
<th>5</th>
<th>4</th>
<th>3</th>
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</tr>
</thead>
<tbody>
<tr>
<td>The HRH coordination mechanism has provided opportunities for enhancing both pre-service and in-service opportunities</td>
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<tr>
<td>The HRH Coordination has a comprehensive plan for scaling up HRH production</td>
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</table>

THANK YOU!
Appendix 3: HRH Coordination Mechanism’s Mandate

The HRH Coordination Mechanism Mandate

• **Vision:** To create a motivated, productive, and sustainable health workforce.

• **Mission:** To improve health services through effective and efficient HRH planning, management, and system and policy development.

• **Objectives:**
  - To contribute to the realization of the broader health sector goals outlined in the Health Sector Strategy Plans.
  - To ensure initiatives are coordinated effectively through advocacy and innovation to improve and strengthen HRH management systems.

Source: Ministry of Health Kenya, 2013