Neonatal nursing policy and practice in Kenya: Key stakeholders and their views on task-shifting as an intervention to improve care quality. [version 1; peer review: 1 approved, 1 approved with reservations]

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Abstract

Background: Improving the quality of facility based neonatal care is central to tackling the burden of neonatal mortality in Low and Middle Income Countries (LMIC). Quality neonatal care is highly dependent on nursing care but a major challenge facing health systems in LMICs is human resource shortage. In Kenya, task-shifting among professional care cadres is being discussed as one potential strategy of addressing the human resource shortage, but little attention is being paid to the potential for task-shifting in the provision of in-patient sick newborn care. This study identified key neonatal policy-making and implementation stakeholders in Kenya and explored their perceptions of task-shifting in newborn units.

Methods: The study was exploratory and descriptive, employing qualitative methods including: document review, stakeholder analysis, observation of policy review process meetings and stakeholder feedback. A framework approach was used for analysis.

Results: In Kenya, guidelines for the care of sick neonates exist but there are few specialized neonatal nurses and no policy documents outlining the nurse to patient ratio required in neonatal care or other higher dependency areas. The Ministry of Health, Nursing Council of Kenya and international agencies were identified as playing key roles in policy formulation while County governments, the National Nurses Association of Kenya and frontline care providers are central to implementation. Newborns were perceived to be highly vulnerable requiring skilled care but in light of human resources challenges, most expressed some support for shifting ‘unskilled’ tasks. However, a few of the key implementers were concerned about the use of unqualified staff and all stakeholders emphasized the need for training, regulation and supervision.

Conclusions: Task-shifting has the potential to help address human resource challenge in low-income settings. However, any potential task-shifting intervention in neonatal care would require a carefully planned
process involving all key stakeholders and clear regulations to steer implementation.

**Keywords**
Task-shifting, newborn, neonatal care, stakeholder analysis, policy.
Abbreviations
World Health Organization (WHO)
Technical Working Group (TWG)
Expert Advisory Group (EAG)
The Ministry of Health (MoH)
Nursing Council of Kenya (NCK)
KPA (Kenya Pediatric Association)
National Nurses Association of Kenya (NNAK)
KEMRI (Kenya Medical Research Institute).

Introduction
Neonatal mortality currently accounts for over 40% of all child mortality in many countries in sub-Saharan Africa. Reducing neonatal mortality is a global priority and improving access to quality care is central to these efforts. As access to facility based health care for maternity and neonatal services is slowly improving, particularly in urban areas (see UNICEF page on maternal and newborn health) weaknesses in facility based healthcare delivery are emerging as a major factor contributing to the neonatal mortality burden.

Improving the quality of care for neonates, and specifically for sick newborns, involves particular challenges as this group often have multiple morbidity and require multiple interventions, given repetitively often over many days. In addition to carefully planned medical care, providing quality care to sick newborns is highly dependent on the availability and quality of nursing care. In countries such as the UK it is recommended that, even for babies who do not require intensive care, there should be 1 nurse for every 2 to 4 sick babies with evidence suggesting higher mortality where such standards are not met. Providing such levels of nursing care is a major challenge in low-income settings where there are considerable deficits in human resources for health. Many countries in sub-Saharan Africa fail to reach the World Health Organization (WHO) recommended minimum ratio of 2.5 health workers per 1,000 population. In Kenya, a recent study examined services in 22 large county hospitals and found a median ratio of inpatient children to nurses on paediatric wards of 11:1, a ratio often higher at night. Comparable data were not available for newborn units but a complete absence of qualified nursing staff in some facilities has been noted in prior reports.

A strategy suggested for addressing health workforce challenges in low income settings is task-shifting, defined by the WHO as: “the rational redistribution of tasks among health workforce teams”, wherein “specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health”. That task-shifting may be effective is supported by work on HIV, on non-physician clinicians and a recent systematic review on community based care. In many sub-Saharan African countries, there is often considerable informal sharing of tasks between existing professional cadres. For example, nurses perform diagnostic tests and prescribe medicines and non-physician clinicians perform surgery. In Kenya, such forms of task-shifting are the subject of policy discussions intended to update the legal and regulatory framework guiding professional roles for health care providers. However, there is as yet no discussion of shifting tasks to non-professionals who work alongside health professionals within hospitals. This study aimed to explore the potential of task-shifting as a policy option to address constraints in the provision of sick newborn care in Kenya. Specifically, the objectives were to: describe neonatal nursing care policies; identify key neonatal nursing policy development and implementation stakeholders; and explore stakeholder perceptions of the potential role of task-shifting in improving the quality of neonatal nursing care.

