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Research Article

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Repositioning Public Health Officers in Kenya's Devolved Health System: A Policy Analysis to Strengthen Primary Health Care and Advance Universal Health Coverage

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Abstract

Background

Health systems in low- and middle-income countries are prioritizing primary health care (PHC) to advance universal health coverage (UHC) and health security. In Kenya, devolution has restructured governance and service delivery, creating both opportunities and coordination challenges. Within this context, Public Health Officers (PHOs)—key to environmental health, disease prevention, and health promotion—remain insufficiently defined and underutilized. This study examines the policy and institutional factors shaping the positioning of PHOs in Kenya's devolved health system.

Methods

A qualitative-dominant mixed-methods policy analysis was conducted. Data were collected through a structured online survey of 40 purposively selected stakeholders, including PHOs, county health managers, clinicians, and academics, alongside a review of national policy documents and legal frameworks. The Walt and Gilson policy analysis triangle guided the analysis of policy content, context, actors, and processes. Quantitative data were analyzed descriptively, while qualitative data were analyzed thematically.

Results

Findings reveal persistent role ambiguity, weak policy recognition, and fragmented integration of PHOs within county health systems. Despite competencies central to PHC—such as environmental health management, disease prevention, and community health promotion—PHOs are often marginalized within clinically oriented models. Key constraints include unclear reporting structures, limited participation in decision-making, policy gaps, and restricted career progression, compounded by institutional silos and underinvestment in preventive services.

Conclusions

Repositioning PHOs is critical for strengthening PHC and achieving UHC. Policy reforms should prioritize role clarity, institutional integration, and investment in preventive health to enhance system resilience and equity.

1. Introduction

Health systems globally are increasingly prioritizing primary health care (PHC) as the foundation for achieving universal health coverage (UHC) and improving population health outcomes. Strong PHC systems are associated with enhanced equity, efficiency and resilience, particularly in low- and middle-income countries (LMICs) facing complex and evolving health challenges [1,2]. The renewed global commitment to PHC, as articulated in the Astana Declaration, emphasizes integrated, people-centred services, multisectoral action and empowered communities as essential pillars for health system strengthening [3]. Evidence from LMICs demonstrates that countries investing in robust PHC

systems achieve better health outcomes at lower cost, particularly through early disease detection, continuity of care and strengthened community-level interventions [4,5]. However, despite this recognition, many LMIC health systems remain disproportionately oriented toward curative services, with insufficient emphasis on preventive and promotive health functions [6,7].

The pursuit of UHC has further elevated the importance of PHC as a strategic entry point for equitable service delivery. UHC aims to ensure that all individuals receive needed health services without financial hardship, encompassing promotive, preventive, curative, rehabilitative and palliative care [8]. Yet, progress toward UHC in many LMICs has been uneven, often constrained by weak health system governance, inadequate financing and persistent human resource gaps [9,10]. Workforce governance—defined as the policies, institutions and processes that shape the production, distribution, regulation and performance of health workers—has emerged as a critical determinant of health system performance [11]. In many LMIC contexts, fragmented workforce planning, weak regulatory systems and unclear professional roles limit the effectiveness of PHC-oriented service delivery [12,13]. Strengthening workforce governance is therefore central to aligning health worker competencies with evolving population health needs and PHC priorities.

In Kenya, the health system has undergone substantial transformation following the devolution reforms introduced under the 2010 Constitution, which transferred responsibility for health service delivery to county governments. While devolution has improved local decision-making and expanded access to services, it has also introduced fragmentation, variable institutional capacity and coordination challenges across levels of governance [14,15]. Evidence suggests that decentralization in Kenya has produced mixed outcomes, with improvements in service responsiveness but persistent inequities in resource allocation and workforce distribution across counties [16,17]. Comparative experiences from other decentralized LMIC contexts, such as Nigeria and Indonesia, similarly highlight how devolution can both enable context-specific innovation and exacerbate disparities in workforce management, supervision and accountability where governance mechanisms are weak [18,19]. These governance shifts have significant implications for health workforce organization, role clarity and service delivery effectiveness, particularly for cadres involved in preventive and promotive health.

