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Potential Impact of Devolution on Motivation and Job Satisfaction of Healthcare Workers in Kenya: Lessons from early implementation in Kenya and experiences of other Sub-Saharan African Countries

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Abstract

Background: Kenya's healthcare devolution was introduced to enhance the quality of care, user satisfaction, equity, and efficiency in service delivery. However, it has since been facing plethora of challenges mostly because healthcare workers (HCWs), who play a significant role in achieving health objectives, were neglected during implementation.

Objectives: This dissertation tries to identify the potential impact of devolution on motivation and satisfaction of HCWs in a politicised Kenyan context. In the end, it will aid in formulating policies and recommendations to the government that will enhance worker's job performance post-devolution.

Methods: It uses media reports on Kenyan HCWs post-devolution and published academic research on Sub-Sahara Africa (SSA) countries decentralisation experiences to aid in inferring the prospective outcomes to the Kenyan context. Analysis of the literature aggregates some components of Franco et al.'s framework with Principal-Agent (P-A) theory to aid in clarifying the black box of motivation and satisfaction post-devolution in four broad channels: principal-agent relationship, organisation structure, and power and culture.

Conclusion: A well-coordinated leadership is an indispensable tool that if crystalized together with good supervision and proper power play, will influence the achievement the goals of the healthcare system. The government needs to improve the "motivation factors" such recognition and growth besides promoting professional identity and status of HCWs. Kenyan HCWs need value-added culture of monitoring, transparent training and educational opportunities, and equal participation opportunities into a new county health administration to be able to achieve healthcare devolution objectives.

Key words: devolution, health workers, motivation, satisfaction

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Potential Impact of Devolution on Motivation and Job Satisfaction of Healthcare Workers in Kenya: Lessons from early implementation in Kenya and experiences of other Sub-Saharan African Countries

1.0 INTRODUCTION

Qualified, motivated and satisfied healthcare workers (HCWs) are a prerequisite for effective healthcare reform whose aim is to enhance the quality of care, user satisfaction, equity, and efficiency. Whilst a successful implementation of such reform relies heavily on how much support the HCWs receive (Homedes & Ugalde, 2005), there is limited attention given to health human resource motivation and satisfaction (Franco, Bennett, & Kanfer, 2002; Luboga, Hagopian, Ndiku, Bancroft, & McQuide, 2011). One such change that is gaining popularity in developing countries is healthcare decentralization (Kolehmainen-Aitken, 2004; Kyaddondo & Whyte, 2003), to which research by World Bank (WB) has indicated that 63 out of 75 transitional nations with over 5 million population have instigated (The World Bank, 2008).

Decentralisation is a complex, but imperative concept in healthcare management (Gilson, Kilima, & Tanner, 1994) that takes on different forms including *devolution, de-concentration, delegation* and *Privatisation* (Malcolm, 1989; A. Mills, Vaughan, Smith, & Tabibzadeh, 1990; Rondinelli & Cheema, 1983). The concept of devolution involves the transference of authority and power over public service delivery from central government to a semi-autonomous sub-national structure, which aids in the management, decision-making, and public planning (Diana, Hollingworth, & Marks, 2014; Rondinelli & Cheema, 1983). Several Sub-Saharan Africa (SSA) countries have implemented different types of decentralisation (Rocaboy, Vaillancourt, & Hugounenq, 2013). Kenya's healthcare devolution was "one of the most ambitious implemented globally" which resulted from the new constitution promulgated in 2010 (The World Bank, 2012). It saw the creation of 47 new county administration systems (see Appendix 2) that encapsulated in totality the previous regime's arrangements (Kramon & Posner, 2011).

Several theories have been postulated to explain motivation of workers (Adams, 1965; Bandura, 1977; Deci, 1975; Hertzberg, Mausner, & Synderman, 1959; Locke & Latham, 1984; Maslow, 1954) but none has been used self-sufficiently or in combination with the other to explain the impact of devolution on motivation and satisfaction of HCW. Moreover, previous academic studies relating to HCW in Kenya have mainly focused on the roles of clinical officers (COs), contextual influences of motivation, tools to measure motivation (Mbindyo, Blaauw, & English, 2013; P. Mbindyo, Gilson, Blaauw, & English, 2009; Mbindyo, Blaauw, Gilson, & English,

2009). Studies on incentives and retention have been done in developing countries (Mathauer & Imhoff, 2006; Ndetei, Khasakhala, & Omolo, 2008; Willis-Shattuck, et al., 2008). Yet, these studies have not explicitly included analyses of HCW motivation post-devolution. There is little consideration of how devolution affects HCWs as the principal actors who form part of decision-making and determine how resources are utilised (Mwenda, 2010). From a multi-level perspective, problems of the HCWs affect how they interact with service users and the leaders of healthcare devolution reform (Kyaddondo & Whyte, 2003).

Franco et al. (2002) have equally noted that HCWs are not given enough attention during the implementation of reforms and have proposed a framework for instigating the correlation of the reforms and the motivation of the HCWs. The framework proposes three levels of motivation determinants: individual worker, organisational processes, and cultural and/or community influences. The pivotal argument it is based on is that workers motivation is the key determinant of the health system performance. Therefore, they explore how an individual helps with the achievement of the organisational goals. Founded on the framework, there should be equal emphasis on other rewards for instance recognition other than a basic focus on financial incentives.

The framework highlights factors affecting the output of HCWs as a result of the reform (in this case devolution). Considering there is limited evidence on HCWs motivation and satisfaction in developing countries (Luboga, et al., 2011), this dissertation goes beyond identifying the technical determinants of HCW motivation and satisfaction by analysing the prospective impact of devolution to motivation, satisfaction and retention of doctors and nurses in a highly politicised Kenyan context. The analysis will employ Franco et al.'s differentiation of organisational and cultural variables to fit data finding into their model. Nonetheless, this approach will enhance theirs by incorporating the Principal-gent (P-A) theory to discuss the concept of monitoring and supervision. The discussion will look at the events of early healthcare devolution implementation and weave together facts from fiction. All the factors will be grouped in three major topics: supervision & monitoring, power & culture, and organisational factors. It will demonstrate that by enhancing the three interrelated factors, HCW motivation is likely to be enhanced.

1.1 Background information

Kenya is a *Low Income Country (LIC)* in East Africa having a GDP per capita of 865 USD (Luoma, et al., 2010) and a population of 44.35 million (The World Bank, 2014). The average life expectancy is 58 and 61 for male and female respectively (World Health Organisation, 2014). High level of poverty coupled with prevalent inequalities causes vast economic and health challenges (The World Bank, 2014) evidenced by the numerous paradoxes and contrasts. Kenya has a unique mix of population that comprises 42 tribes each contributing to the rich culture and diverse heritage.

After independence, the state adopted hierarchical system managed by the central government with the sub-locations, locations, divisions, districts and provincial levels acting as the sub-national coordinating units (Rocaboy, et al., 2013). Kenya's healthcare system was first decentralised in the early 1980s using the *District Focus for Rural Development (DFRD)* approach where the district was the basic unit of public service

delivery. It aided the central government in budgeting, planning, organising, and implementing essential programmes (Chitere & Ireri, 2004; Kibua & Mwabu, 2008).

Two decades of constitutional review by successive governments characterised by several years of lobbying and advocacy from the citizens, development partners, *and civil society groups* (Othieno, 2011) yielded a "second republic" that was ushered in on 4th August, 2010. Sixty-seven percent of Kenyan electorate overwhelmingly endorsed a new Constitution in a national public referendum that was later adopted into law on August 27th, 2010. At the core of this transformation was the concept of devolution of economic and political powers to the newly established 47 semi-autonomous counties, which were structured to supplant the prior functions of local, district and provincial administrations and managed by elected governors. The counties were fully established after the March 2013 election and were responsible for setting priorities, planning, budgeting and coordinating implementation of the new Constitution (KPMG International., 2013).

The services devolved to county governments include *health, livestock, housing, sports, culture, agriculture, fisheries, transport, rural electricity, environmental conservation, and lands (KPMG International., 2013)*. This paper will mainly focus on the healthcare devolution whose fundamental pillars are *Service delivery systems, leadership and governance, health workforce, health financing, health products and terminologies, health information,* and *health infrastructure.* In addition, the four-tiered organisations of health service delivery are *community service, primary care service, county referral service,* and *national referral service (MoMS. & MoPHS., 2011; The World Bank., 2012)*

The health agenda of the country is headed by the national government whereas counties are the main healthcare pillars (N. Njuguna, Thugge, & Otieno, 2011). The national government provides guidance on the needed competencies and skills, and facility norms in addition to monitoring the distribution and attrition of HCWs. Moreover, it develops the policies and the Standard Operation Procedures (SOPs) that assess and guide the training of HCWs. On the other hand, the counties are the main executioner of the healthcare services and ensures the users get equitable treatment, and that HCWs perform their functions satisfactorily (KHSSP., 2012) as highlighted in Table 1.

