



Healthcare Workers' Perspectives on the Devolved Health Function and Mental Health Staffing Gap in Nairobi County, Kenya

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Abstract: *This research was undertaken to explore healthcare workers' perspectives on the role of the devolved health function in ameliorating mental health staffing gap in Nairobi County, Kenya. It was anchored on two theories: the decentralization theory and the structural functionalist theory. The study adopted the case study research design and was purely qualitative in approach. The saturation method of sample size determination was applied. Data was collected through in-depth interview guides, key informant interviews, and focus group discussions (FGDs), and analyzed through reflexive thematic analysis and document analysis. The findings derived from the Braun and Clarke (2006) analytical framework indicated that Nairobi under the county government addressed mental health staffing gap. The study concluded that devolved health function had played a significant role in ameliorating mental health funding gap in Nairobi County, Kenya. The study recommended that Nairobi City County ought to increase mental health workforce.*

Keywords: *Perspective, Devolution, Devolved Health Function, Mental Health, Mental Health Staffing Gap*

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1. Introduction

The shortage of specialists in the field of mental health is one of the worst in the world. According to WHO (2020) projections, 90% of the global shortfall occurs in LMICs, and 56% of the world's population resides in nations with less than one mental health professional per 100,000 people. Globally, high-income countries have roughly 9 psychiatrists and 11.8 psychologists per 100,000 people, while low-income countries have 0.1 and 0.04 per 100,000 people, respectively—a 90-fold and 295-fold difference (WHO, 2020). Health facility evaluations, human resource information system (HRIS) analysis, and mixed-methods studies that combine workforce censuses with qualitative research on motivation and retention are just a few of the methodological techniques used in global workforce

research. Maldistribution, low retention, and insufficient training were consistently identified as the main causes of workforce gaps in Campbell et al.'s (2013) systematic evaluation of 37 studies looking at health worker shortages in LMICs. Creating competency-based task-shifting frameworks and assessing how workforce wellness interventions affect mental health and service quality are two suggestions for future research.

Sub-Saharan Africa faces the most acute mental health workforce shortage in the world. WHO (2020) data indicate a regional average of 0.06 psychiatrists per 100,000 populations, compared to a minimum requirement of 0.5 per 100,000. Countries such as Liberia, Sierra Leone, and Guinea have fewer than five psychiatrists nationally. Nigeria, with a population of over 200 million, has

approximately 300 psychiatrists—a ratio of 0.15 per 100,000. The main tactic for resolving the expert shortage is task-shifting, which involves assigning mental health responsibilities to less skilled health professionals like nurses, community health workers, and lay counselors. The scalability of task-shifted interventions was shown by Patel et al.'s (2018) SUNDAR trials in India, and comparable models have been tried in Ethiopia (Hanlon et al., 2016), South Africa (Lund et al., 2020), and Uganda (Kigozi et al., 2010). Although task-shifting has potential, African research also reveals its drawbacks, such as insufficient supervision, task overload, and uneven care quality in the absence of specialized oversight.

The mental health workforce in Kenya is weak, unevenly distributed, and underfunded. A population of over 53 million people in Kenya was served by 123 registered psychiatrists, 453 clinical psychologists, and around 2,000 psychiatric nurses, according to the Kenya Health Workforce Report (Ministry of Health Kenya, 2021) (ratios of 0.23, 0.85, and 3.77 per 100,000, respectively). These ratios are all significantly below the WHO-recommended minimums. Nairobi is home to over 60% of Kenya's psychiatrists, which causes acute shortages in rural and semi-arid areas. The first systematic national examination of Kenya's mental health system, conducted by Jenkins et al. (2010), used a mixed-methods approach that included policy document review, facility assessments ($n = 193$ facilities), and stakeholder interviews ($n = 85$). The majority of health workers receive less than 20 hours of mental health training during their entire professional preparation, according to the survey, which revealed significant gaps in pre-service medical and nursing curriculum. The lack of county governments to incorporate mental health professionals into county health workforce planning has exacerbated this training shortfall since devolution. This situation must be reversed.

Despite being the nation's center for health training, Nairobi County has a serious shortage of mental health professionals. Only three of the county's fourteen public health facilities with any capacity for mental health services have specialized psychiatric outpatient departments. In 2022, Mathare Hospital, which serves millions of people, had an authorized staffing of 62 mental nurses and 21 psychiatrists; but, due to attrition, transfers, and vacancies, real staffing was assessed to be 60% of the establishment (Ndetei et al., 2022). As part of its national curriculum, the county's community-based workforce, including CHVs, does not receive official mental health training. A qualitative study conducted by Mbuthia et al. (2022) using semi-structured interviews with 20 health managers in Nairobi County revealed both institutional resistance in addressing the labor gap and broad recognition of it. Inadequate county budget allocations, conflicting health priorities (especially HIV/AIDS,

malaria, and maternal health), and national-level human resource management restrictions—such as the ban on county governments directly hiring specialists without TSC approval—were cited by health managers as obstacles to workforce expansion.

Over the past 20 years, mental health has risen from the periphery of discussions about global health to a central place in the framework of public health policy. This transition has not been caused by an abrupt change in the underlying epidemiology of mental diseases, but rather by an increasing awareness of their scope, financial burden, and the ongoing inability of health systems around the world to effectively address them. The devolved health function established under the 2010 Kenyan Constitution is the specific institutional mechanism through which health services, including mental health services, are organized and delivered in Kenya. The background that follows is developed sequentially, starting from the global picture and moving through the regional (African) and national (Kenyan) contexts before converging on Nairobi County, the specific locale of the study. After previously ranking second in the most recent version of the Global Burden of Disease estimates, mental disorders are now acknowledged as the primary cause of years lived with disability globally (World Health Organization, 2025). Furthermore, current estimates reveal that approximately one billion persons worldwide suffer from a diagnosable mental illness; even after accounting for population growth, this number has increased significantly during the previous three and a half decades.