Public Health Officers (PHOs) represent a critical but often under-recognized cadre within Kenya's health system. Traditionally, PHOs have played a central role in environmental health, disease prevention, sanitation and health promotion—functions that are fundamental to PHC and population health [20]. Globally, there is growing recognition that public health and community-based cadres are essential for delivering essential public health functions, including surveillance, health promotion and emergency preparedness [7]. However, workforce governance frameworks in many LMICs continue to prioritize clinical cadres, often resulting in the marginalization of public health professionals within health system structures [6,13]. In Kenya, despite their strategic importance, PHO roles have not evolved in tandem with ongoing health system reforms, leading to a misalignment between their competencies and current service delivery priorities. Similar trends have been observed across LMICs, where preventive and promotive functions remain underfunded and under-integrated within mainstream health service delivery systems [1,2].

The increasing burden of communicable and non-communicable diseases, alongside emerging threats such as pandemics, antimicrobial resistance and climate-related health risks, underscores the need to strengthen preventive and promotive health systems. The COVID-19 pandemic, in particular, exposed systemic weaknesses in public health capacity globally and highlighted the importance of a well-governed, multidisciplinary health workforce capable of delivering both clinical and public health functions [21,22]. In sub-Saharan Africa, constrained public health infrastructure and workforce shortages further amplify vulnerability to such shocks [23]. Optimizing the contribution of public health cadres, including PHOs, is therefore essential for enhancing health system resilience and advancing UHC. However, there remains limited policy-relevant analysis on how PHOs can be effectively integrated within devolved health systems to support these goals, particularly in sub-Saharan African contexts.

This study draws on the Walt and Gilson (1994) policy analysis triangle, which conceptualizes policy as the product of interactions between content, context, actors and process. The framework is particularly suited to analysing complex health system reforms in decentralized settings, as it facilitates a systematic examination of both formal policy instruments and the institutional and political dynamics that shape their implementation [21].. In the Kenyan context, this approach provides a useful lens for understanding how policy design, governance structures, stakeholder interests and implementation processes influence the positioning and effectiveness of PHOs.

Guided by this framework, the study examines the role of PHOs within Kenya's devolved health system and assesses the extent to which current policy and institutional arrangements support or constrain their contribution to PHC and UHC. Specifically, the study aims to (1) analyse the alignment between PHO roles and PHC priorities, (2) identify systemic and policy barriers to their optimal utilization, and (3) propose policy-relevant strategies for strengthening their role in advancing UHC. By situating the analysis within broader health system reforms and applying a robust policy analysis framework, the study contributes to ongoing debates on workforce governance, health system decentralization and the reorientation of health systems toward prevention, equity and resilience.

2. Methods

2.1. Study Design

This study employed a qualitative-dominant mixed-methods

cross-sectional design to examine the roles, institutional positioning and systemic challenges facing Public Health Officers (PHOs) within Kenya's devolved health system. The design combined quantitative and qualitative approaches to enable methodological triangulation and generate policy-relevant insights into health workforce governance, preventive health functions and implementation of public health mandates at the county level. The qualitative component was prioritized to capture contextual, institutional and experiential dimensions, while the quantitative component provided complementary descriptive and associative evidence to enhance analytical depth and generalizability within the study setting.

The study was conducted in Busia County, western Kenya. The county was purposively selected based on its relevance as a border and high-mobility setting, its established public health structures and its suitability for examining preventive health functions under devolution. As a cross-border point with Uganda, Busia presents unique public health challenges, including communicable disease surveillance, population mobility and environmental health risks, making it a critical case for analysing decentralized public health governance.

2.2. Policy Analysis Framework

The study was guided by the Walt and Gilson (1994) health policy analysis framework, which examines the interaction between actors, context, content and process in shaping policy outcomes. This framework was applied to systematically analyse how legal, institutional and governance arrangements influence the positioning, authority and functions of PHOs within devolved health systems. The framework also enabled the identification of power dynamics, institutional constraints and implementation gaps affecting PHO performance.

2.3. Data Sources

Three complementary data sources were used to enhance analytical depth and contextual understanding.

2.3.1. Documentary Review

A structured review of policy and legal documents was conducted, including public health legislation, national health policies, county strategic plans, budgets, PHO deployment guidelines and schemes of service. The review covered the period from 2013 to the time of the study and provided institutional and historical context for understanding formal policy intent and workforce governance arrangements.