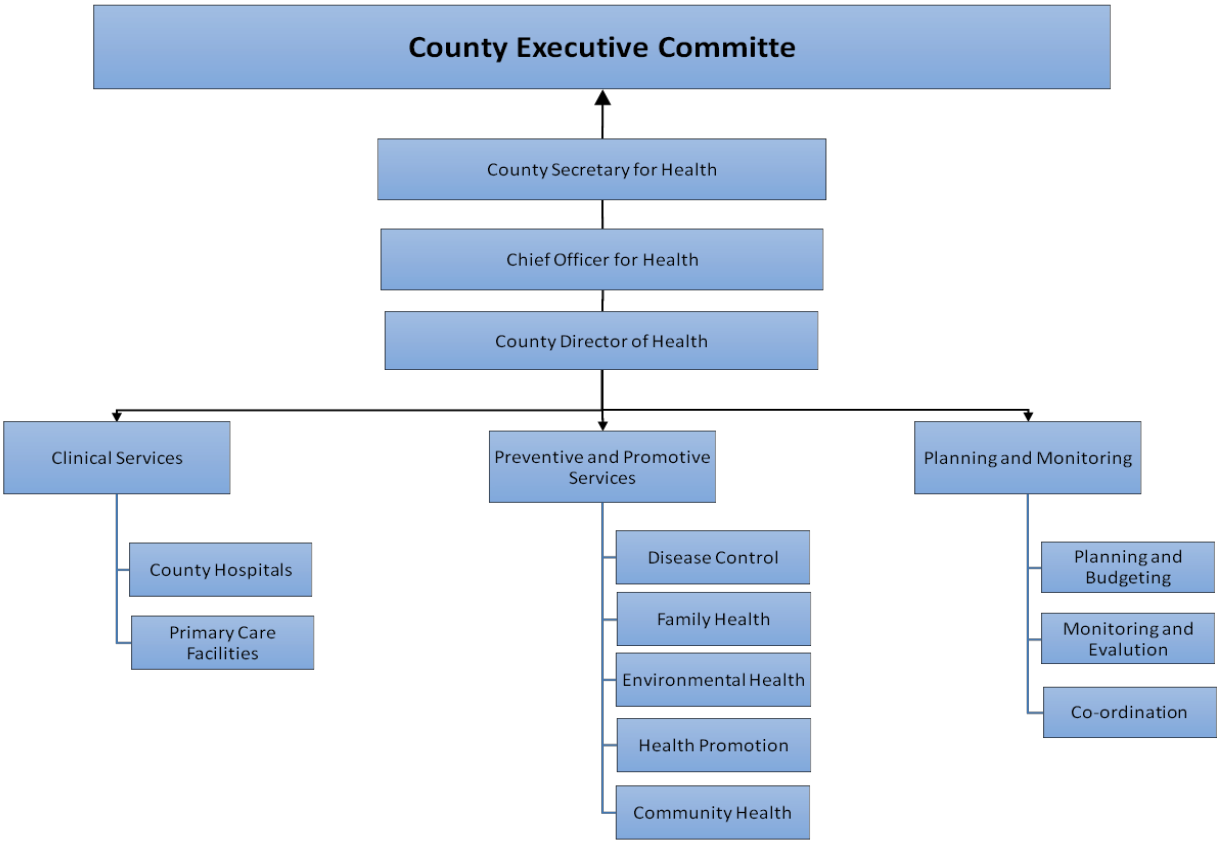
Table 1: Roles of National and County government in HCWs management

Service Area	Function Areas	Role of National Government	Role of County Government
HEALTH WORKFORCE			
Appropriate and equitably distributed health workers	Recruitment of HW	- Development of required competencies - Provision of overall staffing norms - Guidance on defining facility based norms	- Prioritization of staff cadres for recruitment - Advertisement, and recruitment of HW
	Skills and expertise inventory	- Guidance on required skills for service provision	
	Deployment of HW	- Mentoring HW distribution	- Planning, and execution of deployment
Attraction and retention of HW	HW motivation	- Monitoring HW attrition - Provide guidelines/SOP's for HW motivation - Develop career development SOP's	- Provision of incentives for hard to reach areas - Apply non-financial incentives to improve HW motivation
	Monitoring Employee satisfaction	- Coordinate annual employee satisfaction surveys	- Participate in employee satisfaction surveys - Implement employee satisfaction recommendations
Institutional and HW performanc e	Staff performance appraisal	- Develop processes and SOP's for staff performance appraisal	- Apply, and implement recommendations for staff appraisal
	Skills building in Leadership & Management	- Develop curricula and SOP's for leadership & Management trainings	- Train qualifying HW's in Leadership and Management
	Regulatory framework strengthening	- Develop National HW regulatory framework	- Develop County specific by laws for HW regulation
Training capacity building and developmen t of HW	Pre Service training	- Develop training policy guidelines - Curriculum update to align to Service needs - Manage National training facilities	- Train HW's based on training strategy
	In Service training	- Develop guidelines for conducting skills inventories - Develop internship guidelines - Update CPD guidelines	- Conduct skills inventory for HW's - Manage interns - Implement and Monitor CPD

Source: Adapted from (KHSSP., 2012)

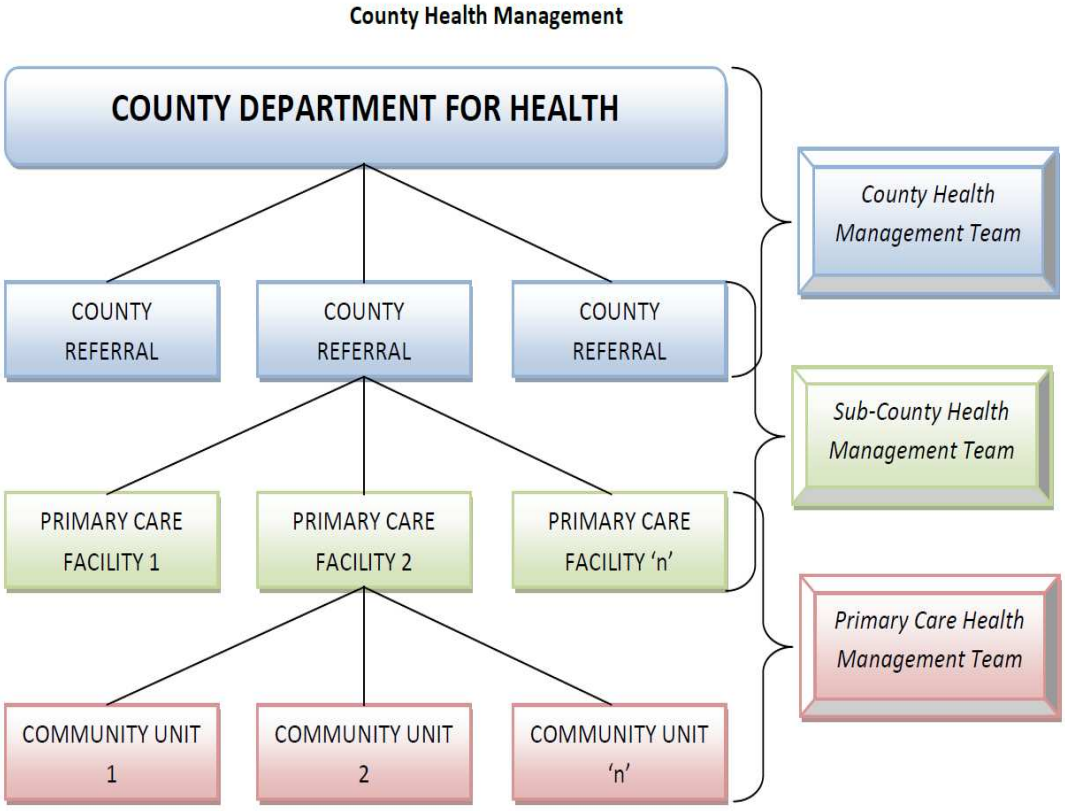
County officer for health (COH) works in conjunction with the county director for health (CDOH) who is responsible for the technical guidance on health issues and supervises three health directorates: *planning and monitoring, clinical services, preventive and promotive services* (see **Figure 1**). Additionally, the County Health Management Team (CHMT) is a technical team which plans, implements, supervises and controls the delivery of the health services in the counties (KHSSP., 2012). The HCWs are hired by the county governments (LAWS OF KENYA., 2010), and are managed by the CHMT. On the other hand, the Sub-County Health Management Team manages the primary care facilities, and the Primary Healthcare Management team manages the community units as shown in **Figure 2**.

Figure 1: Model organogram of county governments



Source: Adapted from (Kenya Vision 2030., 2007; KHSSP., 2012)

Figure 2: Management categories of the health care systems in Kenyan counties



Source: Adapted from KHSSP (2012)

1.2 Aims of the paper

This dissertation explores the potential bearing of devolution on motivation and job satisfaction of HCWs in Kenya and formulates recommendations and policies to the government on how to enhance workers job performance. Specifically, application of emerging literature on devolution from other SSA countries, on one hand, will aid in inferring the prospective outcomes to the Kenyan perspective. Examination of media reports on doctors and nurses, on the other hand, will assist in understanding *what* the short term results of devolution has been and *how* it has affected county governments since implementation of the New Constitution. The first section of this study has introduced the topic, the background, and the aims. Section II will describe the methodology of literature search and justification of chosen papers in addition to highlighting the chosen frameworks. Section III will analyse the literature on the potential impacts of devolution on motivation on HCW using Franco et al.'s conceptual framework. The same section will also use the P-A theory, see (Arrow, 1985; Buchanan, 1988; Ludwig, Van Merode, & Groot, 2010; Sekwat, 2000), to highlight the changes in workload and supervision of doctors and nurses. Section IV will discuss the findings, limitations of the study, and formulate recommendations that will be

imperative for the government to effectively plan future healthcare workforce whereas Section V is the conclusion.

2.0 RESEARCH METHOD

To remain congruent with the subject as outlined previously, qualitative and media reports were sought to help gain a nuanced understanding of the devolution process, dynamics, impacts and success stories. Since devolution is a topical and relatively new issue spanning different disciplines, an expansive search strategy was imperative, and experts guide in choosing relevant reading selections was sought. Subsequently, debate around this topic shifts more often, therefore, an awareness of the happenings, changing political stands, and opinions were maintained throughout the project.

To be cognizant of the existing gap between the healthcare workforce dynamics and the actual service provision resulting from devolution, a detailed Kenya's health profile was explored thoroughly. The official documents and policy papers were systematically accessed from the Ministry of Health (MOH) websites using search words "devolution," "healthcare," "health workers," "doctors and nurses." Other relevant policy documents were obtained from stakeholders (KPMG, World Bank, and World Health Organisation) websites.

To ensure all reports had covered all aspects, content analysis was employed. Articles that had similar themes and concepts were grouped together. The information that was obtained from the articles on issues such as culture and power, status, monitoring and supervision, employment terms, remuneration, recruitment, training and education were clustered together. They were then systematically analysed by copying the relevant messages in an excel sheet table and then correlation the information with the Kenyan devolution context.

Expert's opinions (from LSHTM, WHO, and KEMRI Wellcome Trust-Kilifi. These were, a professor from LSHTM, and two PhD students from LSHTM but attached to WHO and KEMRI Wellcome Trust-Kilifi respectively and were doing studies on devolution of Healthcare in Kenya) were used to enhance literature search/ review process which spanned a three months period from February to April, 2014. Key search engines, PubMed, Google Scholar, Medline, Africa portal and Africa-Wide Information were employed (See Appendix 3 for a summary of the search results). Anticipating that there wouldn't be many academic articles on this topic given the recent implementation of devolution, the range of sources were deliberately broadened to include reports from national and International organizations that were published as from 1997 to 2014, and media articles on devolution that were written as from 2010 when devolution took effect.