Methods
The study was exploratory and descriptive employing a variety of qualitative data collection methods including: document review, stakeholder analysis, observation of policy review process meetings and stakeholder feedback.

Data collection
Document review and identification of key stakeholders
A review of published and unpublished Kenyan national documents relating to neonatal health was undertaken to: i) ascertain the existence and content of policies relating to the provision of inpatient nursing care for sick newborns; and ii) to identify the key stakeholders involved in inpatient neonatal care policy development. The documents were identified through an internet search (Google scholar), and in discussions with experts in the field in Kenya (nurse educators, policy makers and managers) beginning with those known to researchers in the KEMRI-Wellcome Trust Research Programme (KWTRP) as a result of recent nursing workforce studies. These documents and contacts helped identify initial important stakeholders with additional stakeholders identified through snowball sampling. Stakeholder sampling was further guided by a framework used previously in policy analysis that helps categorize stakeholders according to their main roles in policy development and implementation. The categories included: i) statutory policy making/strategic endorsement; ii) technical advice; iii) evidence generation; and iv) consultative.

Stakeholder interviews
Stakeholders were contacted, either via phone or email, requesting an interview. The interviews followed a semi-structured, open ended format (see Supplementary File 1) designed to allow for discussion of: the factors influencing the initiation of policy change; the process of policy making; the actors involved in policy making and implementation along with their roles, responsibilities and relative influence; and views on task-shifting. DO conducted the interviews which were digitally recorded and subsequently transcribed by a transcription service and checked for accuracy. During the process of transcription all participants were anonymized by assigning interviewee codes. The audio recordings and transcripts were stored in a password protected computers.
Non-participant observation of the policy review process

The first author (DO) and two other researchers were observers in the process to develop a task-shifting policy for health care services in Kenya, primarily aimed at updating professional schemes of service among existing formally defined cadres of health workers. Of five Technical Working Groups (TWG) supporting this policy process DO attended and observed the Legal and Regulatory committee meetings that were reviewing policy documents that promote or hinder task-shifting in Kenya. Two authors (JN and DG) observed the Service Delivery committee that was discussing tasks that are/could be shared across existing cadres of staff within the Kenyan health system.

Stakeholder feedback

Building on earlier nursing workforce studies and informed by the stakeholder interview data, the KWTRP has convened an Expert Advisory Group (EAG) to guide current work on neonatal nursing and quality of care (Supplementary File 2). Draft results of the policy context and stakeholder analysis were presented to the group; suggested modifications were noted and incorporated into the final results presented in this paper.

Data analysis

A framework approach linked to the objectives was used to analyze the stakeholder interviews. To determine which stakeholders were likely to be ‘essential’, ‘important’, and or/necessary to involve in exploring how task-shifting might create a new cadre of staff to support inpatient neonatal care, the stakeholders were asked who they thought were the key players in nursing policy development and implementation. Stakeholder policy making and implementation power grids were developed based on an analysis of the number of times an actor or organization was mentioned in the interviews combined with the respondents’ perceptions of who they thought was the most influential. Drafts were shared with the EAG to confirm the position of the actors.

Results

Neonatal & nursing care policies/guidelines

Twelve documents were identified and reviewed (Table 1). Of these, seven were national strategy documents, three clinical care guideline documents and two were concerned with roles and responsibilities of nursing staff. Three national strategy documents identify averting neonatal deaths and improving