2.3.2. Quantitative Survey

Quantitative data were collected using a structured questionnaire administered to health professionals involved in preventive and promotive services. The survey captured deployment patterns, roles and responsibilities, governance arrangements, career progression pathways and perceived system-level constraints affecting PHOs. The instrument included both closed-ended and Likert-scale items to allow measurement of perceptions and comparative analysis across cadres.

2.3.3. Qualitative Interviews

Qualitative data were generated through semi-structured key informant interviews with stakeholders at county and national levels. Interviews explored institutional authority, governance arrangements, professional recognition, inter-cadre dynamics, policy influence and opportunities for strengthening PHO roles. The use of open-ended questions enabled in-depth exploration of contextual and experiential factors shaping workforce performance.

2.4. Sampling and Participant Selection

A stratified random sampling approach was used for the quantitative survey. The sampling frame included Public Health Officers, Public Health Nurses, health administrators and medical officers across county and sub-county levels. Stratification by sub-county and years of service ensured representation across geographic and experience categories. A total of 40 multidisciplinary health professionals participated.

For the qualitative component, purposive sampling was used to select 15 key informants with expertise in public health policy, training, research and service delivery. Selection was guided by relevance, experience and involvement in public health governance under devolution, ensuring diversity of perspectives across institutional levels.

2.5. Data Collection Procedures

Data collection was conducted sequentially. Findings from the documentary review informed the development of survey and interview tools, enhancing content validity and contextual relevance. Quantitative data were collected using self-administered questionnaires, while qualitative data were obtained through face-to-face and virtual interviews. All interviews were audio-recorded with consent and supplemented with detailed field notes to capture non-verbal cues and contextual observations.

2.6. Data Analysis

2.6.1. Quantitative Analysis

Quantitative data were entered, cleaned and analysed using SPSS. Descriptive statistics summarised respondent characteristics, deployment patterns and perceptions of PHO positioning. Inferential analyses, including chi-square tests and correlation analysis where appropriate, were conducted to examine associations between cadre, years of service, deployment level and perceived system performance.

2.6.2. Qualitative Analysis

Qualitative data were transcribed verbatim and analysed thematically using NVivo. Analysis followed an iterative process involving open coding, development of categories and refinement of themes. A combination of inductive and deductive approaches was used, with initial coding guided by the policy analysis framework and emerging themes grounded in the data. To enhance analytical rigour, coding was reviewed iteratively and discrepancies resolved through discussion.

2.6.3. Integration and Policy Analysis

Findings from documentary, quantitative and qualitative components were triangulated to enhance validity and provide a comprehensive understanding of PHO roles. Integration occurred at the interpretation stage, where convergences and divergences across data sources were examined. The Walt and Gilson framework guided synthesis, enabling analysis of how actors, context, content and processes interact to shape workforce positioning and performance.

2.7. Rigour and Trustworthiness

Several strategies were employed to enhance rigour. Credibility was strengthened through triangulation of multiple data sources and methods, as well as prolonged engagement with policy documents and stakeholders. Dependability was ensured through transparent documentation of data collection and analysis procedures. Confirmability was enhanced by maintaining an audit trail of coding decisions and analytical processes. Transferability was supported through detailed contextual description of the study setting and participants. Pre-testing of tools and expert review further strengthened validity, while internal consistency of quantitative measures was assessed using Cronbach's alpha (≥0.7 threshold).

2.8. Limitations

The study has several limitations. First, the cross-sectional design limits the ability to assess changes over time or causal relationships. Second, the study was conducted in a single county, which may limit generalizability to other contexts, although the findings provide analytically transferable insights for similar LMIC settings. Third, reliance on self-reported data may introduce response and social desirability bias. Efforts to mitigate these limitations included triangulation of data sources, inclusion of diverse stakeholders and use of multiple methods to validate findings.

2.9. Ethical Considerations

Ethical approval was obtained from the Alupe University Institutional Scientific and Ethics Review Committee. Written informed consent was obtained from all participants. Confidentiality and anonymity were maintained by removing personal identifiers and securely storing data with restricted access. Findings are reported in aggregate form to prevent identification of individuals or institutions.