Broader searches using combined phrases such as "devolution and decentralisation" "Sub-Saharan Africa" "motivation and satisfaction" "healthcare workers, doctors and nurses," within Kenya and internationally, yielded some relevant articles. Moreover, replacing the phrase "Sub-Saharan Africa" with the each of the 47 (Kenya was excluded from this list since earlier search had revealed no information) SSA country produced relevant documents that formed the basis for analysis. Reference list from relevant studies were hand searched for further papers, as were citations from key authors and

contents in key journals including: *public administration and development, Human resource for health, Health policy, Journal of health organisation and managing,* and *International journal of health planning and management.* The ranges of publishing years of the above articles were 2000-2014.

Grey literature such as briefing papers, presentations, industry reports, and conference papers on Kenyan health care devolution, were retrieved through an overall Internet search, author-specific, and organisation specific searches. Essential reports were equally identified and accessed.

The key local media houses whose print databases were accessed include Standard media group, Nation Media group, Radio Africa media group, K24, and Royal media group. Other international media houses whose print media were retrieved are BBC, CNN and Aljazeera. Search terms that were used in the media databases were "devolution," "healthcare workers," "doctors and nurses." The search produced essential information that was used to analyse the prospective behaviour of HCWs.

2.1 CONCEPTUAL FRAMEWORKS

This dissertation is engrained on the assumption that there are several layers of factors that interact thereby positively or negatively influencing an individual worker's attitude in the pursuit of goals and set objectives. These factors are governed and determined by the interplay of "subjective, relational forces" that are influenced by a change that involves a political process. Hence, to help manage how HCWs respond to reforms, it is essential that the "value functions" caused by these relational forces is thoroughly understood. Bearing the above in mind, Franco et al.'s framework, particularly the organisational and cultural influences, in conjunction with P-A theory were helpful in analysing the findings.

Worker's motivation and job satisfaction are dynamic and multifaceted processes that are difficult to understand (Luboga, et al., 2011). To analyse the impact of implemented or proposed reform, Franco et al.'s framework is imperative in un-packaging several channels that affect motivation. The framework has three levels of motivation determinants which explores how individuals help with the achievement of the organisational goals.

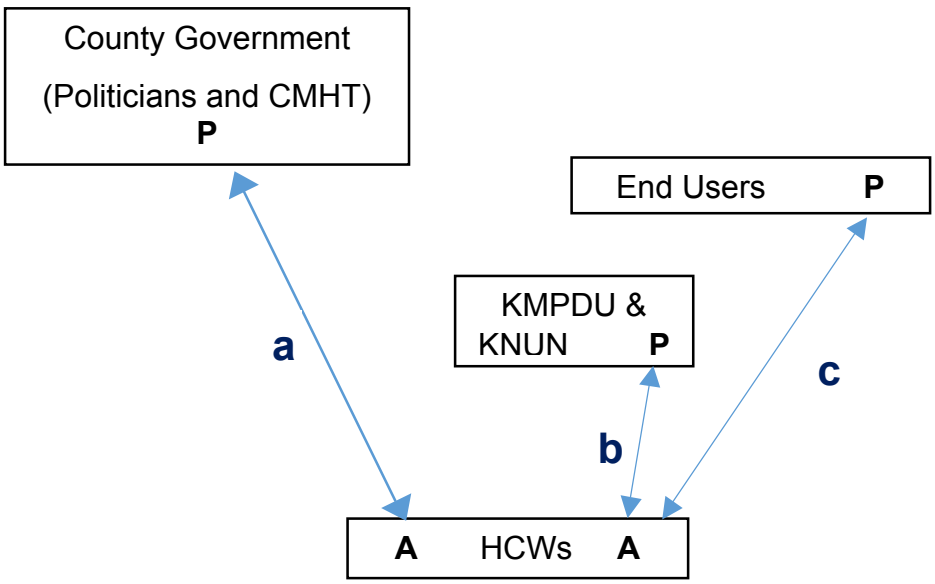
Firstly, the cultural context entails the relationship between culture and patient-provider relationship. It describes the factors that shape the decision-making process of the organisation besides the acceptable workers level of autonomy. It stresses the fact that the community plays a role in influencing individual workers' behaviour. A study by Kyaddondo and Whyte (2003) further expands the cultural context to include social status issues, survival strategies and local politics.

Secondly, in the analysis of organisational factors, the framework summarises ways in which organisational processes, structures, and policies on management of human resource interact to impact the motivation of HCWs. Some of the principal structure emphasised are incentives, recruitment procedures, staff skills, supervision, and job definitions and descriptions. A study by Saide and Stewart (2001) adds insight to the details on organisational structures to which this dissertation seeks to add to the framework.

Thirdly, on individual worker's determinants, the framework recapitulates factors such as internal goals and values, self-concepts and variables (including self-efficacy & esteem), and cognitive expectations that are essential in influencing job satisfaction and work motivation. However, these factors are intrinsic and may be difficult to alter since it takes time to modify the internal beliefs of an individual (Ssengooba, et al., 2007). Therefore, this dissertation will not consider this component of the framework since devolution may not instantaneously enhance the individual's factors.

P-A theory on the other side, is an economic concept in the form of an "agreement in which the principal delegates certain responsibilities to the agent for which the agent receives certain rewards" (Ludwig et al., 2010, pg. 291). The "agent" possesses a utility function that he maximises, and that may partly coincide or differ with that of the "principal." (Arrow, 1985; Ludwig, et al., 2010). The relationship is affected by information asymmetry between the two. Arrow (1985) point out that in the relationship, the principal is incapable of determining whether the agent is pursuing a personal utility task. Additionally, the principal is unable to judge if the agent is fulfilling his own interest or the interest of the principal. In this dissertation, there are several agency relationships that is emphasised on as shown in **Figure 3**. In the figure, **P** stands for Principal while **A** stands for Agent. The arrows show the three agency relationships indicated **a, b** and **c**. This dissertation will focus primarily on **a** but will also highlight the role of **b** in strengthening **a**.

Figure 3: Showing principal- Agent relationships for Kenyan healthcare setting

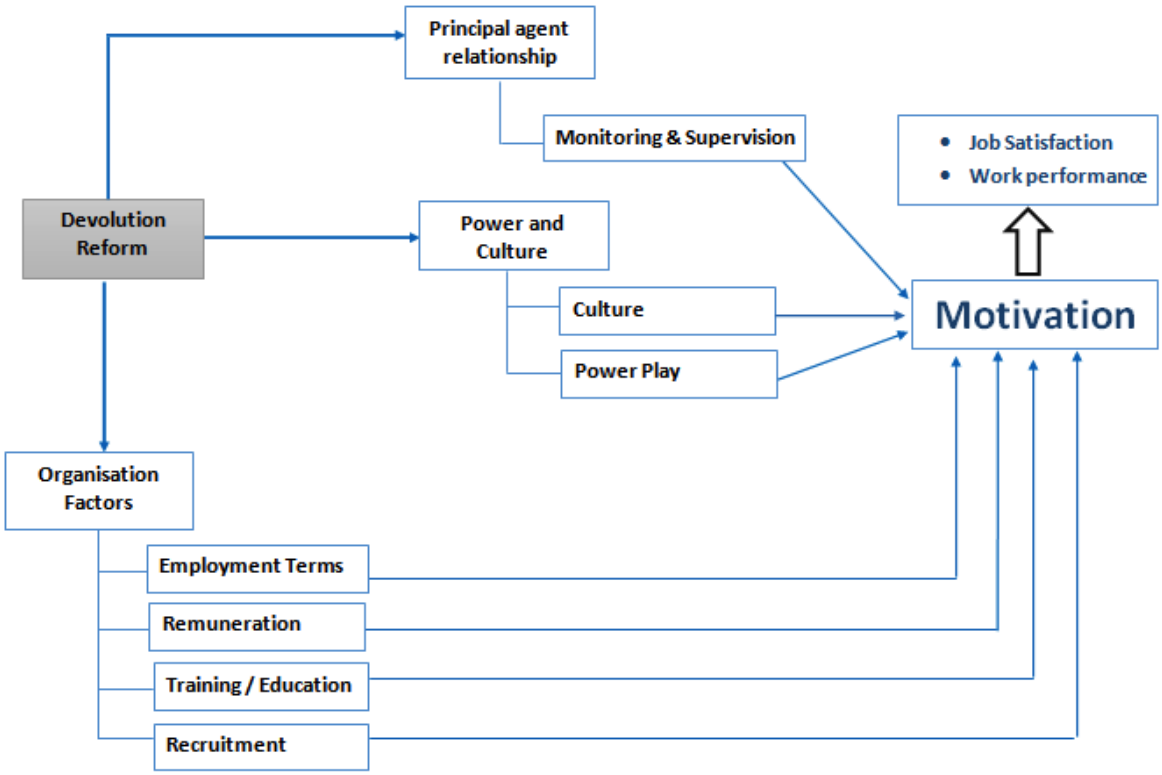


This dissertation proposes to use a new model that combines the two (Franco et al.'s framework and P-A theory) to highlight essential factors that determine the impact of motivation and job satisfaction as shown in **Figure 4**. It will justify that there should be equal emphasis on other rewards for instance recognition other than a basic focus on financial incentives.

3.0 ANALYSIS OF LITERATURE

This section will analyse thirteen media reports, ten published academic papers, and five grey literatures which were the outcome for the literature search. **Figure 4** shows a model I am proposing to use in fitting this literature and aid in discussing the topic. In the figure, devolution is the primary reform with the arrows pointing to four broad channels: principal-agent relationship, organisation structure, and power and culture that highlight the impact of devolution. Each of the channels has component/s that will form the basis for the analysis of literature. The arrows show that the components have a positively or negatively influence on motivation and eventually determine work performance or job satisfaction.

Figure 4: Model of impact of devolution on motivation and satisfaction of HCWs derived from evidence used for this study



Source: Adapted from Franco et al. (2002)

3.1 Principal-agent relationship

From **Figure 3**, the agency relationship between HCWs, politicians (governor), and CMHT (labelled **a**) is an inevitable association resulting from the changed hierarchy of reporting, monitoring, supervision, and information cascade due to devolution and thus will be the pivotal point for discussion in this section. Here the governors delegate some responsibility of implementing the new county healthcare policies to their appointees making up the CMHT and the supplementary "agents" (HCWs- doctors and nurses) whom they can only circuitously control and are hard to monitor. These HCWs are

obliged to operate according to the policy rules set by the governors with the help of COH and CDOH. However, they have failed to engage in fulfilling the wishes and the rules, for example, the doctors and nurses employed by the counties have been viewing themselves as the "learned friends" of the medical profession rather than county employees who take orders from political elites. Their allegiance has also been sworn to their unions *Kenya Medical Pharmacists and Dentists Union* (KMPDU) and *Kenyan National Union of Nurses* (KNUN) – agency labelled **b** in **Figure 3** - from whom they take orders especially when the counties are not meeting their salary and work demands (Wanja, 2013).