One of the cornerstones of participatory democracy was devolved governance. Despite its widespread use in healthcare, its impact has not yet been completely appreciated. According to Fischer et al. (2024), mental health disparities continued to be a major public health concern in the United States of America, with certain communities bearing disproportionate burdens of mental illness and facing hurdles to care. They further contended that to be able to fix these disparities, comprehensive policy interventions, more financing for community-based mental health services, enhanced cultural competency in the provision of healthcare, and focused research to create successful, culturally appropriate interventions for marginalized populations were all necessary.

2. Literature Review

While Kenya's workforce shortage, mental health financing shortfall, and ongoing primary-care integration gap have all been separately documented in the literature, relatively little published research has looked at these issues as results of particular devolved governance mechanisms, such as county assembly budget-setting processes, county health sector strategic and investment

planning, or the interaction between county and Social Health Authority financing streams, rather than as general descriptions of underfunding (Government of Kenya, 2023; Kwobah et al., 2023). The current study aims to bridge this gap between the definition of health systems and the explanation that is governance-focused. There has been little research that directly links the historical, Nairobi-centered concentration of psychiatric infrastructure inherited from the colonial period to the current distribution and integration, or lack thereof, of mental health services under devolved county governance (Human Rights Watch, 2023; Kwobah et al., 2023). To date, historical accounts of Kenyan psychiatric care, most thoroughly documented by Human Rights Watch, and contemporary health-systems assessments of devolved mental health service delivery.

A systematic, county-wide empirical account of how Nairobi County's own devolved health administration, budgeting practices, workforce deployment, facility-level service organization, and integration with national policy and financing reforms are shaping the mental health service gap that its residents continue to experience is what the reviewed literature has not yet provided and what justifies the current study. The health managers in Nairobi County, national legislators enacting the Social Health Insurance Act and the Kenya Mental Health Action Plan, and the larger body of research on devolved health governance in sub-Saharan Africa will all directly benefit from closing this gap.

According to Ballout (2025), the global mental health workforce is experiencing a serious crisis that disproportionately affects marginalized groups and is characterized by burnout, secondary trauma, compassion fatigue, and labor shortages. The Integrated Workforce Trauma and Resilience (IWTR) Model, a thorough framework for comprehending and resolving these interrelated issues, is presented in this research. In order to investigate the difficulties experienced by mental health professionals, specifically trauma, burnout, and a lack of workers, this study uses a conceptual, documentary analysis approach. Although Marchionatti et al. (2024) developed a framework for a community-focused, widely accessible mental health system, a number of obstacles stand in the way of its complete implementation. These include an uneven primary healthcare system, a shortage of public sector specialists, underfunding, a lack of coordination among providers, an uneven distribution of services, and a lack of quality monitoring. In order to assist children's and adolescents' mental health, we recommend primary care practices that plan patient pathways, establish service standards, and monitor results.

Lokota, Miriti, and Okello (2023) noted that staffing capacity emerged as a crucial aspect of healthcare

performance in the worldwide context. The effectiveness and quality of healthcare delivery significantly impacted by hospital settings' workforce availability, skill mix, and staff size. Remote facilities like Lodwar County Referral Hospital continue to voice concerns about the quality of services provided in terms of timeliness, safety, and efficacy despite the government's efforts to supply hospitals with skilled human resources. In their analysis of the four Western Kenyan counties, Kwobah et al. (2023) discovered that the mental health systems were inadequate and poorly organized, that there were insufficient financial and human resources, and that there were no county-specific legislative frameworks to promote mental healthcare. According to the report, counties should make investments in systems that enable their residents to receive high-quality mental health care. Lihanda and Ngaruko (2024) looked into how the devolution of human capital affected the technical effectiveness of public health facilities in Kenya's Nakuru and Baringo Counties. The public health sector still yearns for greater efficiency, even though it was anticipated that higher government spending would improve efficiency. Devolution of healthcare was intended to increase efficiency and citizen participation, however obstacles like budgetary limitations, ineffective bureaucracy, and a lack of training opportunities remained. Although personnel credentials and other parts of service delivery have improved as a result of human capital devolution, important areas like practitioner licensure and conference attendance are still problematic. The report suggests that transferring all powers designated to County Governments in line with Schedule IV of the 2010 Kenyan Constitution would address financial difficulties, the uneven allocation of national resources, and inadequate funding of devolution services.

This work is anchored upon the decentralization theory. Decentralization is based on the theoretical idea that public services are provided more effectively, fairly, and responsively when decisions are made by the level of government closest to the citizens who use them. This is because local authorities have better knowledge of local needs, preferences, and situations than a distant central bureaucracy (World Bank, 2022). In addition to allowing for policy experimentation and innovation across jurisdictions from which lessons can then be extended nationwide, proximity is seen to promote democratic accountability by allowing citizens to more directly watch, reward, and punish local office holders. Kenya's 2010 Constitution operationalized this theoretical idea by establishing two levels of government: the national government, and forty-seven (47) county governments. The national government retained the authority to formulate health policies, manage national referral hospitals, and establish technical norms and standards, while the county governments were tasked with providing health services, including county health facilities,

ambulance services, and primary healthcare promotion (Nyangaka et al., 2026).

Decentralization theory shows a number of advantages when applied to Kenya's decentralized health function. First, since county governments have been able to expand infrastructure and reorient services toward locally felt priorities in a way that the pre-2010 centralized system did not allow, it provides a cogent, evidence-consistent explanation for observed improvements in physical access to health facilities and basic maternal and child health indicators after 2013 (Nyangaka et al., 2026). Second, the theory accurately predicts that decentralization makes room for horizontal comparison between jurisdictions and policy learning: county-level variance offers comparative evidence of what works, which may help guide the revision of national health policy. Third, decentralization theory encapsulates the accountability logic that drove devolution: citizens' close proximity to county assemblies and executives is hypothesized—and somewhat empirically linked—to a greater ability to demand transparency and hold local leaders accountable for service failures (Pita et al., 2021).

The study is also based on the structural functionalist perspective. According to structural-functional theory, which is most closely linked to Talcott Parsons, society is a complex system of interconnected institutions and structures, each of which carries out tasks essential to the stability, integration, and ongoing equilibrium of the whole. Health and illness are viewed as social phenomena that both influence and are influenced by the operations of other institutions; institutions are analyzed in terms of the roles they play for the larger social system rather than in isolation. The idea of the sick role, which treats illness as a kind of deviance that, if untreated, threatens the productive functioning of the social system, is Parsons's most significant contribution to medical sociology. As a result, society assigns the sick a temporary, sanctioned role that requires them to seek competent care and return to normal functioning as soon as possible in exchange for exemption from regular social obligations (EBSCO Research Starters, 2023).