3. Results

3.1. Study Participants and Institutional Context

The analysis draws on data from 40 participants who completed a structured online questionnaire between 27 November and 4 December 2025, complemented by insights from key informants and review of relevant policy and strategic documents. Respondents included Public Health Officers (PHOs), county health managers, clinicians, academics and researchers. More than 65% reported over ten years of professional experience, indicating a highly experienced and policy-informed cohort. While most respondents were based in Busia County, additional representation from Western, Rift Valley and Nyanza regions enabled limited cross-county comparison.

Across the dataset, participants consistently described the devolved system as creating both opportunities and fragmentation in public health service delivery. PHOs were reported to operate at county and sub-county levels, as well as in community settings and ports of entry. However, their institutional positioning varied substantially. In some counties, PHOs were integrated within preventive health departments with defined leadership roles, while in others they were dispersed across programmes with limited coordination. As one key informant noted:

"In some counties, public health is still a strong pillar. In others, PHOs are scattered across units, and their visibility is significantly reduced."

This variability underscores the influence of county-level governance decisions in shaping workforce roles under devolution.

3.2. Role Definition, Expectations, and Operationalization

There was broad consensus regarding the statutory functions of PHOs, including disease surveillance, environmental health and sanitation, food safety inspection, health promotion and enforcement of public health legislation. However, operationalization of these roles varied markedly across counties.

In several counties, PHOs reported expanding responsibilities beyond their formal mandate, particularly in responding to emerging health threats and supporting vertical programmes. One respondent observed:

"We are now expected to handle everything from outbreak response to community sensitization, even where resources are limited."

Conversely, in other settings, elements of PHO mandates—such as health promotion or inspection roles—were reassigned to other cadres, sometimes leading to duplication or gaps in service delivery. This inconsistency contributed to role ambiguity and weakened professional identity.

Devolution was widely perceived to have increased expectations, particularly in community engagement and intersectoral coordination, without corresponding institutional strengthening. This imbalance was associated with role strain and reduced autonomy. As one PHO noted:

"The expectations have grown, but our authority and resources have not kept pace."

3.3. Governance, Deployment, and Decision-Making

County governments exercised primary authority over PHO deployment and management; however, governance arrangements were highly variable. In some counties, PHOs were represented in planning and coordination forums, enabling them to influence

programme design and implementation. In others, decision-making remained centralized, with limited PHO input.

Inconsistent reporting structures emerged as a key governance challenge. Several respondents reported unclear or multiple reporting lines, sometimes to supervisors without public health training. This was perceived to undermine technical oversight and accountability. As one informant explained:

"You may find a PHO reporting to someone with no background in public health, which affects decision-making and prioritization."

Deployment patterns also reflected inequities, with some sub-counties experiencing severe staffing shortages and expanded coverage areas. PHOs were predominantly positioned at operational levels, with limited progression into senior management roles. This constrained their ability to shape policy and resource allocation decisions.

3.4. Workforce Capacity, Skills Utilization, and Operational Constraints

Workforce shortages were consistently reported as a major constraint, with PHOs often responsible for large populations and multiple administrative units. This resulted in prioritization of reactive over preventive activities. As one participant noted:

"Most of our time is spent responding to issues rather than preventing them."

Training opportunities were described as limited, fragmented and often donor-driven. While PHOs demonstrated strong competence in core functions, gaps were identified in emerging areas such as digital health, data analytics and climate-related health risks. A county manager observed:

"We need PHOs who can analyse data and lead planning, not just implement field activities."

Misalignment between competencies and assigned roles further constrained effectiveness. In some cases, PHOs were underutilised in regulatory and planning functions; in others, they were tasked with administrative duties outside their expertise.

Operational constraints—including limited transport, inadequate inspection equipment and weak digital systems—were widely reported. These limitations affected routine inspections, surveillance and timely outbreak response. One respondent stated: "Without transport and tools, even basic public health functions become difficult to implement."

3.5. Intersectoral Collaboration, Community Engagement, and Cross-Border Roles

PHOs were consistently identified as key actors in intersectoral collaboration, particularly in sanitation, environmental health and school health programmes. However, collaboration mechanisms varied, with some counties having formal coordination platforms and others relying on informal arrangements.