If the governors appoint COH and CDOH whose intellect and management capabilities are inferior to that of the HCWs, there is likelihood for an inefficient and ineffective translation of the new devolution policy into reality. These are members who form part of the CMHT boards to whom the HCWs are obliged to report to and with the "agents" having views, ambitions and social status that are different from the "principals," monitoring them may be difficult. HCWs are an integral part of the community they reside, and their professional identity and social status enhance their social standing. However, the new health devolution policy alters this social standing as it empowers the CMHT, some of whom are less educated than the nurses and doctors, to monitor the performance of the HCWs. Their traditional gate-keeping functions such as being in control, leading, and accessing healthcare resources without restrictions has been limited. In Uganda, using lay people who had no prior medical knowledge and skills and could not interpret any medical jargon to supervise medical and nursing professionals (Kyaddondo & Whyte, 2003) had caused some dissatisfaction. Such would most probably be the same case in Kenya.

Devolution has created several hierarchical levels of reporting resulting to more principal-agent relations. With each level relying "on the next level below or beside it" (Buse et al., 2012, pg. 137), the task of managing "agents" is becoming complex. Saide and Stewart (2001) reports that in Nampula province Mozambique, the HCWs had no problem with *who* was supervising them and *how* it was done. However, in Kenya the doctors and nurses may have problems with *who* and *how* supervision is conducted since they feel there are no sufficiently laid down supervisory layouts, guidelines, or manuals to guide the process (Kibet, 2014).

Changing the agency so that the principals are at the county level and not central government may makes it easier to monitor whether HCWs spend more time at work or not. For example, in Homabay County, the governor makes impromptu visits to county public hospitals and even give authority to patients to name and shame the nurses and doctors for mistreatment (Okewo, 2014). Whereas in Elgeyo-Marakwet County the CDOH takes action against lazy HCWs who abscond duty (Suter, 2013). As much as in Mozambique the transfers of HCWs on punitive ground is avoided (Saide & Stewart, 2001), there are reported cases in Kenya where some doctors and nurses only attend to patients when convenient (Okwany, 2013) and thus, the close supervision may help boost service delivery. However, it might not enhance the motivation and satisfaction of the HCWs as they may feel so undermined, and their autonomy disregarded.

3.2 Organisation structure

Franco et al (2002) notes that there are several channels within organisation structure and culture that impact workers motivation and satisfaction. This section will look at four broad channels: employment terms, remunerations, training and education, and recruitment.

3.2.1 Employment terms

Retention and deployment

Permitting HCWs to choose what county to work in rather than the ones they were previously posted in would improve their performance and make it easier to boost their motivation. For example, a study by Njuguna et al. (2014) showed that 97.3% of HCWs in Garissa County were in preference of working in other counties than the ones they were employed in presently. It would likely be easier to enhance the fulfilment rates of these workers because there is a direct correlation between satisfaction and intention to leave or stay at a certain work location (Luboga, et al., 2011). However, there may be problems with such deployments due to administrative glitches, central governments interference with transfers, and financial issues as it is reported in Mozambique (Saide & Stewart, 2001). Nevertheless, a different picture is painted in China (China has been used here as a good example of deployment and retention yet it is not in SSA) where the outcome of healthcare was successful because of retained experienced personnel in government jobs after devolution (Wang, Collins, Tang, & Martineau, 2002). Zinnen et al. (2012) analysed how HCWs responded to decentralisation in Tanzania and reported that staff retention was not as difficult as recruitment and posting as long as the workers were in place and remunerated adequately. Therefore, there should be a balance between posting healthcare workers to counties of their choice and the needs of the area that should also match the government's financial budget and objectives. Experience plays a key role and should be put in consideration when deploying and retaining staff as it is key to heightening the work morale of other newcomers in the area who learn from the already existing players.

Pension

Changing the management of retirement benefits from the central to county government is likely to ease the tracking of employees' information. A study in Tanzania districts, see (Zinnen, Paul, Mwisongo, Nyato, & Robert, 2012), revealed that *pension* was a crucial motivator of HCWs and, therefore, good administration was imperative. This assertion was augmented by a Mozambique study which had shown that decentralisation had improved the management of personnel information thereby enriching the retirement process (Saide & Stewart, 2001). However, problems of central governments interference may be a concern for Kenya as the implementation of the devolution is still a new concept and the capacity of the counties is still a test. Aside from improving the management of pensions, caution on counties political responsibility and autonomy on pension is needed to enhance the step by step implementation and thereby ensure efficient satisfaction and motivation.

3.2.2 Remuneration

Devolving the remuneration authority to the county governments will most likely delay the wages of the HCWs, introduce inequalities in payment and reduce the level of transparency in handling financial affairs. Kyaddondo and Whyte (2003) reports that

decentralisation had reduced the staff income and that some workers in Tororo District, Uganda had gone for 36 months without receiving a salary. Similar instances are evident in the early implementation of devolution in Kenya, for example, in Uasin Gishu County nurses threatened to strike over unpaid dues (Lubanga, 2014) whereas 200 doctors tendered their resignation because of delayed and poor pay (Kibet, 2014). Moreover, HCWs in Nakuru county were worried they were not getting paid (Wanja, 2013).

While financial spur is an essential motivator, the devolved county governments have inadequate incentives to keep their qualified staff (Kimanthi, 2013.) and thus most are opting for greener pastures in private hospitals and Non-Governmental organisations (NGOs). There is evidence in Tana River and Lamu counties that insufficient hardship allowance is causing an acute shortage of doctors and nurses (Nyassy, 2012). It is imperative to, nevertheless, note that not all HCWs are moved by financial incentive like in Tanzania Kilosa District, only 12% of HCWs are enthused by the incentives from decentralised government (Zinnen, et al., 2012). Therefore, other non-financial incentives such as improved working conditions, proper supervision, and decent schooling for children should not be overlooked. However, not all devolved systems have disastrous issues with remuneration. In Busia district Uganda, there was improvement in the regularity of salaries after decentralisation but were however reportedly low (Kyaddondo and Whyte, 2003).

On the inequality in the payment, a study in South Africa highlighted that nurses who were working for the provincial government received lower salaries compared to their counterparts in local authorities (Bachmann & Makan, 1997). Additionally, the devolved districts in Uganda paid their health staff dissimilarly since each had set their allowances and benefits differently from the central government's policy (Bossert, Beauvais, & Bowser, 2000). It can thus be inferred that devolution will create unequal pay for HCWs in different counties thereby creating imbalanced incentives that would potentially undermine staff impetus. A particular concern would be creating inequity in service provision where the lowly ranked and marginalised counties would risk losing qualified personnel and face difficulty employing new ones (discussed below).

Njuguna et al. (2014) pointed out that there are three schemes of service under which nurses in particular are employed: the NGO, Economic stimulus package (ESP), and the county governments (formerly employed by Public service commission - PSC - before devolution). The ESP nurses earn nearly twice as little as county government nurses, while the NGO nurses have better allowances than both despite them having the same academic qualifications. The confounding factor for the inequality is the unclear contractual *terms of service* which puts the nurses in uncertainty for their future. An imperative question would be whether it is crucial for the central government to control staff pay like it is done in Ghana and Zimbabwe, see (A. Mills, Bennett, & Russell, 2001) or whether county government should boost their capacity to handle the pay.

3.2.3 Training and education

Entrusting training opportunities to county governments would most likely improve competence and performance of the county HCWs. An interesting case scenario is from a study in Tanzania, which revealed that upgrading opportunities and trainings was

postulated to enrich the work performance of the HCWs after decentralisation even better than financial incentives (Zinnen, et al., 2012).

However, a hindrance cannot be ruled out in such a set-up due to the challenge of raising the funds to train staff, and identifying those who qualify for the opportunities. For example, in South Africa, training was hindered by paucity of crucial HCWs information and personnel data from the provincial governments after decentralisation (Wang, et al., 2002) whereas in Uganda, the decentralised districts were unable to fund their staffs training (Kyaddondo & Whyte, 2003). A separate study, see (Luboga, et al., 2011), revealed how sundry doctors were frustrated by lack of study leave. In Ghana, inadequate financial resource was cited as a barrier to implementing the decentralised functions such staff training (Sakyi, Awoonor-Williams, & Adzei, 2011). Besides, the Tanzanian Local Government Authority (LGA) which receives in excess of 90% of their budget from the central government, found it difficult to prioritise staff training especially with the strict restrictions that came with the funds (Frumence, Nyamhanga, Mwangu, & Hurtig, 2012). Hence, health devolution may create negative consequences in the careers of HCWs principally when qualified staffs do not get opportunities to advance their knowhow on innovations and technology. The science of healthcare is a growing field that requires a constant upgrade of knowledge and in thus HCWs will feel the worth of applying new techniques in treating and managing healthcare.

3.2.4 Recruitment

Recruitment procedures

Counties having complete autonomy in recruitment of HCW without any interference from central government will enhance adeptness and raise the value of service. Human resource planning is one of the most essential procedures of enhancing motivation in any newly devolved system (Ndetei D.M, et al., 2008). Evidence from early implementation of devolution in Kenya supplements this assertion, for example, having had the authority to hire HCWs, the Samburu county leaders have planned to offer incentives to keep their workers in the hardship area (Kimanthi, 2013.). Moreover, Kisumu County are recruiting nurses and doctors to the tune of KSh 2.4 billion annually (approximately $27.13 million) to boost the numbers (Apollo, 2014) whereas the health leaders in Migori County bettered the HCWs work condition and recruitment (Nation media correspondent., 2013). In addition, county leaders in West Pokot county are improving retention of their theatre staff by building a theatre worth KSh 28 million (Nation Media Correspondent., 2014). Consequently, the worker's performance and motivation would improve since counties are more aware of their human resource needs and would prioritise them adequately.