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<tr>
<td><strong>Document</strong></td>
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<tr>
<td>Basic Paediatric Protocols for ages up to 5 years _Nov 2013</td>
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<tr>
<td>National Guidelines for Quality Obstetrics and Perinatal Care</td>
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<tr>
<td>National Harmonized Emergency Obstetrics and Neonatal Care Learning Resource Package</td>
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<tr>
<td>Kenya Health policy 2014–2030</td>
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<tr>
<td>The Vision 2030_October 2007</td>
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<tr>
<td>Kenya Health Sector Strategic and Investment plan</td>
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<tr>
<td>Kenya National AIDS Strategic Plan November 2009</td>
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<tr>
<td>National Roadmap for Accelerating the attainment of the MDGs Related to Maternal and Newborn Health in Kenya_August 2010</td>
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<td>Republic of Kenya Ministry of Health scheme of service for nursing officers and enrolled nurses</td>
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<td>Human Resources For Health Norms and Standards Guidelines For The Health Sector</td>
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new-born health as a priority for the country: The Vision 2030 - Kenya’s strategic road map for development and poverty reduction strategy; The Kenya Health Policy 2014 –2030; and the Kenya Health Sector Strategic and Investment plan. Additionally, four specific national health strategy documents identify newborn mortality and morbidity as a major problem that requires focus: the Health Sector Reproductive, Maternal, Newborn and Child Health (RMNCH) policies and strategies; the Kenya National Road Map for accelerating the attainment of the MDGs related to maternal and neonatal health in Kenya; the Child Survival and Development Strategy (CSDS); and the Kenya National AIDS Strategic Plan (KNASP IV). All seven documents set high level policy goals but do not articulate specific plans related to neonatal nursing to achieve them.

Specific guidelines for the care of sick neonates exist and can be found in three government documents: The Basic Paediatric Protocols; The National Guidelines for Quality Obstetrics and Perinatal Care; and the National Harmonized Emergency Obstetric and Neonatal Care (EmONC) Learning Resource Package. Each of these documents contain sections specific to neonatal care with a focus on clinical guidelines. However, none of these documents makes reference to the potential roles and responsibilities of different cadres of health staff, or how these may be shared, in neonatal care provision.

Information regarding the roles and responsibilities of nursing staff in general is provided in the Scheme of Service for Nursing Officers and Enrolled Nurses in Kenya. This document lists two categories of nurse: Enrolled Nurse and Nursing Officer. The category of Nursing Officer is further divided into three cadres: Registered Nurse (degree/diploma with no specialization); Registered Midwife (diploma and/or degree level); and Specialist Nurse (Master’s degree training). While there is no specific cadre of ‘neonatal nurse’, one training institution in Kenya (Kenyatta National Teaching and Referral Hospital) provides a one year higher diploma in neonatal nursing to approximately 15–20 nurses per academic year. This specialist training was started in 2011. Nurses who graduate from this training course join the more general cadre of ‘Specialist Nurse’.

No formal Kenyan policy document stating the nurse to patient ratio required in neonatal care or other higher dependency areas or the qualifications of such staff was identified.

Nursing policy development
A total of 19 stakeholders were interviewed from 8 organizations (Table 2). The main roles of each organization in policy development are illustrated in Figure 1. The Ministry of Health (MoH) and the Nursing Council of Kenya (NCK) were confirmed by the interview participants and EAG members as holding formal positions in statutory policy making with technical advice being provided by national and international academic institutions and international agencies; evidence provided by national research institutions and nationally run projects; in consultation with national professional associations, civil society and faith-based and private health providers. In addition to providing technical support, the international bodies provide financial support to health projects and interventions in Kenya.

The stakeholder power-grid (Figure 2) demonstrates the relative influence and importance of each stakeholder in policy making. Stakeholders reported that while the MoH and NCK are

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<td>Ministry of Health.</td>
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<td>Nairobi City County.</td>
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<td>Donor and international Organizations.</td>
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<td>Training institutions.</td>
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<td>Public Health facilities/front line providers.</td>
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<td>Nursing council of Kenya.</td>
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both highly involved and have high influence, international debate, supported by a technical donor partner voice, was the most frequent stimulus for instigating nursing policy change.

“first of all the UN agency are very key like UNICEF and WHO. Then we also have the USAID and then we also have the bilateral agencies, DANIDA has been very active in terms of working directly, but most of the others may not work directly with us, and then training institutions, professional bodies like KPA, nursing council and then the regulatory bodies” (Policy stakeholder, PSH005)

Once discussions around policy formulation have begun, the MoH takes the lead role, relying heavily on technical and consultative partners for advice and funding. The first step typically involves the leaders of the appropriate departments within the MoH convening one or more TWGs with participation from the stakeholders defined in Figure 1. The role of the TWGs, as described by the stakeholders and observed during TWG participation, is to examine existing evidence and solicit local knowledge to help develop a draft policy document, standard or guideline. Drafts are subsequently sent to the designated Policy Advisory Committee within the MoH for ratification.

