

# BUILDING A SUSTAINABLE FINANCIAL RESOURCE BASE TO SUPPORT HEALTH WORKFORCE TRAINING TOWARD UNIVERSAL HEALTH COVERAGE

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## KEY MESSAGES

- Establish a policy to support resource mobilization for increasing health worker training at the county level
- Increase the number of health workers based on proper assessment and forecasting to ensure equitable access to health care
- Determine the cadres to be supported based on county, regional, and national needs
- Determine the number of beneficiaries eligible for funding each year
- Put a framework in place for revolving funding to ensure sustainability
- Grow the fund such that all health disciplines are supported at all levels of training

## BACKGROUND AND CONTEXT

In 2018, Kenya had approximately 148,322 registered health workers in the public and private sectors (Kenya Human Resources for Health Strategic Plan End Term Review Report 2019). A total of 33,241 doctors, nurses, and clinical officers were not in active practice, with medical doctors recording the highest gap at 35% (n=11,651). There were 7,626 doctors, 14,536 clinical officers, 8,077 pharmacy staff (pharmacists and pharmaceutical technologists), 57,775 nurses, and 8,695 laboratory staff retained in 2018. The end-term review of the Kenya Health Sector Human Resources Strategy 2014–2018 established that the country had a

total of 79,937 doctors, nurses, and clinical officers retained against a registration of 113,178 as of 2018. This translates to approximately 17 core health workers per 10,000 population, falling short of the World Health Organization (WHO) minimum staffing level of 23 per 10,000 population.

A major contributing factor to the chronic health worker shortage is the high cost of medical education, which many Kenyan families cannot afford. Qualified vulnerable youth are more disadvantaged, and they drop out of training due to their inability to pay tuition fees. Currently, the production of health workers does not meet the needs of the country. Moreover, the gaps are getting worse, as the population is growing and



the disease burden rising. In 2012, out of 35,000 applications received by Kenya Medical Training College (KMTc) only 5,000 students were admitted. Of those, 4,500 students enrolled; however, only 3,375 graduated, representing a 25% dropout rate. In 2013, IntraHealth International, with funding from USAID and in partnership with the Higher Education Loans Board (HELB), the private sector, and the Ministry of Health (MOH), established the Afya Elimu Fund (AEF). The AEF targets needy students, especially those from underserved regions of the country, who cannot afford medical training. Sustainability of the fund depends on private sector support, as well as county investment. While counties have benefited from the AEF and understand the need to invest in it, they lack specific policy guidelines to support AEF investment. Currently, they rely on a policy on medical training and any policy under which tertiary education is based. This brief highlights the need to establish a county-level policy that supports resource mobilization to increase health worker training.

## EVOLUTION OF THE AEF

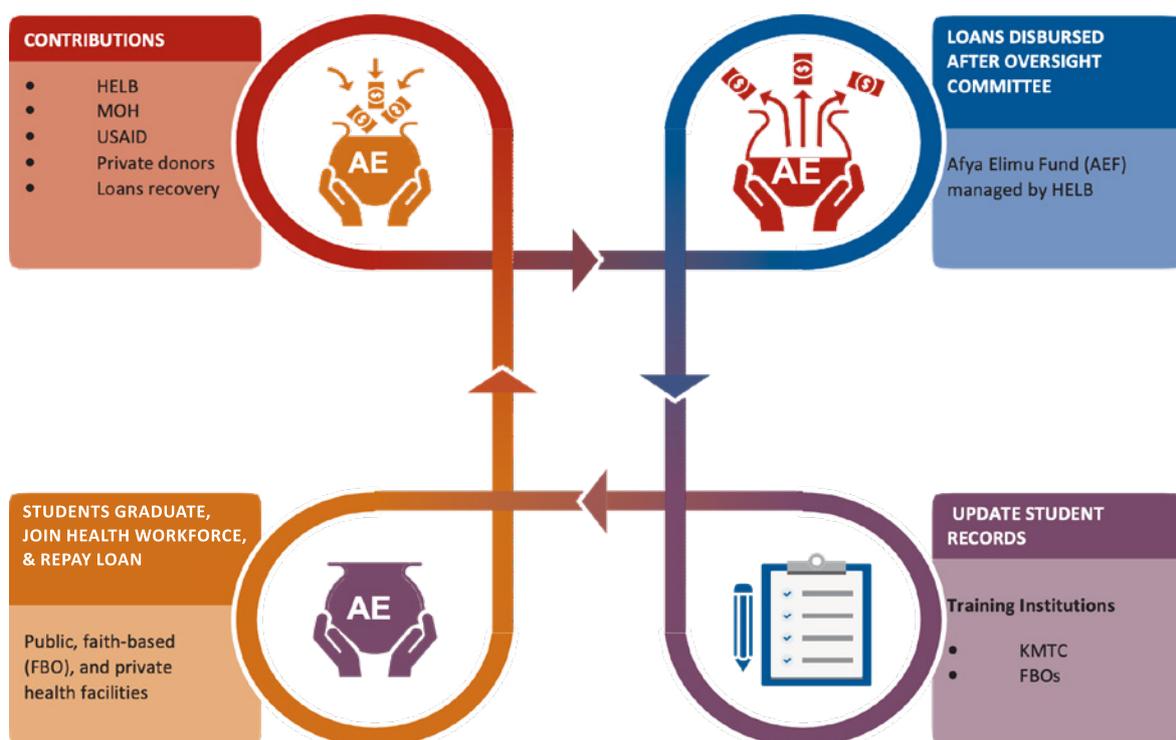
Since the AEF's launch in 2013, the USAID-funded, IntraHealth-led FUNZOKenya project (2012–2017) and the follow-on Human Resources for Health (HRH) Kenya Mechanism (2016–2021) have gradually transitioned the program to the HELB.