Devolved recruitment has enhanced motivation in Uganda (Bossert, et al., 2000). Nonetheless, this is not always the case as some countries have had better motivation experience when there is combined centralised and decentralised recruitment for example South Africa and Zambia (Bossert, et al., 2000; Wang, et al., 2002). The same picture is painted in Kongwa district in Tanzania, see (Frumence, et al., 2012) where local authorities only recruits lower cadre staff while the central government recruited permanent staff. A different study, however, see (A. Mills, et al., 2001) revealed that Ghana and Zimbabwe worked well with a strong centralised recruitment. Whilst the above examples are documented in the literature, there is still scanty information on

how devolved systems would affect motivation and satisfaction of HCWs but they however reveal essential issues that the proponents of healthcare devolution need to put into consideration.

In another front, with the law of demand and supply coming into effect with balancing recruitments, a centralised recruitment will enhance the balance of human resource between areas with surplus and areas of shortage. Munga et al. (2009) pointed out that Tanzania's recruitment was re-centralised to safeguard mainly underdeveloped districts losing staff to competitive and vibrant districts. A decentralised human resource allocation is, on the other hand, marred by poor coordination, tribalism (highlighted below), and inequalities that impact on HCWs (Conyers, 2007; Munga, Songstad, Blystad, & Maestad, 2009). Other motivation gaps are most likely to exist especially in dealing with issues of HCWs, who had previously left work with county governments/ central governments and were willing to return. An interesting case is that of Mozambique nurses who had their motivation hampered by the recruitment procedure of the provincial government that did not give them a leeway back to the provincial governments once their NGO contracts expired (Saide & Stewart, 2001). Imperative questions of imbalance in the HCW choice of working between the rich and poor counties need to be analysed, and a policy reorganised.

Employment pattern

It is most likely that devolution of healthcare to the autonomous county government will change the patterns of employment and thus impact workers performance and motivation. For example, changes in the roles of the purchasers and regulators of healthcare in UK (The paper focuses on SSA but here UK is used as a good positive case example) - that has an enviable functional devolved system – enabled the trusts to decide *what type* and *number* of staff were resourceful in running the services efficiently (Bossert, et al., 2000). This is not the case in other devolved systems such as Zambia that experienced difficulties and resistance (Wang, et al., 2002). In Kenya, with the counties having the authority to hire HCWs, doctors are of the opinion that seeking employment from county governments is detrimental to their livelihood and status (discussed above) since the counties are not capable of providing much comfort as the central government (Nyassy, 2012). On the contrary, nurses are comfortable seeking employment with the counties since their numbers are huge, and several are unemployed, unlike the doctors (J. Njuguna, Mwangi, & Kamau, 2014).

Devolving the authority to hire HCWs will worsen favouritism in deployment especially in counties that have dominance of one particular tribe. With the constitution giving the county governments the mandate and the authority to hire, transfer, and dismiss HCWs (LAWS OF KENYA., 2010), staff who originate from the same counties as the county leaders may be preferred and given a lease of life compared to the non-origins. It is most likely they will support the policies and goals of the leaders. In Uganda, for example, Bossert et al. (2000), argues that there was reduced staff quality due to tribalism. In Kenyan setting, it has the potential of demoralising proficient staff who had initially been posted to the regions by the central government before devolution as is evidenced by Machakos County example, see (Editorial, 2013) where "non-residence" where moved away from the county. Therefore, issues of tribe and corruption in deployment - although rarely reported in the media or on scientific papers - are some

other issues that need to be considered if the devolution proposal is to achieve its objective.

3.3 Power and culture

Besides organisational structure, politics and culture plays an imperative role in the motivation process (Franco, et al., 2002). This section will incorporate and discuss the role of power play, which is part of politics, and culture.

Culture

HCWs being a fundamental player of the community they reside have a professional identity and social status (discussed above) which contributes to their high social ladder. Professional identity of the HCWs augments respect from the community (Kyaddondo & Whyte, 2003) meaning living in a manner signifying someone of high social status. Social-cultural factors including strict patronage were identified as sources of problems to implementation of decentralisation in Zimbabwe that degraded the professional identity of the workers (Mutizwa-Mangiza, 1998). HCWs would want to dress appropriately, pay debts at local shops promptly, educate their children in the best schools, and even entertain their visitors adequately that are some of the things the communities expect from people of their social standing. It is highly unlikely to achieve these needs as several counties have reported slashed allowances of doctors and nurses (Hajir, 2014; Kibet, 2014; Nation media correspondent., 2013; Nation Media Group., 2013), and delayed pay thus reducing their respect and in turn demoralising their efforts.

Power play

Healthcare devolution is not politically impartial as it exacerbates political domination and interference (Homedes & Ugalde, 2005). An example of the domination is evidenced at the Kisumu's referral hospital where consultants (A consultant is a medical specialist in a specific medical field after undertaking a master's degree in medicine.) have resigned citing "interference from the county government executives" (Apollo, 2014). Additionally, other reports have shown that frustration from the county government health officials has driven doctors away from Garissa, Embu, Kitui, Kisii, Tharaka Nithi, Busia and Meru counties (Hajir, 2014). In Tanzania, councillors (Councillors are elected political ward leaders who are part of the Local Governing Authority) would influence construction of hospitals in their constituency without considering medical staff availability and medical supplies (Frumence, et al., 2012). Moreover, Smoke (2008) reveals that local and national power players - in most emerging countries – sways the decisions of county officials especially if their power is perceived to be under threat. Elsewhere in Zimbabwe and Swaziland, local political contests affected the devolutionary policies and thus interfered with running of local clinics (Andrews & Schroeder, 2003). Therefore, the political intrigues and complex relationship between politicians and executives hinder the performance of the HCWs as their inputs in the decisions are not sort. This would push more doctors and nurses away from the counties.

On the contrary, not all political domination has a negative influence; it increases political accountability. For example, in West Pokot County, the leaders and county executives have prioritised its healthcare provision by building a theatre with specialised surgical equipment, aiming at reducing the travelling distance of up to 100kms that the patients had been covering to seek treatment at Uasin Gishu district

hospital (Nation Media Correspondent., 2014). Hence, more HCWs will be motivated to stay to work in a well-equipped system.

Power play between doctors and nurses, on the other hand, may reduce the efficiency and the quality of care to the patient and thus alter the motivation. In Zimbabwe, for example, nurses and other HCWs were discontented by the fact that medical officers were given an upper hand to help with the management of health facilities despite having no formal management training (Wang, et al., 2002). Hence, they did not support devolution. In Kenya Garissa County, a medical officer with two years experience was put in charge of a referral hospital overlooking other HCWs who had amassed a great wealth of experience in management (Information retrieved from http://www.kmpdu.org/). There will more likely be tension on the relationship of HCWs and will also modify the efforts being put towards improving the livelihood of the patient, which eventually may trigger an exodus of HCWs, who perceive their efforts are not sufficiently rewarded.

4.0 DISCUSSION

It is essential to consider the methodological stand for the high component of the negative views expressed before discussing the above literature. Firstly, this report looked at the initial perspective of devolution which is facing challenges like any other new reform being implemented. Secondly, Kenya's devolution process has been crowded by hyperbolic narrations of truths and false opinions because of uncertainty and expectations from the public and HCWs. However, the proponents of devolution may argue that it takes time to analyse the impact of change and that the accurate result of HCWs attitude and motivation would be apt after 10- 20 years post-devolution.

Having synchronised the P-A theory with Franco et al.'s framework on motivation enhanced by reform to highlight on devolution, analysis of published documents on decentralisation in SSA and media reports have revealed that there appears to be a strong correlation between devolution and motivation and satisfaction.

Monitoring and Supervision

In several ways, the professional autonomies of the HCWs may be compromised by devolution in several different ways as the finding reveals. Their proficient autonomy may be infringed in some counties especially where the governors appoint lay people to lead the health care management without the necessary grasp of the technical issues that improves service delivery within the health care system. Moreover, having numerous and unclear hierarchical reporting points and individuals may confuse the HCWs and make it more complicated. Aside from that, close supervision is necessary to allow the doctors concentrate on their work and not treat the patients only when they feel like.

Organisation Structure

From the findings, reasons such as proximity to their family will enhance the HCWs choice of a placement. In addition, workers may be more stable working in places where their pension is upheld. Of particular interest are the HCWs who work in remote areas and may not only be motivated by the financial incentives, but proper and consistent non-financial spurs which give them adequate prestige and satisfaction (Mathauer &

Imhoff, 2006). The freedom of choosing where to work, however, may give the workers on over endearing authority that will be hard to maintain.

Findings on recruitment have shown that it is significant to prioritise the needs of the county according to available resources. It gives the leaders an upper hand to determine the skill mix (Wang, et al., 2002) that is more cost effective and that they can maintain. When there is a balance in healthcare staff, even the workers become motivated to perform the allocated functions without any coercion. While issues of centralising and decentralising healthcare are still debatable, problems of recruitment have been shown to reduce the accomplishment of anticipated health goals and objectives such as expanding service coverage and enhancing the possibility placement in remote and underserved areas.

Whereas there is an altered recruitment pattern as a result of devolution, delaying the recruitment process may particularly alter the professional development of the nurses who because of their immense number, may miss out on opportunities to enhance their knowledge and skills (Saide & Stewart, 2001). It has further been shown that the county recruitment process may be auxiliary marred by favouritism and tribalism which when coupled together with the worst state of corruption in the country (Transparency International., 2013), the deployment state would thus reduce the quality of staff in counties. When quality is changed, there is deficient service delivery and thus poor health outcome. It may further catapult the counties into losing qualified staff whose level of motivation is not at par with other countries examples.

Motivation has a "can do" component which is affected by inadequate training and education (Kyaddondo & Whyte, 2003). According to Franco et al. (2002, pg. 1261), developing the skills and knowledge of staff equips them for better performance and thus improves their self-efficacy and eventually motivates them. This analysis has shown that counties may be willing to support the education of HCW but challenges such as funds may be the main hindrance. Therefore, it will be imperative for the counties to work closer with the central government to be able to achieve educational success if HCW, especially those in extremely remote area, are to be satisfied with their work. However, after education and training, some HCWs may opt for others counties with enormous financial power than the training county or better still they may look for greener pastures (Dambisya, 2007; Mathauer & Imhoff, 2006). Rules and mandatory service to curb this are necessary.