Although represented by officials from the National Nurses Association of Kenya (NNAK), frontline nurses appear to have little influence on the process or outcome of policy making. Even though there are a number of training institutions in the country, only two were mentioned as being involved in policy formulation. The important role of faith based organizations and the private sector in provision and running of health facilities was recognized by individual stakeholders and the EAG but these groups were rarely mentioned in discussions on inpatient neonatal nursing care policy formulation.

Nursing policy implementation

Once a policy has been promulgated at the national level, it is cascaded to the County governments who incorporate it into their strategic plans and, as the focus moves from policy formulation to policy implementation, there is a shift in the relative importance of several key stakeholders (Figure 3). Two of the

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Figure 1. Functions of actors in nursing policy formulation.
Figure 2. Nursing task policy change matrix.

Figure 3. Policy implementation influence matrix.
groups (front line nurses and County governments) with low influence and low involvement in policy formulation join the NNAK as having high influence and involvement in policy implementation. The County governments, the NNAK and front line nurses have the potential to influence policy implementation in a variety of ways. Following devolution in Kenya the responsibility for implementing national health policies was devolved from National to County government. In theory, the County government receives policy advice from the national level (MoH) which they then adopt/adapt for implementation. Almost all resource allocation (budgeting and staffing) necessary for the running of health services is now undertaken by the County governments\(^1\). County health officials also provide continuous supportive supervision to front line service providers working in the health facilities. Those at county level thus have considerable power to either promote or reject national policy.

“We domesticate health policies from the national level, and oversee their implementation in the county, and basically in coordination there are a lot of things, support supervision and eh of course rationalizing placement of personnel within the county and also ensuring that the facilities are stocked with health commodities” (County official PSH001)

The NNAK is professional body that represents the welfare and practice of its members. As a registered national association it has the capacity to adopt a stance at odds with government policy if such policy appears not to be in its members’ interests; playing an important role in setting professional norms that may prevent or promote policy adoption. In extreme cases, it may call for strikes especially in cases where the members’ needs are not met or when the members are dissatisfied with work conditions, terms and policies.

Front line service providers, facility managers and mid-level managers, while playing little or no role in policy formulation, play the most important role when it comes to policy implementation. Clinicians and nurses provide care to the sick newborns. Their practice is guided by policy briefs, directives and codes of conduct formulated by the MOH and by the NCK. However, if these frontline providers of health care are not adequately trained or briefed on changes, if they disagree or are uncomfortable with what they are being asked to do, or if they are not provided with the means to undertake the required tasks, then implementation can be hampered.

Perspectives on task-shifting
The stakeholders were asked for their views on task-shifting as a potential strategy for addressing health workforce challenges in inpatient neonatal nursing care. The majority (16/19) supported the shifting of nursing tasks requiring low skill levels to lower cadre staff. Fourteen of the nineteen key stakeholders interviewed fell into the high influence/high involvement quadrant for either policy formulation or implementation. Of these high influence stakeholders, all except one supported the idea of a task-shifting strategy. The support for task-shifting as a solution to the human resources shortage appeared to be born out of necessity linked to the strains on staff caused by inadequate existing human resources and reluctant acceptance that substantially increasing the recruitment of professional nursing cadres is a major financial challenge for the government.

“the reality is that nurses are probably either over worked because of the numbers that they have in the ward and all that they have to do, there are probably either two nurses who are caring for up to twenty or thirty newborns.” (Policy stakeholder, PSH002)

While supporting task-shifting as a pragmatic strategy, all participants emphasized the vulnerability and sensitivity of sick newborns, and were clear that shifting of tasks should not encroach on the provision of skilled clinical care. Tasks mentioned as having the potential for shifting included bathing (‘top tailing’), feeding, milk preparation, changing and sorting of linen. Shifting these tasks would allow the nurses time to concentrate on providing more knowledge intensive clinical nursing care, especially to the sickest newborns.

Respondents acknowledged the existence of some level of “informal task-shifting” already happening in public health facilities due to the shortage of qualified staff.

“Task-shifting is already taking place but in haphazard manner. There is nothing guiding it” (NCK official PSH008).

Even among those who supported task-shifting, concerns were expressed about the current informal way in which it was happening, with lapses in supervision and regulation providing leeway for some non-clinical staff to take on roles beyond their scope and mandate, with rising incidence of harm to patients. An example was given of a recent highly publicized case of malpractice in western Kenya to support such concerns. In this case errors in a procedure (injection) given by unqualified staff resulted in injuries to children affecting their mobility.