3. Methodology

3.1 Research Design

Creswell (2009) pointed out that a research design was either qualitative, quantitative or mixed methods. Matt, Weinstein and Foard (2006) pointed out that a research design positioned the researcher in the empirical world, linked the research study questions to field data, and was the pivotal blueprint for a piece of research. This study employed the case study research design. This is because out of the 47 counties in Kenya, the researcher focused

solely on Nairobi County. Also, this design was suitable for conducting an in-depth investigation of a real-life phenomenon. Furthermore, the design relies on triangulation of data collection methods, therefore suitable for this study where data collection relied on in-depth interviews, key informant interviews, focus group discussions, and content analysis. The study yielded a qualitative study.

3.2 Area of Study

Nairobi County was the site of this investigation. Kenya's capital, Nairobi, is located in the highlands at 1deg17S, 36deg49E, 140 kilometers (87 miles) south of the Equator. It has been reported that Nairobi is the only capital city having a national park. Nairobi National Park, which is surrounded by the Rift Valley and contains cities like Ngong Hills, is located in a highland area with a somewhat temperate climate. It is the capital city that has a heterogeneous population and that is why was purposely selected as the research area. The present-day Nairobi County was the previous Nairobi Province. The area is about 696.1% of the total.

3.3 Sampling Design and Procedures

This research was purely qualitative in nature. As a result, the saturation method of sampling size determination was used to arrive at 108 respondents. Bouncken et al (2022) observed that qualitative research does not pursue the objective of offering statistically generalizable results. The key criterion in qualitative research for assessing the adequacy of sample size is saturation. This sampling size determination strategy is evaluated by researchers after the data analysis process is in operation rather than being predefined at the empirical research design stage. Interestingly, saturation can be identified, substantiated, and reported only after the saturation point has been reached. It is only when additional data do not add new insights do researchers realize their study is saturated. Liping et al (2022) postulated that saturation is a metric used to evaluate the quality of research data, and a sufficient sample ensures research validity in a qualitative study. Saturation indicates that there is no need to continue gathering data since, based on the evidence that has already been gathered and examined, doing so will not enable researchers to get a deeper comprehension of the narrative or theory. Neem et al (2024) observed that saturation is regarded as a crucial concept since it guarantees that the results are reliable and that the data are fully utilized to accomplish the study's goal. Ahmed (2025) pointed out that a key building block in qualitative research methodology was data saturation, which is the point at which no new themes, patterns, or information can be found in the data. When data saturation is reached, the researcher has sufficiently investigated the topic under study and can stop

gathering data without running the danger of missing important information. This idea is crucial for establishing sample size as well as for boosting the validity and reliability of qualitative research. When the researcher and his team of research assistants reached the 108th respondent, it was realized that no new data or themes emerged and therefore data collection was stopped at that point.

3.4 Sources of Data and Data Collection

Methods

3.4.1 Primary Data

In-depth Interviews

Knott et al (2022) posited that researchers in the social sciences employed in-depth interviews as a flexible method of gathering qualitative data. They enabled people to describe how they perceived and comprehended the world in their own terms. People engage in a surprisingly familiar social interaction during interviews by asking and responding to questions. To get data on how the devolved health function influences mental health gaps, the researcher conducted the study using in-depth interview guides. A set of guides were used by the researcher and his team of research assistants to correctly fill in information pertinent to the research topic being investigated. Doctors, clinical officers and nurses who participated in the interviews across Embakasi, Kasarani, Njiru, Dagoretti, and Westlands sub-counties of Nairobi County, Kenya, were 108 in number.

Key Informant Interviews

Xu et al (2025) postulated that through in-depth discussions with participants, in-depth interviews seek to investigate the lived experiences and behavioral patterns of particular social groups. This qualitative approach is used to produce insights and suggestions for problem-solving as well as to look into the underlying mechanisms behind certain phenomena. The interviewer allowed the interviewee to freely to talk about any and everything about the topic under discussion and the interview was designed based on the perceptions of the interviewee. Information was sought through the survey of county and federal government officials who possessed a wide background knowledge of the concept of decentralization. The key informant interview guide was applied in the key informant interview process.

Focus Group Discussion

Mack, Woodsong, Macqueen, Guest and Namey (2005) defined a focus group as a data collection method which is effective in enabling researchers to get acquainted with a

realm of viewpoints existing within a group or subgroup of people and their ultimate goal is to emblazon group opinion. It involves one or two researchers alongside a handful of participants (usually comprising 8-12 members) meeting as a group to explore a topic of interest. One researcher moderates the discussion by asking the members to respond to open-ended questions while the second researcher takes extensive notes on the discussion. A key advantage of focus group discussions is that they generate large amounts of data within a comparatively short period of time. Also, as observed earlier, they are effectual in gaining a wide range of perspectives on a research topic as a result of the diversity in the group in question. The Focus Group Discussion schedule was used in the collection of field data.

3.4.2 Secondary Data

3.5 Document Content Analysis

Annual report, draft, judgment, notes, statistics, and professional opinions were regarded as a document based on the definition of standardized artifacts given by Flick (2009). These items were found in print or electronic copies. Bryman (2016) defined it as a document and text analysis method that seeks to quantitatively categorize content in a systematic and repeatable manner based on set pre-emerged criteria, and that the latter is known as content analysis. The term is very broad covering a large range of ways of making the conclusion of communications and texts through the careful isolation of certain characteristics. It is not a research method as it is a technique in document/text analysis. Nevertheless, it is its extraordinary method of analysis that made it be seen by many as a research method. Chand (2025) defined document analysis as the methodical review and interpretation of documents in order to obtain understanding of a certain occurrence. Analyzing written, visual, or digital materials that offer proof of social, cultural, institutional, or individual experiences is a common practice in the social sciences, education, public policy, and historical research. It is a non-intrusive and economical approach of gathering data because it depends on existent resources, unlike interviews and observations, which necessitate direct engagement with individuals. Documents can be used as primary or supplemental data sources, enabling researchers to examine subjects that might not be available through direct participant interactions or validate findings from other qualitative methodologies.