Community engagement emerged as a defining feature of PHO roles. PHOs were described as trusted intermediaries linking communities with health systems and regulatory structures. This role was particularly evident in health promotion and behaviour change interventions.

In border areas such as Busia, PHOs played critical roles in port health services and cross-border surveillance. However, these functions were often under-resourced and weakly integrated into broader county systems. As one informant noted:

"Cross-border health is critical here, but it is not fully embedded in county planning."

3.6. Career Progression, Motivation, and Institutional Incentives

Career progression pathways were widely described as unclear and inconsistently implemented. Respondents reported delays in promotion and limited recognition of qualifications. This was attributed to the absence of a harmonized scheme of service across counties.

Despite these challenges, PHOs demonstrated strong intrinsic motivation and commitment to public service. However, declining morale was noted in relation to limited advancement opportunities and perceived marginalization. One respondent remarked:

"We are committed to our work, but the system does not always recognize or reward that commitment."

Retention challenges were reported, particularly among highly qualified PHOs seeking opportunities in non-governmental or private sectors.

3.7. Opportunities for Reform and System Strengthening

Respondents identified several opportunities to strengthen PHO roles within devolved systems. These included clarifying governance structures, strengthening PHO representation in decision-making and improving coordination between national and county levels.

Workforce priorities included development of harmonized schemes of service, structured career pathways and expanded professional development aligned with emerging health challenges. Investment in digital systems, surveillance infrastructure and operational resources was also highlighted.

Importantly, respondents emphasized the need to reposition PHOs as strategic actors within PHC systems. As one key informant concluded:

"If we are serious about prevention and UHC, then PHOs must be at the centre of the system, not at the margins."

Collectively, these findings highlight both the systemic constraints and the untapped potential of PHOs in strengthening preventive and population health functions within Kenya's devolved health system.

4. Discussion

4.1. Principal Findings

This study provides system-level evidence on how the roles of Public Health Officers (PHOs) are evolving within Kenya's devolved health system. The findings reveal a consistent pattern of policy–practice misalignment, whereby statutory mandates for preventive and regulatory functions are well defined but unevenly implemented across counties.

Devolution has expanded expectations of PHOs—particularly in community engagement, intersectoral action and emergency response—without commensurate authority, workforce capacity or operational resources. PHOs remain predominantly positioned at operational levels, with limited influence over strategic decision-making, resource allocation and policy processes. These constraints are compounded by workforce shortages, skills–task mismatches and weak institutional support systems.

Despite these challenges, PHOs continue to perform critical boundary-spanning roles, linking communities, sectors and administrative levels. However, these roles remain weakly institutionalised and dependent on individual initiative rather than embedded governance arrangements [25]. This creates a structural paradox: PHOs are central to preventive health delivery, yet peripheral in governance and policy influence.

4.2. Interpretation in Relation to Existing Literature

The findings are consistent with broader evidence on decentralisation in low- and middle-income countries (LMICs), which demonstrates that devolved governance often produces heterogeneous implementation outcomes shaped by local political priorities, administrative capacity and fiscal space [26,27]. Comparative studies from countries such as Uganda, Tanzania and Indonesia similarly show that decentralisation can enhance responsiveness while simultaneously generating fragmentation in workforce management and service delivery [18,22]. The inter-county variability observed in Kenya reflects this broader pattern of "decision space" variability, where local autonomy leads to divergent interpretations and implementation of national policy frameworks.

The limited inclusion of PHOs in decision-making structures reflects a wider global trend in which preventive and regulatory functions are subordinated within health systems that prioritise curative and hospital-based services [1,6]. This imbalance has been widely documented in LMICs, where resource allocation, political visibility and performance metrics tend to favour clinical services over population health interventions. As a result, cadres responsible for environmental health, health promotion and surveillance are often marginalised within planning and budgeting processes [7].

From a theoretical perspective, these findings align with health systems governance literature that emphasises the importance of actor power, institutional arrangements and policy framing in shaping implementation outcomes [24]. PHOs, despite their technical mandate, appear to have limited institutional power within devolved structures, constraining their ability to influence priorities and resource allocation. This reflects broader dynamics of professional hierarchy and epistemic dominance of biomedical paradigms within health systems [6].