There are two ways in which deficient and unequal pay affects motivation. Franco and colleagues, borrowing from Hertzberg et al. (1959), separate "motivating factors" such as recognition and growth, which are "high order" elements of performance from "hygiene factors" such as salaries and working conditions which define the dissatisfaction level. As per the findings, good remuneration as a form of recognition will help in fulfilling other low order necessities which enhance survival of the HCWs. Despite the county leaders having the autonomy to pay the HCWs, the pay rate among several HCWs needs to be uniform across different cadres to avoid the conflicts and dissatisfaction among the workers. Additionally, proper incentives such as good housing, security and hardship allowance is essential to ensuring the workers are retained in hardship areas (J. Njuguna, et al., 2014).

Culture and Power

The findings reveal that the interaction with the community members and maintaining the professional dignity of the workers is quintessential to enhance their job performance. It enables the workers to get an inward satisfaction without necessarily developing the survival strategies including having a side job, locum, and "moonlighting" like it happened in Uganda (Kyaddondo & Whyte, 2003). A positive power play has been shown as an effective motivator by giving the leaders an opportunity to prioritize developmental plans that the health workers deem efficient. Nonetheless, negative power and political energies both from the unions and the members interfere with the development agendas.

4.1 Policy Implication

The findings above highlight policy concerns for the county government and the national government. Whilst the authority to run the health affairs of the regions remain with the county government, the national governments play an essential role in developing policy guidelines for the HCWs attraction and retention, performance monitoring, and capacity building (KHSSP., 2012).

Firstly, devolution is still a new concept in the country and adequate preparation of health workers transfer ought to have taken place to avoid the power play and politics of disrespecting the status and identity of the HCWs. It is likely to trigger strikes and resistance from HCWs and thus interference with devolution and motivation. I however acknowledge that the political interference increased number of stakeholders in healthcare, and multiplicity of interests after devolution might be difficult to reverse. The central government can enforce clear and succinct policy that would help avoid conflicts in the reporting hierarchy and that would state precise roles of the principals and agents.

Secondly, to enhance the eminence of health services, increase user satisfaction vis-à-vis augmenting workers motivation, the HCWs need more in-service capacity building and enhanced supervision. It requires both the county and national government to work towards the development of such projects. Besides, the county government needs to work closely with the health workers union towards identifying the most beneficial way of identifying those to be trained and areas to prioritise training.

Thirdly, the issues on pension, deployment and recruitment procedures should be addressed. It should include working closely with other bodies such as National Social Security Fund (NSSF) which determines how other governments' workers save part of their salary for pension and the government's policy advisors. It is particularly essential as it affects other health workers as well and not just doctors and nurses.

4.2 Limitations of the Study

Firstly, most articles that matched the inclusion criteria were papers that were published in as early as 1997 meaning there are further changes that might have taken place between then and 2014. Moreover, the newspaper articles used have not undergone an academic review, and some of them might be presenting information that is most likely based on hearsay and may not have been researched. However, they are imperative for use as they are useful to highlight the happenings of early implementation since a search

on Kenya articles on devolution after promulgation of the constitution revealed no articles.

Secondly, in as much as some of the papers were relevant, their comparability and inclusion may have been limited because of methodological heterogeneity involving the study population and design. Furthermore, generalising other countries study to Kenya may not have given the most accurate information because of the studies own limitations to which the authors had cited and stated to be used with caution and hence maybe a potential source of bias for this analysis. It is, therefore, imperative that any information obtained from this study is used with caution.

Lastly, limitations of P-A theory cannot be overlooked. For example, when different people want different things as is the case of HCWs, CDOH, and governors, settling on a "trade-off" may prove a daunting task. Moreover, the theory does not explain issues when different cadre of HCWs have different objectives, functions, asymmetry of information, and imbalance of power, for example, when either the doctors or nurses are so powerful than the other. However, this theory gives us an insight that the complexity of the agency relation is affected by the nature and context of the problems. In essence, an organisation and establishment of the proper machinery is needed to improve the policy (Buse, Mays, & Walt, 2012).

4.3 Proposed Future Research

This study would have particularly benefited from informant interviews or focused group discussions with the affected HCWs or the experts to highlight their perception. However, that could not happen due to unavoidable circumstances. I would propose that this is a gap in this exploration that the future research in this area can take up. Besides, other gaps that might be filled by other theories include how to enhance reporting feedback and supervision that had few literatures to support. The issue of culture had insufficient literature to review and may form a future topic for discussion.

The framework suggested by Mathauer and Imhoff (2006) may have been beneficial for this study but was not used because it only focuses on non-financial incentives and does not sufficiently explores other imperative factors that affect motivation and satisfaction.

4.4 Recommendations

Every country with a decentralised healthcare system experiences a distinctive human resource state that reflects the stage of the reform. Therefore, there is no complete blueprint that can work best to enhance the motivation and satisfaction of the HCWs. Every county will require a mix factors that will fit best to improve the working of the new system aside from ensuring staff are motivated enough to give their best in improving service delivery. I, therefore, propose the below strategies to enhance motivation:

I. Develop innovative study courses such as South Africa's Eastern Cape Town Course on leadership (Kolehmainen-Aitken, 2004) which would prioritise training for the hardworking and academically qualified health workers especially those working in remote counties. An independent fund only dealing with education and capacity development of HCW should be formed. Part of the rules and regulation that the fund should develop include a contractual

agreement with the HCWs to avoid migrating from one county to another in searching for greener pastures.

II. Establish better monitoring and supervisory layout, guidelines, and procedures that would be used by the local county leaders to monitor the work of the HCWs. It should be based on objective supervision to establish and develop a high standard and quality of work by the HCWs thereby dropping the rates of migration between counties and reducing collision between HCWs and leaders. It was successful in South Africa (Kolehmainen-Aitken, 2004). In addition, there is a need to employ professional health managers to run the affairs of all county hospital as they are not influenced by power play and politics (KHSSP., 2012).

III. Have an independent commission akin to Teachers Service Commission (TSC) (TSC was established in 1957 by the government to help in managing the affairs of the teachers. It has been very effective in handling pension, remuneration, recruitment and deployment) for HCWs that will centrally control their recruitment, pension, and remuneration without necessarily empowering the county governments to do so. There might be a political challenge in trying to ensure it works. I, however, propose that the county government retains the authority to pay workers other allowances such as hardship allowance, and incentives to improve work. It has worked well in Ghana and Zimbabwe (Wang, 2002). Delinking wages has been used very successfully in Rwanda (Mathauer & Imhoff, 2006). The commission should work on standardising pay for all HCWs.

IV. Develop a cohesive working environment that permits all HCWs to work without any tribal discrimination. Here, the participation of the Central government is significant to help with this achievement. A rotational plan of work would apply so that each HCW works in one county for a period of three years before moving to the next one. The problem is; Kenya is very corrupt, and some individuals may manoeuvre their ways out of the remote counties.

5.0 CONCLUSION

In conclusion, a well-motivated HCW who is sufficiently incentivised will aid in achieving the objectives of devolution such as enhancing user's satisfaction and equity, improving quality of health service, and boosting efficiency and effectiveness of delivering healthcare. To enhance the motivation and satisfaction post-devolution in Kenya, there is need for protection, promotion, and enhancement of professional identity and status of nurses and doctors. Moreover, the government needs to assess and improve "motivation factors" such as recognition and growth besides enhancing value-added culture of monitoring and supervision. Transparent training and educational opportunities, and an all inclusive participation by the new county health administration, will illuminate the black-box of HCWs motivation and satisfaction post-devolution. Furthermore, a well-coordinated leadership is an indispensable tool that if crystallized together with quality of activities and proper power play, will influence the achievement the goals of the healthcare system.

6.0 REFERENCES

Adams, J. S. (1965). Inequity in social exchange. In L. Berkowitz (Ed.), *Advances in experimental psychology*. New York: Academic Press.

Andrews, M., & Schroeder, L. (2003). Sectoral decentralisation and intergovernmental arrangements in Africa. *Public Administration and Development, 23*(1), 29-40.

Apollo, S. (2014, 18-March-2014). Kisumu County to recruit more doctors, nurses. *Daily Nation* Retrieved 04-08, 2014, from http://www.nation.co.ke/counties/kisumu/Kisumu-County-to-recruit-more-doctors-nurses/-/1954182/2248836/-/j4n5foz/-/index.html

Arrow, K. (1985). The economics of agency. In J. Pratt & R. Zeckhauser (Eds.), *Principals and agents- the structure of business* (pp. 37-51). Boston: Havard Business School Press.

Bachmann, M. O., & Makan, B. (1997). Salary inequality and primary care integration in South Africa. *Social Science & Medicine, 45*(5), 723-729.

Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychol Rev, 84*(2), 191-215.

Bossert, T., Beauvais, J., & Bowser, D. (2000). *Decentralisation of health systems: Four country case studies*: Partnership for Health Reform.

Buchanan, A. (1988). Principal/agent theory and decision making in health care. *Bioethics, 2*(4), 317-333.

Buse, K., Mays, N., & Walt, G. (2012). *Making Health Policy*. Maidenhead: McGraw-Hill/ Oxford University Press.

Chitere, P. O., & Ireri, O. (2004). *District focus for rural development in Kenya: Its limitations as a decentralisation and participatory planning strategy and prospects for the future*. Nairobi: Institute of policy analysis and research

Conyers, D. (2007). Decentralisation and Service Delivery: Lessons from Sub-Saharan Africa. *IDS bulletin, 38*(1), 18-32.

Dambisya, Y. M. (2007). A review of non-financial incentives for health worker retention in East and Southern Africa. University of Limpopo, South Africa: EQUINET.

Deci, E. L. (1975). *Intrincic motivation*. New York: Plenum Press.

Diana, A., Hollingworth, S. A., & Marks, G. C. (2014). Effects of decentralisation and health system reform on health workforce and quality-of-care in Indonesia, 1993-2007. *International Journal of Health Planning and Management*.

Editorial (2013). Tribalism may prove last straw for doctors. Retrieved 18-08-2014, from Standard media group: http://www.standardmedia.co.ke/article/2000098585/tribalism-may-prove-last-straw-for-doctors

Franco, L. M., Bennett, S., & Kanfer, R. (2002). Health sector reform and public sector health worker motivation: a conceptual framework. *Soc Sci Med, 54*(8), 1255-1266.

Frumence, G., Nyamhanga, T., Mwangu, M., & Hurtig, A. K. (2012). Challenges to the implementation of health sector decentralization in Tanzania: experiences from Kongwa district council. *Glob Health Action, 6*, 20983.