3.6 Ethical Considerations

The researcher only engaged those participants who agreed beforehand to respond to the data collection instruments. The interviewers were sensitive and did not take a lot of time and also ensured that the in-depth interview guide was

well balanced with a reasonable number of questions. Also, the researcher was guided by the Kenya Data Protection Act (2019) by concealing the identity of key informant interviewees by quoting them verbatim while simultaneously anonymizing the quotes. The researcher was issued with an ethical approval certificate and then a research permit from the research body NACOSTI. Before any data was collected, each participant provided their informed consent. All information obtained from the study was handled with the highest confidentiality, and participants were free to leave the study at any moment without facing any consequences.

3.7 Data Analysis Procedures

Reflexive thematic analysis for qualitative research by the Braun & Clarke (2006) Six-Phase Framework was applied to identify, analyze, and interpret thematic patterns across

the data sets. This involved first of all reading the responses of research participants, jotting down notes of important details, categorizing the summarized information into themes, analyzing these themes, and writing the findings.

4. Results and Discussion

4.1 Socio-Demographics

4.1.1 Distribution of Respondents According to Gender

Data revealed that males who took part in the research were the minority representing 41 percent of respondents while females were the majority representing 59 percent of respondents. Therefore, females were slightly more than males. This is summarized in Table 1.

Table 1: Gender of Respondents

Gender	Frequency	Percent
Male	44	41.0
Female	64	59.0
Total	108	100.0

The high number of females is a mirror reflection of the Kenya Population and Housing Census

The higher number of females is a mirror reflection of the Kenya Population and Housing Census (2019) statistics which indicates that the percent of females (50.5%) was higher than that of males (49.5%). According to the Echo Network Africa Foundation (2021), women comprised the majority of Kenya's overall workforce at roughly 75 percent. Love et al (2022) examined gender diversity and its influence on scientific research teams and concluded that there was moderate impact of gender on the output of research teams. This study revealed that most of the medical practitioners (doctors, clinical officers and nurses) who responded to the tools of data collection were female whereas the remainder were male. According to Okoroafor et al. (2022), 58% of Kenya's health professionals were female. The majority of health professionals are dominated by men, with the exception of nurses (70%), who have a higher proportion of female employees. Interestingly, a significant portion of orthopedic technicians and

technologists (67%), physiotherapists (64%), dentists (61%), and medical specialists (62%) are men. Other occupations with a higher percentage of men than women include pharmacy technologists (55%), public health officers (59%), occupational therapists (58%), laboratory technicians and technologists (60%), pharmacists (58%), and clinical officers (55%).

4.1.2 Distribution of Respondents According to Age

Field data indicated that majority of the respondents were in the 18-30 years' category (27 in number and representing 25 percent of the total number of respondents). The 31-43 years' age category had 42 respondents representing 39 percent of the total number of respondents. The 44-56 years' age category had 39 respondents representing 36 percent. No respondent reported to be in the 57-69 years' category. Similarly, there was no respondent in the 70 years and above category. This is summarized in Table 2.

Table 2: Age of Respondents

Age Category	Frequency	Percent
18-30 years	27	25.0
31 – 43 years	42	39.0
44 – 56 years	39	36.0
57 – 69 years	--	0.00
70 years & above	--	0.00
Total	108	100

Most of the medical practitioners that responded to the in-depth interviews were concentrated within the 31-43 and 44-56 years' age category and followed closely by those in the 18-30 years' age category. None of the respondents were 57 years and above. However, the researcher assumed there was no special reason which could explain this and that it could be mere coincidence. This study was interested in the 18-30 years, 31-43 years, 44-56 years, 57-69 years, and 70 years and above age categories. Other studies are biased towards specific age categories. For instance, Wang et al (2024) were interested in adults of 50 years and older across 24 countries while examining the associations of socio-economic status, social activities, and loneliness in relationship to depressive symptoms. Darko et al (2022) interrogated social media use for research participant recruitment and focused on ages 9 and below, 10-18 years, 19-35 years, 36-55 years, 56-64 years, and 65 years and above.

Okoroafor et al. (2022) reported that 67.5% of public sector health workers were between the ages of 25 and 44. Only 10% of these medical professionals were 54 years of age or older; the percentage was higher among certain medical

experts, such as surgeons (11.8%), obstetricians and gynecologists (11.73%), and specialists in the ears, nose, and throat (22.22%). Specifically, 70% of nurses are female, and somewhat more than 63% of them are under 45 (figure 6). Additionally, young professionals between the ages of 25 and 34 made up a sizable majority of medical officers (50%). Males made up the majority of medical experts (62%), with 48% of them being between the ages of 35 and 44. Additionally, the majority of public health officers (37%) were older (45–54 years), whereas the majority of pharmacists (46%) and pharmacy technologists (45%) were between the ages of 35 and 44.

4.1.3 Distribution of Respondents According to Specialization

Field data revealed that the majority of the respondents were nurses (representing 79 percent of the total number) whereas the least were doctors (representing 4 percent). A significant percentage of clinical officers (representing 17 percent) participated in the exercise. This is summarized in Table 3:

Table 3: Specialization

Specialization	Frequency	Percent
Doctor	5	4.0
Clinical Officer	18	17
Nurse	85	79
Total	108	100

Linley (2024) observed that Kenya's Ministry of Health depended heavily on the high numbers of diploma-trained medical practitioners to fill workforce gaps, and most of the Diploma holders were nurses. Nurses with Bachelor of Science degrees in Nursing were a few in number. Okoroafor (2022) observed that 58 per cent of the health

workers in Kenya are nurses, and are followed by clinical officers at 13%, doctors (7%), nutritionists and clinical dieticians and medical laboratory technologists (5.3%), and public health officers (5%), and pharmaceutical technologists (3%).