“The only dilemma is it has to be clearly specified which tasks can be shared, so we don’t have like what happened in Busia Yeah to the kids injected wrongly, where someone decided that they have worked in the facility for quite some years, and now people know them as nurses and they start injecting babies”. (Policy stakeholder, PSH007)

Such examples were used by participants to emphasize that, if task-shifting were to happen, then at least it should be formalized in terms of training, a scheme of service, supervision and regulation.

A small minority of stakeholders (3/19) were strongly opposed to any task-shifting in newborn care, citing concerns about safety and levels of competency of “unskilled/untrained” low cadre staff. One was in the high influence/high involvement quadrant for policy implementation while two were from training institutions. These three stakeholders explained that nurses are recognized and regulated by the NCK while “lower cadre staff”, such as nurse aids or patient attendants are not; linking
the lack of regulation to poor quality care. Furthermore, their views appeared to be influenced by previous experiences of a lower cadre of nursing staff, abolished more than 10 years ago due to concerns about their providing health care services they were not qualified to deliver:

“No I don’t think we have a place for nurse aids, it is like taking house helps from the houses and bringing them to the hospitals, please no, they are not even allowed. They are not even recognized by the nursing body. Anybody using nurse aids you are using it at your own peril. Who are they? We used to have them, but they were causing more damage, harm to patients than good” (Training stakeholder, TSH004)

Discussion
In many low-income settings a number of health system bottlenecks exist, preventing the scale-up of essential interventions that are key to reducing neonatal morbidity and mortality.41 Key among these is tackling the deficit in human resources for health.35 Kenya has high-level policy goals for reducing neonatal mortality but few nurses in the country have special training in neonatal care. Even if more skilled nurses were to be trained, there is no guarantee that they would be employed in neonatal units as, paradoxically, the supply of generally skilled nurses is not the primary health workforce problem in Kenya, rather it is the ability (and perhaps the willingness) to finance a major expansion in the professional healthcare workforce overall that is limiting.40

Task-shifting has been successful in expanding access to specific forms of care, but concerns have also been raised. A recent review of health workers’ experiences of task-shifting in sub-Saharan Africa found that the strategy had the potential to negatively impact health workers’ sense of agency and ability to perform their work.47 Furthermore, introducing task-shifting to complex, multi-professional, facility environments such as hospitals raises different challenges to those experienced in deploying community health workers.49 Success in the latter is felt to be more likely if task-shifting approaches are based on the values, preferences, knowledge and skills of all stakeholders, and on the feasibility and applicability of the intervention for particular settings and healthcare systems.48

In this study, among those stakeholders identified as playing a key role in neonatal nursing policy formulation there was broad acceptance of the concept of task-shifting. This acceptance was largely born of resignation that a major expansion of an increasingly professionalized nursing workforce was unlikely to be realized, and that there is an imperative for action to improve newborn survival. However, several respondents urged considerable caution, highlighting past and recent episodes of malpractice in which lower cadre staff had overstepped their roles resulting in patient harm. Negative past experiences of an intervention can slow the process of policy change and it was clear that, particularly among stakeholders who would be involved in the implementation of a neonatal nursing task-shifting policy, previous negative experiences would be likely to hamper the acceptance of the introduction of a lower cadre of staff. These concerns echo the challenges identified in a recent review of health-worker task-shifting where the relinquishing of tasks within more traditional, facility based health care settings was found to include a creeping expansion of roles taken on by less well qualified personnel, unclear accountability mechanisms and tension between expanding the quantity of service provision and maintaining quality.49

Changing health policy is recognized as a complex and context specific process.36–41 In Kenya, moving beyond the acceptance, in principal, of task-shifting from professional nurses to lower-level cadres of worker as a solution to the shortage of nurses available to provide care to sick newborns will require careful navigation in a complex policy and implementation environment with different stakeholders important in different phases of this process. It is also important to learn lessons from prior efforts to develop task-shifting solutions; using a participatory process to ensure that key stakeholders are involved in characterizing the problems and designing potential task-shifting solutions to help address these challenges. In this study, important insights were gained that could inform the design of such a workforce solution in Kenya so that it addresses legitimate concerns (such as scope of practice) and the particular context of neonatal care where patients are both highly dependent and highly vulnerable (including establishing clear lines of accountability and related supervisory arrangements).