Gilson, L., Kilima, P., & Tanner, M. (1994). Local government decentralization and the health sector in Tanzania. *Public Administration and Development, 14*(5), 451-477.

Hajir, A. (2014). Doctors did not resign, says Garissa governor Nathif Jama. *Daily Nation.* Retrieved 07-08, 2014, from http://www.nation.co.ke/counties/Nathif-Jama-Garissa-County-Health-Workers/-/1107872/2246308/-/1448bpdz/-/index.html

Hertzberg, F., Mausner, B., & Synderman, B. (1959). *The motivation to work*. New York: Wiley.

Homedes, N., & Ugalde, A. (2005). Human resources: the Cinderella of health sector reform in Latin America. *Hum Resour Health, 3*(1), 1.

Kenya Vision 2030. (2007). *The Vision 2030: The popular version* Retrieved 27-08-2014. from http://www.vision2030.go.ke/cms/vds/Popular_Version.pdf.

KHSSP. (2012). *Accelerating attainment of Health Goals: The KENYA HEALTH SECTOR STRATEGIC AND INVESTMENT PLAN – KHSSP July 2012 – June 2017*. Retrieved 14-08-2014. from http://www.who.int/pmnch/media/events/2013/kenya_hssp.pdf.

Kibet, L. (2014). Crisis looms as 200 doctors resign. *The Standard* Retrieved 07-08, 2014, from http://www.standardmedia.co.ke/health/article/2000106818/crisis-looms-as-200-doctors-resign

Kibua, T. N., & Mwabu, G. M. (2008). *Decentralization and Devolution in Kenya: New Approaches*: University of Nairobi Press.

Kimanthi, K. (2013., 23-August-2013.). Offer incentives to medics in hardship area - Samburu leaders. *Daily Nation* Retrieved 04-08, 2014, from http://www.nation.co.ke/counties/Offer-incentives-to-medics-in-hardship-areas-/-/1107872/1966490/-/o21tbhz/-/index.html

Kolehmainen-Aitken, R.-L. (2004). Decentralization's impact on the health workforce: Perspectives of managers, workers and national leaders. *Human Resources for Health, 2*(5), 1-11.

KPMG International. (2013). Devolution of healthcare services in Kenya: lessons learnt from other countries *Devolution of healthcare services in Kenya: lessons learnt from other countries* Retrieved 10-July, 2014, from http://www.kpmg.com/Africa/en/IssuesAndInsights/Articles-Publications/Documents/Devolution%20of%20HC%20Services%20in%20Kenya.pdf

Kramon, E., & Posner, D. N. (2011). Kenya's new constitution. *Journal of Democracy, 22*(2), 89-103.

Kyaddondo, D., & Whyte, S. R. (2003). Working in a decentralized system: a threat to health workers' respect and survival in Uganda. *Int J Health Plann Manage, 18*(4), 329-342.

Laws of Kenya. (2010). The Constitution of Kenya, 2010: Attorney General Nairobi.

Locke, E. A., & Latham, G. P. (1984). *Goal Setting:A motivational technique that works*. Englewood Cliffs, NJ: Prentice-Hall.

Lubanga, D. (2014). Nurses threaten to call strike over unpaid dues. *Daily nation* Retrieved 07-08, 2014, from http://www.nation.co.ke/counties/eldoret/unpaid-dues-strike-Uasin-Gishu/-/1954186/2242404/-/pqcxuw/-/index.html

Luboga, S., Hagopian, A., Ndiku, J., Bancroft, E., & McQuide, P. (2011). Satisfaction, motivation, and intent to stay among Ugandan physicians: a survey from 18 national hospitals. *The International journal of health planning and management, 26*(1), 2-17.

Ludwig, M., Van Merode, F., & Groot, W. (2010). Principal agent relationships and the efficiency of hospitals. *Eur J Health Econ, 11*(3), 291-304.

Luoma, M., Doherty, J., Muchiri, S., Barasa, T., Hofler, K., Maniscalco, L., et al. (2010). *Kenya Health System Assessment- 2010*. Bethesda, MD. Abt Associates Inc.

Malcolm, L. A. (1989). Decentralisation trends in the management of New Zealand's health services. *Health Policy, 12*(3), 285-299.

Maslow, A. (1954). *Motivation and Personality*. New York: Harper and Row.

Mathauer, I., & Imhoff, I. (2006). Health worker motivation in Africa: the role of non-financial incentives and human resource management tools. *Human resources for health, 4*(1), 24.

Mbindyo, P., Blaauw, D., & English, M. (2013). The role of Clinical Officers in the Kenyan health system: a question of perspective. *Hum Resour Health, 11*(1), 32.

Mbindyo, P., Gilson, L., Blaauw, D., & English, M. (2009). Contextual influences on health worker motivation in district hospitals in Kenya. *Implement Sci, 4*, 43.

Mbindyo, P. M., Blaauw, D., Gilson, L., & English, M. (2009). Developing a tool to measure health worker motivation in district hospitals in Kenya. *Hum Resour Health, 7*, 40.

Mills, A., Bennett, S., & Russell, S. (2001). *The challenge of health sector reform: what must governments do?* New York: Palgrave.

Mills, A., Vaughan, J. P., Smith, D. L., & Tabibzadeh, I. (1990). *Health system decentralisation: Concepts, issues and country experience*. England: World Health Organisation.

MoMS., & MoPHS. (2011). Kenya Health Policy 2012-2030.

Munga, M. A., Songstad, N. G., Blystad, A., & Maestad, O. (2009). The decentralisation-centralisation dilemma: recruitment and distribution of health workers in remote districts of Tanzania. *BMC Int Health Hum Rights, 9*, 9.

Mutizwa-Mangiza, D. (1998). The impact of health sector reform on public sector health worker motivation in Zimbabwe.

Mwenda, A. K. (2010). *Devolution in Kenya: Prospects, Challenges and the future*. Nairobi: Institute of Economic Affairs.

Nation media correspondent. (2013, 26-12-2013). Health workers resume duty in Migori County *Daily Nation* Retrieved 04-08, 2014, from http://www.nation.co.ke/counties/-/1107872/2125408/-/bfwx24/-/index.html

Nation Media Correspondent. (2014, 09-July-2014). Sh28m theatre set for construction. *Daily Nation* Retrieved 04-08, 2014, from http://www.nation.co.ke/counties/-/1107872/2125408/-/bfwx24/-/index.html

Nation Media Group. (2013, Wednesday, March 12, 2014). Ministry directs counties to pay striking health workers. *Daily Nation* Retrieved 29-08, 2014, from http://www.nation.co.ke/counties/Cabinet-Secretary-James-Macharia-Health-Nurses-Salarie/-/1107872/2241528/-/e48cwn/-/index.html

Ndetei D.M, Khasakhala L, & Omolo J.O (Eds.). (2008). *Incentives for health worker retention in Kenya: An assessment of the current practice*. Kenya, Dar e Salaam.

Njuguna, J., Mwangi, P., & Kamau, N. (2014). Incentives among health workers in a remote Kenyan district: implications for proposed county health system. *J Health Care Poor Underserved, 25*(1), 204-214.

Njuguna, N., Thugge, K., & Otieno, O. (2011). Unlocking the future potential for Kenya: The vision 2030 Retrieved 21-08, 2014, from http://www.csae.ox.ac.uk/conferences/2009-edia/papers/509-owino.pdf

Nyassy, D. (2012). Doctors shortage hits Coast hospitals. *Daily Nation* Retrieved 07-08, 2014, from http://www.nation.co.ke/counties/Doctor-shortage-hits-Coast-hospitals-/-/1107872/1447240/-/j5miae/-/index.html

Okewo, E. (2014). County chiefs read riot act to health workers. *Daily Nation* Retrieved 29-08, 2014, from http://www.nation.co.ke/counties/nairobi/Governors-warn-health-workers/-/1954174/2350618/-/rghg59z/-/index.html

Okwany, R. (2013). Shortage of health workers cripples Coast hospital services. *Daily Nation* Retrieved 07-08, 2014, from http://www.nation.co.ke/counties/mombasa/Shortage-of-health-workers-cripples-hospital/-/1954178/1962470/-/4y1pbs/-/index.html

Othieno, N. (2011). Devolution in Kenya's new constitution, *Constitution Working Paper No. 4* (pp. 17). Nairobi: Society for International Development.

Rocaboy, Y., Vaillancourt, F., & Hugounenq, R. (2013). Public finances of local govenment in Kenya. In B. Dafflon & T. Madies (Eds.), *The political economy of decentralisation in Sub-Saharan Africa: A new implementation model in Burkina Faso, Ghana, Kenya, and Senegal*. Washington, DC: World Bank.

Rondinelli, D., & Cheema, G. (1983). *Decentralisation in developing countries: A review of recent experience*. Washington, DC: World Bank.

Saide, M. A., & Stewart, D. E. (2001). Decentralization and human resource management in the health sector: a case study (1996–1998) from Nampula province, Mozambique. *The International journal of health planning and management, 16*(2), 155-168.

Sakyi, E. K., Awoonor-Williams, J. K., & Adzei, F. A. (2011). Barriers to implementing health sector administrative decentralisation in Ghana: A study of the Nkwanta district health management team. *Journal of health organization and management, 25*(4), 400-419.

Sekwat, A. (2000). Principal-agent theory: a framework for improving health care reform in Tennessee. *J Health Hum Serv Adm, 22*(3), 277-291.

SoftKenya Team. (2010). Kenya County Map Retrieved 29/08/2014, 2014, from http://softkenya.com/map/kenya-county-map/

Ssengooba, F., Rahman, S. A., Hongoro, C., Rutebemberwa, E., Mustafa, A., Kielmann, T., et al. (2007). Health sector reforms and human resources for health in Uganda and Bangladesh: mechanisms of effect. *Human Resources for Health, 5*(1), 3.

Suter, P. (2013). Governor 'treated' by watchman. *Daily Nation* Retrieved 15/08/, 2014, from http://www.nation.co.ke/counties/Governor-treated-by-watchman/-/1107872/2069038/-/11qhomt/-/index.html

The World Bank. (2008). *Decentralisation in client countries: an evaluation of World Bank support, 1990-2007*. Washington, DC: World Bank.