Kimani and Gatimu (2023) assert that nurses and midwives are an essential component of any health system; they participate in health promotion and are crucial in anticipating, responding to, and recovering from pandemics and disasters. Nursing density is directly linked to patient safety, the standard of the nursing environment, patient happiness, and health outcomes, including vaccination, according to recent research conducted in both low- and high-resource settings. By 2035, there will be a need for an extra 18 million health workers worldwide, half of whom must be nurses and midwives. The workforce shortfall in sub-Saharan Africa (SSA) is expected to intensify despite efforts to increase the health personnel density to 25 per 10,000 people, especially in nations that have difficulty providing primary health interventions. Additionally, there is an unequal distribution of healthcare professionals in these nations, with rural communities having less access to high-quality medical care. According to Wanjiku (2022), there is empirical data that links a country's population's access to high-quality patient-centered care with a highly educated nursing workforce. In particular, a Bachelor of Science in Nursing

degree was associated with improved patient outcomes and safety. Nonetheless, it was estimated that less than half of nurses worldwide had a BScN. A review of the literature reveals that diploma nurses worldwide have a poor adoption of the BScN upgrading program. Just 4.4% of Kenya's 33,595 diploma nurses had advanced to a BScN degree, compared to 9% of Nairobi County's 1131 diploma nurses. Concern over diploma nurses' failure to advance to a BScN degree was growing on a global scale.

4.1.4 Distribution of Respondents According to Level of Education

Given that medical practitioners are expected to have no less than secondary-level academic credentials, the least level of education was the College Diploma. According to data collected from the field, this category was in the majority representing 92.7 percent of respondents. This was followed by Bachelor’s degree holders at 7 percent. The least was the Master’s Degree category representing 0.3 percent of respondents. This is summarized in Table 4:

Table 4: Level of Education

Level of Education	Frequency	Percent
College Diploma	100	92.6
Bachelor’s Degree	7	7.1
Master’s Degree	1	0.3
Total	108	100

It is worth noting that majority of those who responded to the in-depth interviews were College Diploma holders. This could be because most of them have been trained at the Kenya Medical Training Colleges alongside other medical training institutions that are privately-owned. Nowadays, Universities are offering Bachelor of Nursing programmes which means that with time those with the Bachelor of Science degree in Nursing will increase in number. This study left out those who pursued Certificate programmes given that they failed to meet to threshold of becoming nurses. Linley (2024) observed that Kenya’s Ministry of Health depended heavily on the high numbers of diploma-trained medical practitioners to fill workforce gaps.

According to Okoroafor et al. (2022), the nursing programs had the highest average enrollment of 904 students, with the peak enrollment of 1140 in 2016 and the lowest enrollment of 900 in 2019. In 2019, there were 628 students enrolled in medical and surgical programs, with an average of 341 students. Occupational therapy, physiotherapy, and dental surgery enrolled less than 50 students between 2016

and 2019, while health records management and clinical medicine and surgery programs (for clinical officers) enrolled an average of 113 and 149 students, respectively. The number of graduates from the medical and surgical program increased by 96% between 2016 and 2019, from 320 to 628. The number of pharmacy program graduates increased by 84% from 209 in 2016 to 379 in 2018, but then dropped to 259 in 2019 (a 31.7% decline from the 2018 figure). From 1140 in 2016 to 900 in 2019, the number of graduates from nursing programs steadily decreased by 21%. However, the medical laboratory sciences program saw the largest drop, with 588 graduates in 2016 and 288 in 2019—a decrease of more than 49%.

4.5 Distribution of Respondents According to Religion

Data gathered from the field indicated that majority of the respondents representing 79.9 percent were Christians whereas Hindus were the minority representing 0.3

percent. Muslims were modest number representing 19.8 percent. This is summarized in Table 5.

Table 5: Religion of Respondents

Religion	Frequency	Percent
Christian	87	81.0
Muslim	19	18.5
Hindu/Buddhist	1	0.25
Others	1	0.25
Total	108	100

The findings in this research that identify Christianity as the biggest religion mirrors the Kenya Population Housing Census Report (2009) that identified Christianity as the dominant religion in Kenya (85.5 percent) whereas Muslims were 10.9 percent. Ng'ang'a et al. (2025) noted that the management of infectious disease epidemics, where prompt reaction and efficient containment are crucial, is greatly influenced by cultural and religious beliefs and practices globally. Some of these attitudes and behaviors encourage health-seeking habits that can undermine interventions, while others can support attempts to manage highly contagious diseases. Certain medical procedures have a religious component. For example, according to Oshow et al. (2024), advance care directives (AD) are patient instructions on the treatment they would want in the event that they are unable to make future medical decisions. It is commonly known that sex, race,

and ethnicity can all have an impact on AD, especially in the West. Only 35.3% of people were found to be aware about AD. Interestingly, people of Asian origin and Hinduism showed noticeably greater understanding of AD. Additionally, compared to women, more men reported having a living will and thought that AD was essential for patients who were unable to make their own medical decisions.

4.1.6 Marital Status

Field data indicated that majority of the respondents were single representing 74.7 percent of respondents while those who divorced were the least representing 0.8 percent of respondents. This is summarized in Table 6.

Table 6: Marital Status

Marital Status	Frequency	Percent
Single	80	74.3
Married	27	25.0
Divorced	1	0.7
Total	108	100

The high number of unmarried medical practitioners in this research is reflective of the contemporary workforce trends whereby most of the newly hired are youthful in age and fresh from college or university. Most of those in this category are yet to consider settling down in marriage probably due to the urge to address other more immediate life goals such as supporting their unemployed siblings through school, college or university. In a study published in 2025, Omondi et al. examined the associations between

self-reported depression and sociodemographic characteristics such as age, gender, education level, married status, household wealth index, and urban/rural domicile, as well as chronic conditions such as heart and lung diseases, hypertension, and diabetes. According to Monari et al. (2022), factors such as employment status, marital status, religion, media exposure, the status of living with a partner, and sexual relations practice are linked to

adolescent fertility but differ from nation to nation and even within nations.