The expansion of PHO roles without corresponding institutional support aligns with evidence on workforce role strain, task shifting and professional ambiguity in decentralised systems [13,28]. Similar patterns have been observed among community health workers and environmental health officers in other LMICs, where expanded responsibilities are not matched by training, supervision or remuneration, leading to reduced effectiveness and burnout.

The boundary-spanning roles identified in this study—particularly in intersectoral collaboration and cross-border health—are consistent with global health systems literature emphasising multisectoral action as essential for addressing complex and transboundary health risks [29,30]. Experiences from countries such as Thailand and Brazil demonstrate that effective PHC systems integrate public health functions across sectors, supported by strong governance and financing mechanisms. However, as in Kenya, these roles often remain under-institutionalised in many LMICs, limiting their scalability and sustainability.

The findings also resonate with emerging literature on essential public health functions (ephfs), which highlight the need for clearly defined institutional responsibilities, workforce competencies and governance arrangements to support prevention and health security [7]. The misalignment observed in Kenya suggests gaps in translating EPHF frameworks into operational workforce structures under decentralised governance.

4.3. Policy and Health Systems Implications

The findings point to several priority areas for policy and system reform.

First, governance alignment is critical. Clarifying and standardising PHO mandates, reporting structures and institutional positioning across counties would reduce fragmentation and strengthen accountability [22]. From a policy perspective, this requires a balance between national stewardship and county autonomy, ensuring minimum standards while preserving local adaptability. Strengthened intergovernmental coordination mechanisms are essential to align preventive health priorities across levels of governance.

Second, workforce governance reforms are urgently needed. The absence of a harmonised scheme of service and clear career progression pathways undermines motivation, retention and professional identity. Evidence from LMICs suggests that structured career pathways, supportive supervision and

performance-based incentives are key determinants of workforce effectiveness [13,31]. Nationally guided but locally adaptable human resource frameworks could address inter-county inequities while supporting decentralised implementation. Institutionalising continuous professional development—particularly in leadership, digital health, data analytics and emerging public health threats—is essential to align competencies with evolving system needs.

Third, institutional integration of PHOs into decision-making processes is necessary to rebalance health system priorities. Embedding PHOs within planning, budgeting and emergency preparedness structures would enhance the visibility and prioritisation of preventive and promotive health [11]. This aligns with global calls to reorient health systems toward PHC and population health as pathways to UHC.

Fourth, investment in public health infrastructure and digital systems is essential. Strengthening surveillance systems, inspection capacity and data use at county level would enhance early detection, response and regulatory enforcement. Experiences from countries such as Rwanda and Ethiopia demonstrate that investments in community-based surveillance and digital health systems can significantly strengthen preventive health functions and system resilience.

4.4. Implications for Health System Strengthening

From a health systems perspective, the findings highlight structural weaknesses across governance, workforce, service delivery and intersectoral coordination functions [32]. Variability in PHO positioning reflects broader challenges in achieving coherence under devolved governance, particularly in aligning national policy intent with local implementation.

The exclusion of PHOs from strategic processes weakens surveillance–response linkages, regulatory enforcement and early risk detection. This has implications not only for routine public health functions but also for preparedness and response to health emergencies. Strengthening PHO roles therefore represents a broader system design challenge, rather than solely a workforce issue.

Repositioning PHOs within health systems could enhance integration between community-level intelligence, regulatory systems and policy response—critical for advancing UHC, health security and resilience (Kruk et al. 2015; World Health Organization 2021). Conceptually, this aligns with integrated health systems models that emphasise the interdependence of preventive, promotive and curative services within PHC-oriented systems.

4.5. Strengths and Limitations

This study draws on multiple data sources, including documentary review, quantitative survey and qualitative interviews, enhancing credibility, triangulation and contextual depth. The use of a policy analysis framework strengthens analytical rigour and supports interpretation of findings within broader governance dynamics.

However, several limitations should be noted. The cross-sectional design limits the ability to assess temporal changes and causal relationships. The relatively small and geographically concentrated sample may limit generalisability, although the findings are analytically transferable to similar LMIC contexts. In addition, reliance on self-reported data may introduce response bias, although triangulation across data sources helped mitigate this risk.