The World Bank. (2012). *World Bank Fiscal Decentralisation Knowledge Programme Team.*

The World Bank. (2014). Kenya Overview Retrieved 15-July, 2014, from http://www.worldbank.org/en/country/kenya/overview#1

Transparency International. (2013). CORRUPTION MEASUREMENT TOOLS. *CORRUPTION BY COUNTRY / TERRITORY* Retrieved 19- August, 2014, from http://www.transparency.org/country#KEN

Wang, Y., Collins, C., Tang, S., & Martineau, T. (2002). Health systems decentralization and human resources management in low and middle income countries. *Public Administration and Development, 22*(5), 439-453.

Wanja, M. (2013). Health workers give ultimatum over pay. *Daily Nation* Retrieved 07-08, 2014, from http://www.nation.co.ke/counties/Health-workers-give-ultimatum-over-pay/-/1107872/1933448/-/78riij/-/index.html

Willis-Shattuck, M., Bidwell, P., Thomas, S., Wyness, L., Blaauw, D., & Ditlopo, P. (2008). Motivation and retention of health workers in developing countries: a systematic review. *BMC Health Serv Res, 8*, 247.

World Health Organisation. (2014). Kenya Retrieved 15-July, 2014, from http://www.who.int/countries/ken/en/

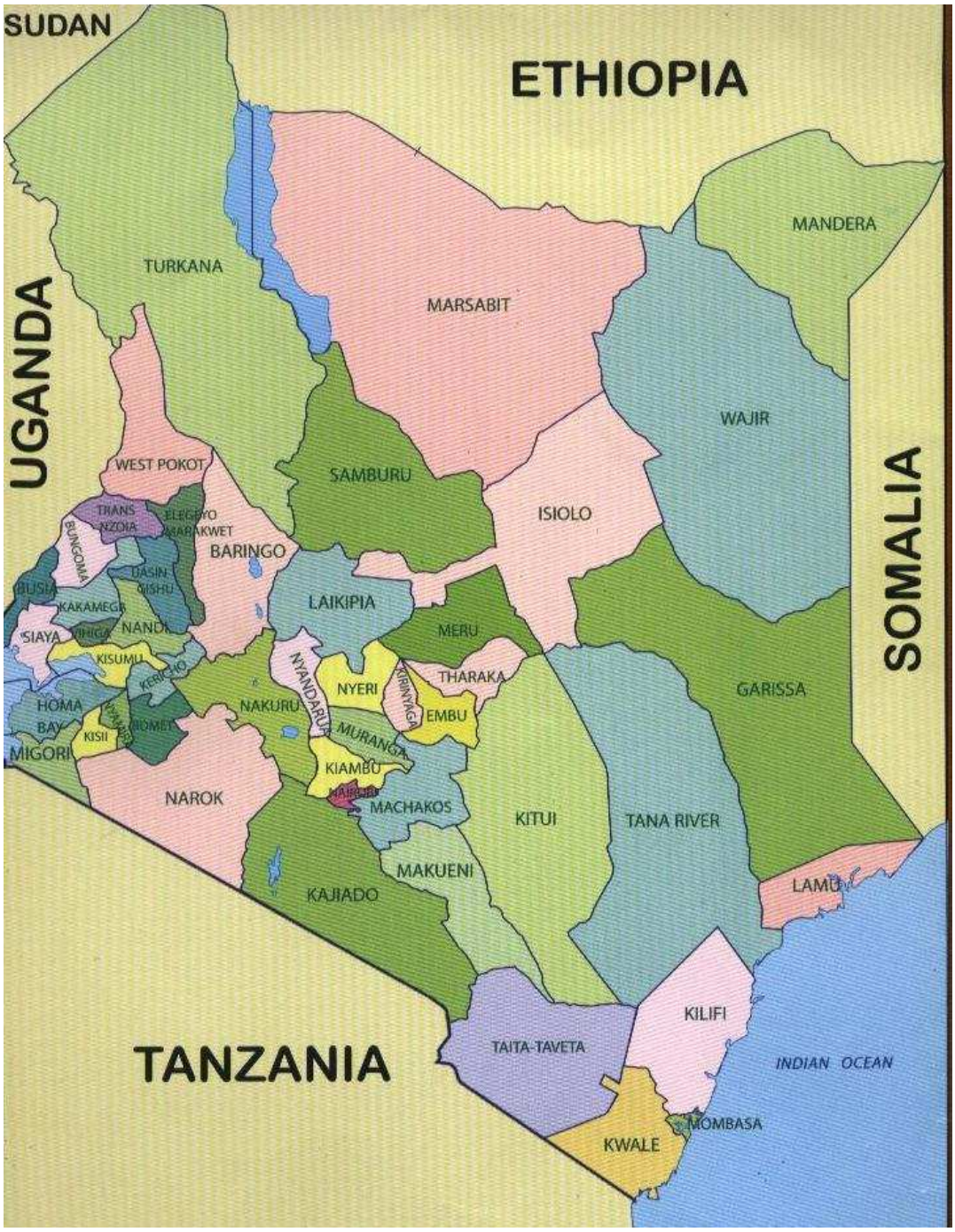
Zinnen, V., Paul, E., Mwisongo, A., Nyato, D., & Robert, A. (2012). Motivation of human resources for health: A case study at rural district level in Tanzania. *The International journal of health planning and management, 27*(4), 327-347.

7.0 APPENDIX

Appendix 1: Showing all the countries in the Sub-Saharan Africa

Angola	Côte d'Ivoire	Madagascar	Seychelles
Benin	Djibouti	Malawi	Sierra
Botswana	Equatorial Guinea	Mali	Leone
Burkina Faso	Eritrea	Mauritania	Somalia
Burundi	Ethiopia	Mauritius	South
Cameroon	Gabon	Mozambique	Africa
Cape Verde	The Gambia	Namibia	Sudan
Central African	Ghana	Niger	Swaziland
Republic	Guinea	Nigeria	Tanzania
Chad	Guinea-Bissau	Réunion	Togo
Comoros	Kenya	Rwanda	Uganda
Congo (Brazzaville)	Lesotho	Sao Tome and	Western
Congo (Democratic	Liberia	Principe	Sahara
Republic)		Senegal	Zambia
			Zimbabwe

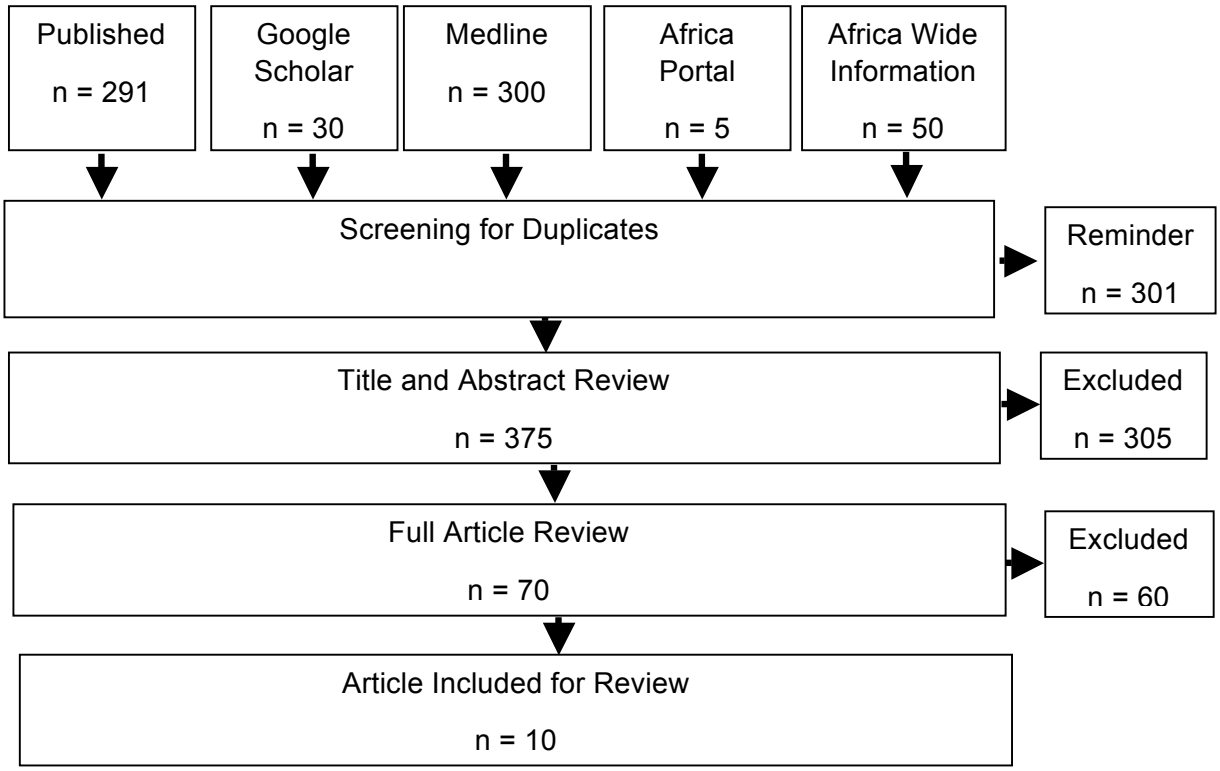
Appendix 2: Map of Kenya Showing the 47 County Governments



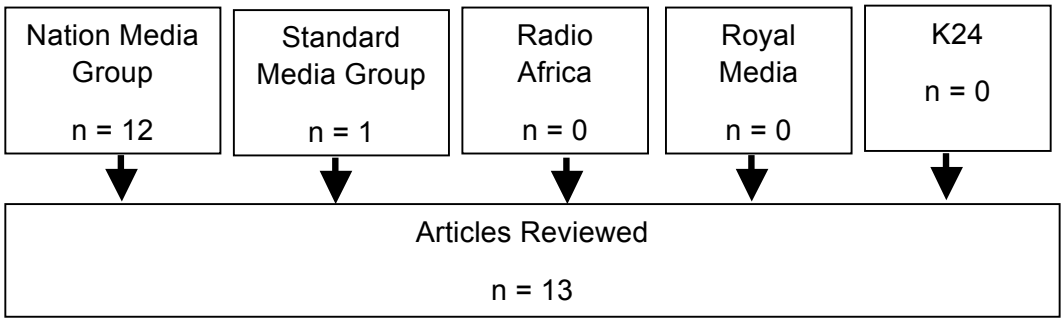
Source: (SoftKenya Team., 2010)

Appendix 3: Search Strategy and Results

1. Published Articles



2. Media Articles



3. Grey Literature - n = 5