4.2 Findings

4.2.1 Reflexive Thematic Analysis by the Braun and Clarke Six-Phase Framework

The findings of reflexive thematic analytical framework reinforced the findings derived from the in-depth interviews, key informant interviews, and focus group discussions. Braun and Clarke's six-phase analytical framework is not tied to a certain epistemological stance, it can be used for both theoretical and inductive investigations (Braun & Clarke, 2006, 2019). The framework is used theoretically in this dissertation: the four themes were found in the literature beforehand, refined by methodical code development, and assessed by cross-jurisdictional comparison. The application of this framework is in line with Nowell et al.'s (2017) claim that thematic analysis is a method of high scholarly merit that can produce nuanced theoretical insights from complex, multi-source data (observation, questionnaires, focus group discussions, and key informant interviews) when applied rigorously and reflexively. Peer-reviewed publications, grey literature, World Health Organization (WHO) and Ministry of Health (MoH) reports, county health plans, and legal documents are all included in this application of this analytical framework.

Reflexive thematic analysis, according to Bryne (2022), was a conceptually flexible and simply accessible interpretative method for qualitative data analysis that makes it easier to find and examine patterns or themes in a particular data set. In Nakuru County, Kenya, Gichuki et al. (2022) evaluated how the county legal framework affected the implementation of mental health programs. They used narratives to present their thematic analysis of qualitative data. The study came to the conclusion that Nakuru County, Kenya's implementation of mental health

programs would benefit from strengthening the county's legislative framework. Kanyaru et al (2026) applied the thematic analytical framework by Braun and Clarke to assess the contribution of community health promoters in the devolved healthcare system in Kenya.

A transformative devolution framework was adopted with the adoption of the Kenyan Constitution in 2010, giving 47 county administrations control over health. The idea behind this structural reform was that decentralization would improve health service delivery by facilitating context-specific resource allocation, bringing decision-making closer to communities, and raising accountability (Barasa et al., 2017). As the nation's capital and home to more than four million people, Nairobi County was anticipated to use its resource base and governance framework to lead the way in better health outcomes. The six-phase thematic analysis framework developed by Braun and Clarke (2006) served as the analytical foundation for this dissertation's investigation of these four themes. The framework is highly suited for synthesizing diverse collections of literature and policy findings because of its rigor, reflexivity, and epistemological flexibility. In order to place local findings within larger patterns of mental health governance and service delivery, the comparative study covers a variety of geographic scales, from global and continental to regional, national, and Nairobi-specific. Intanin et al. (2025) used reflexive thematic analysis to evaluate curriculum development requirements and execution while investigating the viewpoints of various stakeholders on the integration of life skills in Thai teacher education. In order to examine the non-technical abilities of anesthesia in the operating room clinical learning setting in the United States, Ward (2022) employed reflexive thematic analysis. Using the Braun and Clarke reflexive thematic analytical framework, Hill et al. (2023) produced three main themes while analyzing nurses' return to work following parental leave: childcare, lactation, and work involvement. The six phases in the Braun and Clarke reflexive thematic analysis are summarized in Figure 1:

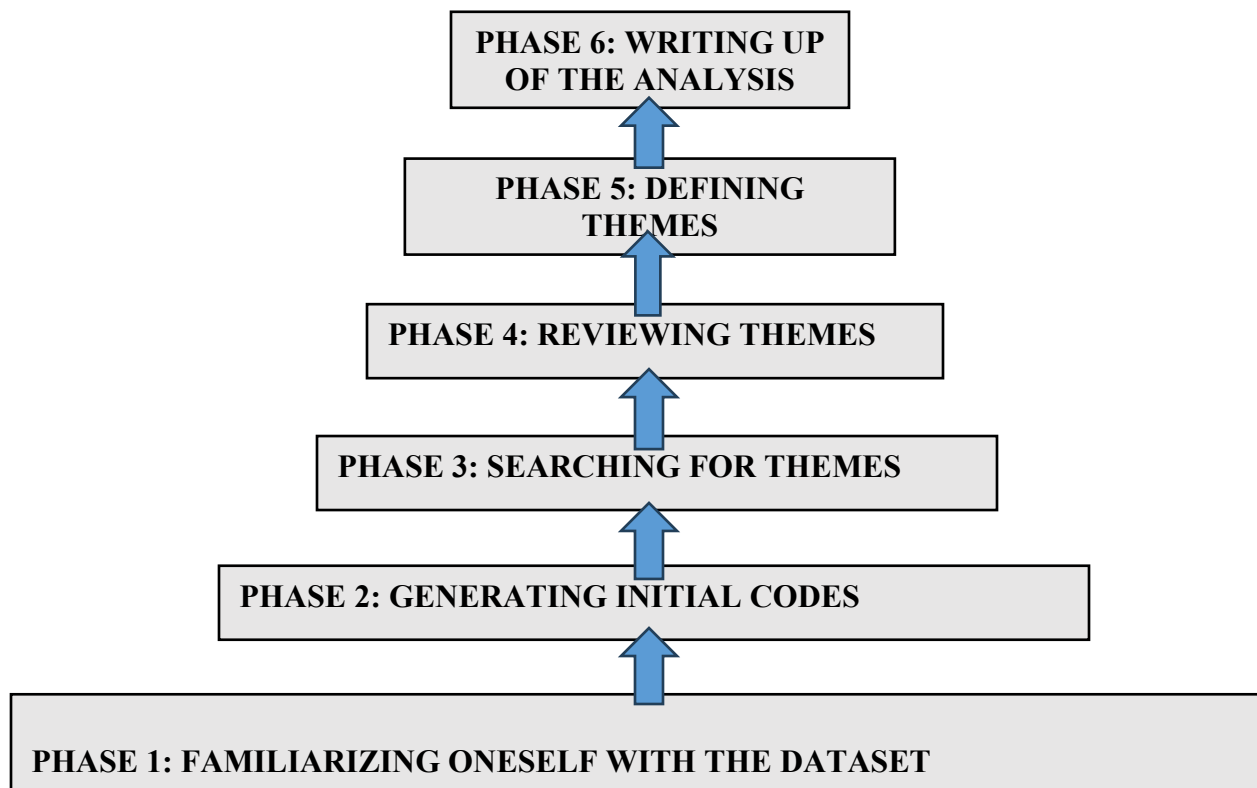


Figure 1: A diagram showing application of 6-Phase Framework by Braun & Clarke

Qualitative data were transcribed verbatim and analyzed by the use of the reflexive thematic analytical framework. Firstly, under familiarizing oneself with the dataset, the researcher began by reading through all the responses from respondents, key informants and participants in focus group discussions. During the first perusal, the researcher did not take any notes. He read with the purpose of getting an overview of the type of responses contained in the in-depth interview guides, key informant interview schedules, and FGD guides. Later, the researcher read through the responses more keenly while underlining key ideas that were outstanding. Secondly, the researcher alongside two independent was keen on generating codes. These were simply the recurring ideas across the data collection instruments. All these reemerging ideas were summarized under brief statements. This is what is being referred to as coding. It was basically breaking down the data into smaller and meaningful statements. This was accomplished by identifying specific pieces of data and assigning labels.