Study Limitations
While every effort was made to include prominent policy-making and implementation stakeholders some stakeholders may have been missed. Assigning institutional actors specific capacities (eg. level of policy influence) is potentially an oversimplification of the varied ways in which institutions, and individuals within them, may affect both policy making and policy implementation. However, the form of stakeholder analysis we employed is widely used to help provide a general framework to guide understanding of, and engagement with, what can be complex networks of actors and their roles, to ensure that their legitimate interests and concerns are addressed.42–44

Conclusion
There was broad acceptance among key nursing policy makers in Kenya of the idea that addressing the deficit in neonatal nursing care may require some form of task-shifting. However, concerns about task-shifting were raised, particularly among key stakeholders involved in policy implementation. Any task-shifting strategy will need to be undertaken with considerable caution working in collaboration with key policy making and implementing stakeholders to navigate the complex policy and implementation environment with different stakeholders important in different phases of this process.

Ethics approval and consent to participate
Ethical approval was granted by the Kenya Medical Research Institute, Scientific and Ethics Review Unit (SSC No. 2897). All study participants signed a written informed consent form before participating in the study.
Data availability
The data that support the findings are not publicly available due to restrictions. Public availability of data could potentially compromise participant privacy. Participants did not consent to have their full transcripts or excerpts of transcripts made publicly available.

Competing interests
No competing interests were disclosed.

Grant information
This work was also supported by the Wellcome Trust [109943].

Acknowledgement
We wish to thank all the stakeholders who participated in this study. We also thank Mr. Steve Adala who helped with contacting and liaising with the stakeholders. We acknowledge the support of KEMRI. This work is published with the permission of the director KEMRI.

Supplementary material
Supplementary File 1: Stakeholder interview guide.
Click here to access the data.

Supplementary File 2: list of EAG members.
Click here to access the data.

References


Open Peer Review

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Version 1

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This is a well-written piece that explores the potential of task-shifting as a policy option to address the acute human resources for health (HRH) shortage to address constraints in the provision of sick new-born care in Kenya. The article makes an important contribution to on-going policy discussions on task-shifting by highlighting the potential for non-professionals to work alongside health professionals within hospitals. Based on the literature the authors make the case that, given a substantial increase in the nursing workforce in these settings is unlikely to be realised, the use of non-professionals is a pragmatic approach to addressing the human resources challenges in the health sector in Kenya. The study is motivated by an understanding of the complexity of policy change in this area and the many vested interests that can influence the advancement of policies that support task shifting. The authors also rightly allude to the negative impacts of poorly formulated or poorly implemented task-shifting policies. There was concern that these past negative experiences may impede efforts to realise a policy shift. The greatest strength of this article is that it highlights perceptions of key stakeholders in neonatal nursing policy formulation and the complexity that comes with any (health) policy change.

Methods Section:
The study uses a variety of data collection methods to facilitate a deeper understanding of the issue under study. However, this section could benefit from amendments in the following aspects;

Document Review
It is not quite clear how the document review was carried out; For example
1. Why was the literature search restricted to Google Scholar?
2. What were the main questions driving the analysis, apart from the identification of key stakeholders?
3. What was the specific protocol and approach to documentary analysis?
4. Were particular terms applied to the search?
5. What were inclusion/exclusion criteria, specific search terms.
6. How many documents were retrieved using these terms? These could be presented in a flow chart for more clarity.

7. Analyzing documents incorporates coding content into themes similar to how focus group or interview transcripts are analyzed (Bowen, 2009). Did the authors employ content analysis to identify meaningful and relevant passages (p.32) or thematic analysis to recognize patterns in the documents' data (2009).

**Stakeholder interviews**

1. How stakeholders were specifically selected following the categorization exercise? (What may have influenced participation?).

2. *A framework approach linked to the objectives was used to analyze the stakeholder interviews.* This typically suggests 7 steps (Ritchie and Lewis 2003). I would have liked to see evidence for how they approached this process.

3. The authors have captured verbatim statements; but I believe the paper could benefit from further interpretation of the data. As qualitative analysis entails a range of processes and procedures from data collection, organization, data reduction to themes and sub-themes, and interpretation, there is need for further work. It would be helpful for readers to see how the themes and concepts emerged from the data and what relationships were explored in the analysis.

4. Who was involved in the data analysis – have any quality or inter-rater reliability checks been performed? If so these should be reported in the paper.