Despite these limitations, the study provides important empirical and policy-relevant insights into preventive health governance under devolution and identifies actionable priorities for strengthening PHC and advancing UHC.

5. Policy Implications and Recommendations

5.1. Standardise Governance and Institutional Positioning

Develop and implement national guidelines to harmonise PHO roles, reporting structures and placement across counties, while preserving devolved decision-making.

5.2. Strengthen PHO Participation in Decision-Making

Institutionalise PHO representation in county health management teams, planning forums and budgeting processes to enhance prioritisation of preventive and promotive health.

5.3. Establish a Harmonised Scheme of Service

Introduce clear career progression pathways, job classifications and promotion criteria to improve motivation, retention and professional recognition.

5.4. Invest in Workforce Capacity and Skills Development

Expand continuous professional development in leadership, digital health, data analytics, climate and One Health approaches, aligned with evolving public health needs.

5.5. Enhance Operational Capacity for Preventive Health Functions

Allocate dedicated resources for transport, inspection tools, digital surveillance systems and protective equipment to support effective service delivery.

5.6. Strengthen Intersectoral and Cross-Border Coordination

Formalise collaboration mechanisms between health and other sectors (e.g. Water, environment, education) and integrate port health functions into county planning frameworks.

5.7. Rebalance Health System Priorities Toward Prevention

Embed preventive and promotive health indicators within performance frameworks and resource allocation decisions to support PHC-oriented health system reform.

6. Conclusion

This study highlights a fundamental misalignment between the recognized importance of preventive and promotive health functions and their institutional positioning within Kenya's devolved health system. While Public Health Officers (PHOs)

remain central to the delivery of essential public health functions—including surveillance, environmental health, health promotion and emergency response—their roles are constrained by fragmented governance arrangements, limited decision-making authority and inadequate workforce support systems.

The findings demonstrate that devolution, while offering opportunities for context-specific innovation, has also introduced variability and inconsistency in how PHO roles are defined, deployed and supported across counties. This has resulted in a system where preventive health functions are operationally present but strategically underprioritized. As a consequence, the full potential of PHOs to contribute to primary health care (PHC), universal health coverage (UHC) and health security remains underutilised.

Repositioning PHOs within Kenya's health system requires a shift from viewing them as peripheral implementers to recognising them as strategic actors in health system governance and population health management. This entails strengthening their integration into planning, budgeting and policy processes; clarifying institutional mandates and reporting structures; and establishing harmonised workforce frameworks that support career progression, retention and professional development.

At a broader level, the study underscores the need to rebalance health systems toward prevention, in line with global commitments to PHC and UHC. Strengthening PHO roles is not solely a workforce issue but a system-wide reform imperative that requires coordinated action across governance, financing, workforce and service delivery domains. Lessons from this study are relevant beyond Kenya, offering insights for other LMICs navigating decentralisation and seeking to strengthen preventive health systems.

Future research should explore longitudinal changes in workforce positioning under devolution, assess the impact of specific policy reforms, and examine how PHO integration influences health outcomes and system resilience. Strengthening the evidence base in this area will be critical for informing policy decisions and advancing the global agenda for PHC, UHC and health security.

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Competing interests

The author declares that there are no competing interests.

Data availability

The datasets generated and analyzed during the current study are not publicly available due to ethical considerations and commitments made to participants but are available from the corresponding author on reasonable request, subject to institutional and ethical approvals.

Ethics statement

Ethical approval for this study was obtained from the Alupe University Institutional Scientific Ethics Review Committee (ISERC), and a research licence was granted by the National Commission for Science, Technology and Innovation (NACOSTI), Kenya. All participants were informed about the purpose of the study, the voluntary nature of participation, and their right to withdraw at any time. Informed consent was obtained from all participants prior to completion of the self-administered questionnaire and participation in key informant interviews.

Author contribution

William Nyabola Okedi conceptualized the study, designed the methodology, led data collection, conducted the document review and key informant interviews, analyzed and interpreted the data, and drafted the manuscript. The author reviewed and approved the final manuscript.

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