Thirdly, the researcher went through all the key ideas he had captured and listed. The key ideas that are similar were grouped together to form several sub-themes. Sub-themes

are the building blocks that form the themes. This procedure condensed the data into manageable sizes; therefore, the sub-themes generate themes. Fourthly, the researcher reviewed the themes he had come up with. Here, themes that made sense were refined and retained, those that were broad are split into two, whereas the ones that were narrow in scope were combined. It is worth noting that at this stage, themes that did not make sense were discarded altogether. Fifthly, the refined themes were defined so as a reviewer could understand what they were all about. Definition involved a detailed explanation about what the theme is made up. Lastly, the researcher wrote up the analysis by explaining how the theme fitted into the research that was conducted. This was supported by literature review on the topic of the research. At that stage, qualitative data analysis through the Braun and Klarke six-phase framework was complete.

The researcher followed the steps involved to generate four themes: under-reporting of mental health cases; stigmatization of mental health; underfunding of mental health; and understaffing of mental health. These are summarized in Table 7.

Table 7: Codes, Sub-Themes, and Themes

S/No.	CODE	SUB-THEMES	THEMES
1.	Reliability of database on mental health cases Reporting of mental health cases at healthcare facilities Standardized screening protocols of mental health cases at primary healthcare level Surveillance systems that can detect mental health cases Execution of epidemiological surveys, though quite few Paper-based mental health records in some hospitals	There is available data on mental health cases, an improvement on the previous situation, though still insufficient and needs to be improved on Patients are screened for possibility of mental health issues, unfortunately on a small scale which should be up-scaled Digitization of mental health reporting at the county government level has helped secure data	Improved reporting of mental health cases
2.	Availability of basic counselling services in a number of primary healthcare facilities Reduced marginalization of mental health patients by community Insufficient awareness campaigns around the issue of mental health Improved comprehension of signs and symptoms for mental health issues A reversal of the trivialization of mental health issues	Mental health awareness campaigns to reduce marginalization and stigmatization of mental health patients Shift from retrogressive trend of over-prioritization of communicable diseases over mental health issues	Reduced stigmatization of mental health cases
3.	There is a specific budget line for mental health at the county level Better monitoring and evaluation systems for funds dedicated to mental health Enhanced allowances for mental health specialists Increased funds for smart devices to be used in mental health diagnosis and care Shift from culture of budgetary neglect of mental healthcare	The specific budget line is unique for Nairobi county and a handful of other counties Reversal of the over-prioritization of budgets for communicable diseases at the expense of mental healthcare	Enhanced funding for mental healthcare
4.	Reversal of brain drain affecting mental health specialists through better pay packages Overworking of the few available psychiatric experts but services are available Even though there is a higher concentration of mental health	Inadequate psychiatric care specialists but nonetheless an improvement on previous staffing levels Despite concentration of mental health experts in Level 6 hospitals,	Enhanced staffing of mental healthcare

	specialists in a few national government facilities, their number is growing steadily Prioritization of hiring in primary healthcare Improved budgetary allocations for hiring of mental health specialists	the number of newly hired keeps rising	
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Source: Researcher, 2026.

Four interrelated themes were examined using the Braun and Clark six-phase framework: (i) enhanced reporting of mental health cases (ii) reduced stigmatization of mental health cases (iii) improved funding of mental health; (iv) and enhanced staffing levels.

Emergent Themes Derived by Braun and Clarke Six-Phase Analysis

The themes that were generated by the Braun and Clarke six-phase analytical framework are: enhanced reporting of mental health cases; reduced stigmatization of mental health cases; enhanced funding for mental health; and improved staffing for mental health. However, the focus of this study was on the funding gap. This theme indicates that the devolved health function had a positive influence on mental health staffing gap.

Theme: Improved Staffing of Mental Healthcare

This section discussed several contexts under the theme based on all the responses captured by interview guides, focus group discussion schedules, and key informant guides. Nairobi City County was reported to have increased the number of mental healthcare professionals since the inception of devolved healthcare. However, the general understaffing at the national and county government facilities across the country is worrying. To worsen the situation, the country is losing a significant proportion of mental health experts to brain drain. These experts are offered better perks outside the country and they opt to work abroad. Understaffing also arises from the concentration of mental health experts in a few city-based institutions at the expense of the rural zones that are difficult to access. Even though devolved healthcare was meant to be the antidote to this, it is yet to ensure that psychiatric experts are stationed at remote hospitals.

Furthermore, there is prioritization of funding and staffing for communicable diseases, leading to some level of neglect towards mental healthcare. Some of the strategies that can be applied to fix these include the introduction of tele-psychiatry. This entails the use of technological space such as videos and audios on helping address mental health issues. Integrating mental health into primary healthcare is another strategy that can help whereby general practice nurses receive regular training on how to identify mentally

ill patients. Specific budget lines devoted to mental healthcare will enable county governments to invest in mental health workforce. Motivation of mental health experts through enhanced pay perks, allowances, and guaranteed pathways to promotion will ensure they maximize their input. Other counties can benchmark from Nairobi City County that is on track to implement best practices in mental healthcare.