5. What were the steps taken to integrate documentary and interview data in creating the frameworks? It would be important to document these in the paper in order to inform studies of a similar nature that may be undertaken in other countries.

**Observation**

What observation protocol was used to carry out observations? What information was collected and how did this feed into the results.

**Results Section:**

The results section is nicely structured and the results are clearly presented. However, the section on perceptions of task-shifting is disappointing in its’ brevity, particularly given that 19 interviews were conducted with highly relevant stakeholders. As suggested in the methods comments above, we feel a more systematic and thorough analysis of the interview data could add richness and depth to these results.

The paper by Agyapong et al. (2016) on task shifting in Ghana may be helpful as an example.

**Discussion:**

The discussion is considered and main points are clearly articulated, but the reader gets little sense of the weight of support or opposition to task shifting in this context. Again, there is a sense that the data from 19 interviews with key stakeholders should give a stronger sense of how challenging a task it would be to develop polices on task shifting in this context.

**Limitations**

This section should be expanded to include any methodological limitations that may emerge arising from the questions we have posed in the Methods Section in this review. In addition, one of the main limitations of this paper is its’ exclusive focus on the national policy level. The authors acknowledge the important role of the county level in the translation of policy to practice. It is surprising therefore that the study did not include any analysis of polices or guidelines developed at the county level. For an insight into the potential differences at different levels of the healthcare system, we would recommend the authors see Lobis et al. (2011).
In summary, this is a well written paper on a topic of considerable importance. Revision of the methods and limitations sections as recommended above would, in our opinion, bring it to an acceptable standard for indexing.

References

Is the work clearly and accurately presented and does it cite the current literature?
Yes

Is the study design appropriate and is the work technically sound?
Yes

Are sufficient details of methods and analysis provided to allow replication by others?
Partly

If applicable, is the statistical analysis and its interpretation appropriate?
Not applicable

Are all the source data underlying the results available to ensure full reproducibility?
No

Are the conclusions drawn adequately supported by the results?
Yes

Competing Interests: No competing interests were disclosed.

We confirm that we have read this submission and believe that we have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however we have significant reservations, as outlined above.

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Kenyan neonatal nursing care is difficult due to a shortage in trained neonatal health professionals - especially nurses. One strategy to combat this problem is task shifting to other health care workers. This exploratory/descriptive study examined neonatal nursing policies and the practice of task shifting in Kenya. Data collection included interviews with stakeholders, examination of policies, and process meetings. The results demonstrated that neonatal care guidelines are used but they do not address staffing ratios, nurses are not well prepared for neonatal care - especially for the very sick and small baby. Task shifting to health care workers rather than health professionals could work but there training, regulation, and supervision of these personnel would be needed. Partnerships with governmental and non-governmental organizations are needed to address this problem and improve quality of care.

In light of the SDGs and the recognition that to decrease neonatal mortality by 2020 better preparation of the workforce including nurses is needed, this study addresses a most important topic. The study is just the beginning of looking at all the factors that impact quality neonatal care and should include in the future, strengthening the health care system including financing of this care. Inclusion of parent voices would strengthen the argument for improved care as parental support will improve health outcomes both in the hospital and the community. Recommendations for nursing education/training is another aspect that should be carefully examined in the future using a competency framework.

The manuscript is well written and addresses a very important topic. References are up to date. The work clearly and accurately presented and does cite current literature. The study design is appropriate and technically sound. There are generally sufficient details of the methods and analysis provide to allow replication by others. The article would be strengthened if there was an explanation of how the document reviews were done and was just one person doing the reviews; the same holds true for stakeholder interviews - one person or more than one. If in either of these cases there was more than one then was inter-rater reliability established? The data sources are publicly available. The conclusion drawn do support the results. There are only three questions that if answered would strengthen the article.

1. What is the definition of an enrolled nurses - not all readers will know?

2. Did more than one researcher conduct the interviews - if so was inter-rater reliability established?

3. How were interviewees selected?

I support the approval of this manuscript.

Is the work clearly and accurately presented and does it cite the current literature?
Yes

Is the study design appropriate and is the work technically sound?
Yes

Are sufficient details of methods and analysis provided to allow replication by others?
Yes

If applicable, is the statistical analysis and its interpretation appropriate?
Yes

Are all the source data underlying the results available to ensure full reproducibility?
Yes
Are the conclusions drawn adequately supported by the results?
Yes

*Competing Interests:* No competing interests were disclosed.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.