The AEF (Figure 1) is a revolving loan initiative that provides low-interest (4%) loans to prospective trainees at mid-level medical training institutions, including KMTc. The fund focuses on mid-level cadres, such as nurses, laboratory technologists, and clinical officers, who form approximately 90% of Kenya's health workforce. The aim of the AEF is to progressively expand the availability of health workers, which will contribute to attaining the overarching goal of the Kenya Health Policy 2012–2030 and ultimately the health sector objective of Vision 2030 and universal health coverage.

## THE NEED FOR SPECIALIZED HEALTH WORKERS

The expansion of health workers through AEF can also address the lack of specialized providers at the county level. Doctors tend to be concentrated at level 5 hospitals, leaving levels 2 and 3 to largely be served by clinical officers (MOH 2014). Providing training to increase the number of specialized clinical officers could fill the gap at lower-level facilities and reduce the burden on referral hospitals. Additionally, a lot of specialization training occurs at post-graduate levels, with the counties having 6,566 and 682 medicine and dentistry specialists, respectively, as of 2014 compared to post-diploma (mid-level specialization) levels, where only 2,124 clinical officers had different specialization (MOH 2014).

**Figure 1: AEF operational model**



This disparity is a challenge in many counties. For example, in 2019, despite Kwale County having a fully equipped renal unit, it had only two renal nurses vs. the required 13, greatly limiting the unit's optimal utilization. The county also lacked oncology nurses despite an increased burden of non-communicable diseases, which weigh heavily on mid-level specialization cadre support. This brief presents a case for the counties to respond to the urgent demand for specialized care by investing in the health workforce.

## GAINS FROM THE AFYA ELIMU FUND

As of July 2021, the AEF had supported 40,257 students at a total cost of KES 3.06 billion (USD 30.6 M). This remarkable growth is attributable to the expanded partnership with the private and public sector. Of the total AEF beneficiaries, 11,878 students have graduated. A total sum of KES 224,017,844 (USD 224,018) has been repaid by the beneficiaries. A total of 3,983 (34% of the graduated) are employed and available to support provision of health services including HIV prevention, care, and treatment and reproductive, maternal, neonatal, child and adolescent health care.

## POLICY IMPLICATIONS

Certain models of medical training financing, such as scholarships, have proven to be unsustainable. In many cases, the return on investment is either not measured or less than optimal. Scholarships lack a revolving fund feature to support other future trainees. In addition, the scholarship becomes a wasted investment if the sponsored health worker fails to graduate or take up a posting. Most counties lack policies to guide resource allocation and mobilization for health workforce training. It is also evident that counties allocate very little of their health budget for health workforce training—funds are largely spent on medical equipment and infrastructure, with limited forethought on the need for specialized users.

Funding partners interested in supporting health worker training have also faced challenges. There is need for a policy that will give direction on county resource mobilization for health worker training, including where counties need to establish a funding scheme supported by both the private and public sector.

Another challenge that needs to be better addressed through resource mobilization, advocacy, and policy measures is the large percentage of AEF graduates who are not subsequently employed in the health sector.

## POLICY RECOMMENDATIONS

The AEF is an innovative, proactive financing initiative that supports increasing the numbers and quality of trained health workers. It has demonstrated resilience and sustainability in its management, leveraging the infrastructure of the HELB to manage applications and loan recovery. It operates under varying policies, such as the county education policy, and others by indirect association; however, the counties should define health training within the context of health services rather than education. It would help to develop county-specific health training policies that would provide for legal, administrative, and budgetary support to the AEF and any other county revolving funds.

With the AEF in place, counties can confidently prioritize their areas of training based on training needs assessments, develop training projections, allocate budgets, and develop executable training plans. Counties with revolving funds will concentrate on immediate in-service as well as preservice training needs. The benefits of this policy indirectly contribute to averting health worker strikes, since career progression grievances significantly contribute to industrial unrest. The policy will also cushion the framework for training in case of changes to county governments.

One key outcome from the assessment of the training of medical specialists in Kenya done in September 2019 was the Council of Governors' proposal that medical specialist training fees be paid by the national government through the HELB. In this regard, the AEF is best suited to secure funding for medical specialists. The fund helps address questions of training sustainability, equity, and the distribution of medical specialists and will bring stability to their overall management and utilization toward achieving universal health coverage in Kenya.

AEF stakeholders should undertake lobbying and advocacy activities for increasing the chances of employing AEF graduates. More than half of the AEF graduates remain unemployed, yet the graduates can be employed by the public or private sectors.

Public service boards in county governments should be made more aware of the AEF and how beneficiaries of the fund can be given employment priority. To increase employment opportunities for AEF graduates, the HRH Kenya Mechanism held annual employers' forums bringing together current and potential employers of AEF graduates.

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