Recent data showing Nairobi County's expansion of its community-level health workforce supports the fourth finding, which is that the county's healthcare system has significantly reduced the understaffing of mental healthcare. However, comparison with facility-level and specialist-workforce literature indicates that this improvement has been concentrated at the community health promoter tier rather than uniformly across all cadres relevant to mental health care. Community health promoters (CHPs) working in Nairobi's Viwandani informal settlement participated in a photo-voice study by Njoroge et al. (2025). The study documented the CHPs' integration as a formally recognized, government-supported cadre within Nairobi's devolved health system, directly embedded within the communities they serve and essential to the county's implementation of Kenya's national Community Health Strategy and its 2023 initiative to professionalize and expand the CHP workforce nationwide.

The KEMRI-Wellcome Trust Research Program (2025) places this workforce expansion within its larger account of Kenya's mental health system reform, pointing out that the country's current strategy clearly positions Community Health Promoters as the first point of contact for households, with each CHP in charge of providing basic curative, preventive, and promotional outreach to about 100 households. The government's 2023 initiative to professionalize and integrate 100,000 CHPs nationwide is a significant step toward increasing the number of frontline mental health workforce available at the community level, including in Nairobi County.

This proof of Nairobi's community-tier workforce growth is supported by its alignment with national policy design. The Kenya Mental Health Action Plan 2021-2025 identifies workforce expansion at the community level as a

specific strategic action and clearly prioritizes the incremental training and recruitment of mental health workers against established human resource norms and standards, including training programs for primary care providers and community health units provided through Kenya Medical Training Colleges (Government of Kenya, Ministry of Health, Taskforce on Mental Health, 2021). According to Njoroge et al. (2025), Nairobi County has operationalized this national CHP strategy within its own jurisdiction, embedding CHPs within informal settlements that bear a disproportionate share of the county's psychosocial risk burden. This represents a credible, county-specific mechanism through which the current study's finding of significantly reduced understaffing could plausibly have been achieved, at least at the community and primary-outreach tier of the mental health workforce.

When this community-tier finding is contrasted with research on specialized and facility-based mental health personnel, both nationally and in Nairobi, a more qualified picture becomes apparent. Despite concentrating on four Western Kenyan counties rather than Nairobi specifically, Kwobah et al. (2023) reported a severe national shortage, with the total number of psychiatrists, psychiatric nurses, psychologists, social workers, and occupational therapists identified across three counties and one national referral facility only in the low hundreds against a multi-million-person catchment population, and the national total of registered psychiatrists at the time only in the low hundreds against an Auditor-General-assessed need that was many times greater.

It is conceivable that Nairobi's specialist staffing position is more favorable than that of counties without any such infrastructure because it is home to the nation's primary psychiatrist training pipeline and its only national psychiatric referral hospital. Nevertheless, the facility-level data collected directly within Nairobi complicates an assumption of resolved understaffing even at this level. In their analysis of two primary health facilities in Nairobi City County, Kumar et al. (2021) discovered that the mental health services at both locations were staffed by an outsourced mental health nursing organization that provided coverage only once a week, that only a small percentage of healthcare professionals who were interviewed had received any psychiatric training beyond a brief undergraduate exposure, and that healthcare professionals themselves expressed a clear desire for additional training and staffing support to meet documented patient needs. When considered collectively, this comparative reading indicates that Nairobi's implementation of the national CHP professionalization policy offers a documented, mechanistically plausible pathway to improvement at the community health promoter and primary-outreach tier of the workforce, where the current study's finding of significantly reduced

understaffing in Nairobi County's healthcare system is most strongly supported (Government of Kenya, Ministry of Health, Taskforce on Mental Health, 2021; Njoroge et al., 2025).

Since workforce adequacy cannot be reduced to headcount alone, another aspect of comparison is the working circumstances and institutional recognition of the community health personnel that support the community-tier improvement reported above. According to Njoroge et al. (2025), CHPs in Viwandani described a persistently paradoxical institutional position: they were treated as trusted insiders by the communities they served, but they were also denied several material markers of full professional recognition, such as consistent stipend payment and an adequate supply of basic equipment, despite their formal integration into Nairobi's health system and their crucial role in extending mental-health-relevant outreach into informal settlements.

While Nairobi County has been successful in increasing the number of community-level health workers relevant to mental health outreach, the quality, stability, and professional sustainability of this expanded workforce remain an area of documented concern. This finding, taken at face value, risks understating the distinction between quantitative staffing expansion and qualitative staffing adequacy. A comparison with the sub-Saharan African regional literature on task-sharing as a method for managing mental health workforce shortages under conditions of specialist scarcity is also made possible by placing the community-tier and specialist-tier evidence side by side. In line with the World Health Organization's regionally endorsed approach to closing the mental health workforce gap in low-resource settings through structured delegation of basic screening, psychoeducation, and referral tasks to non-specialist cadres, the KEMRI-Wellcome Trust Research Program (2025) clearly frames Kenya's CHP-centered strategy as a task-sharing response to the country's severe specialist shortage.

In contrast to this regional framing, the documented CHP expansion in Nairobi County (Njoroge et al., 2025) is a locally implemented example of a task-sharing strategy that the regional literature has identified as the most likely near-term way to reduce effective understaffing in settings like Kenya where pipelines for specialized psychiatric training cannot realistically be scaled quickly enough to meet documented need (Kwobah et al., 2023). Therefore, it is best to interpret the fourth finding of this study as proof that Nairobi County has made substantial, task-sharing-based progress in reducing understaffing at the point of first contact with the health system. This progress is real and consequential, but it works in tandem with, rather than in place of, the ongoing specialist and mid-level clinical staffing constraints documented at the facility level within the county itself.

5. Conclusion and Recommendations

5.1 Conclusion

The findings of the study based on the reflexive thematic analysis anchored on the Braun and Clarke (2006) framework indicated that Nairobi under the county government had made several gains in addressing mental health staffing gap.

5.2 Recommendations

Based on the findings of the study the following recommendations are made:

1. Reinforcement of the mental health workforce so as to enhance mental health service delivery in Nairobi County, Kenya.

5.3 Recommendations for Further Research Studies

The following areas for further research were recommended based on the findings and conclusions of the study:

- Evaluate how the human resource management section of the county governments influences retention of mental health workers in public facilities

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