A Narrative Review of Clinical Officers' Scope and Boundaries of Clinical Practice in Kenya.

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ABSTRACT

Background: Clinical Officers cadre is a long-established healthcare workforce integral to Kenyans healthcare services delivery at primary and tertiary levels of hospitals. This cadre emerged during the colonial period to complement the work of few physicians offering clinical care services. Since then, the training, scope of practice, and regulation of clinical officers have significantly evolved. Unfortunately, even with these evolutions, the boundaries of their clinical practice remain contested, contributing to role ambiguity and inconsistent allocation of clinical responsibility.

Objectives: To analyze the current scope of practice of clinical officers in Kenya, identify policy gaps, and propose directions for policy development. The review examined four determinants of practice: the legal and regulatory frameworks, education and competency, judicial interpretation, and health-system context.

Methods: We conducted policy and regulatory analysis using structured document analysis and narrative synthesis, following the READ approach. Evidence was drawn from six source categories: Kenyan legislation and regulatory instruments; government policy and workforce documents; Clinical Officers Council and professional documents; education and competency documents; judicial decisions; and peer-reviewed literature on clinical officer practice in Kenya. Searches of PubMed and MEDLINE were supplemented by searches of government, regulatory, and institutional repositories and of the Kenya Law database. A structured extraction framework was applied, and findings were organised using a deductive four-domain framework.

Key findings: The review found that the boundaries of clinical officers' practices were determined by the legal and regulatory framework; education and preparation; clinical competency; healthcare system and demand; and judicial interpretations. The boundaries of clinical practice were presented as a layered construct rather than a list of permitted activities. The findings also highlight the gaps that exist between formal authority and observed practice, educational preparation and service expectation, specialization qualification and credentialing, and professional scope and facility-level scope. In addition, this review highlights judicial rulings that confirmed clinical officer competence and suggests policy recommendations to enhance clinical officer practice.

Conclusion: Ambiguity of the clinical officer's scope of practice arises not from a lack of documents stating their roles, but from the unclear relationship between layers of these documents. The lack of clarity on how these layers relate when they diverge and who resolves the divergence is the main problem. Therefore, Kenya urgently requires a competency-based scope framework, explicit specialist credentialing, and periodic evidence-informed review, rather than a static decision to expand or restrict permitted activities.

Keywords: Career Guideline; Clinical officers; Clinical Practice; Scope of Practice; Kenya; Health Policy; Healthcare workforce.

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INTRODUCTION

Clinical officers (COs) are an established component of Kenya's health workforce and remain important providers of clinical care, particularly within lower levels of healthcare and underserved settings (Githuthi et al., 2026). The contribution of clinical officers has been reported to be more significant at the primary health care (PHC) level, where they act first and are the principal clinical decision-makers in remote areas where physician availability is limited (Linley, 2024). Advancements in the training of COs from diploma to PhD level have expanded their competency-based approaches, clinical exposure, and professional opportunities (Githuthi et al., 2026; Oginga et al., 2024). This evolution CO's is extremely relevant to broader questions of how their scope of practice is defined, regulated, and utilised within the existing Kenyan health system.

The scope of practice is more than a description of tasks performed by a professional cadre. It concerns the boundaries within which qualified health professionals are permitted to provide services in conjunction with legal licensure and professional regulation (Ndirangu-Mugo et al., 2024). The clarity of these boundaries can influence access to care by determining which services can be delivered and by whom, and the patient's safety. The scope of practice reflects the interaction of several domains, including statutory authority, professional regulation, educational preparation, demonstrated competency, and the demands of practitioners' service. Clarity of scope of practice establishes accountability and can facilitate effective interprofessional practice by defining responsibilities and professional authority (Ndirangu-Mugo et al., 2024). However, the lack of clarity arising from the divergence of explanations of these domains that highlight boundaries of clinical practices often becomes a source of ambiguity.

Kenya's changing health-system priorities make this issue increasingly consequential. Persistent workforce shortages have created service-delivery gaps (Kinuthia et al., 2022). Devolution, on the other hand, has led to the distribution of responsibility for health service organisation to forty-seven county governments, producing variation in how the same qualification is deployed (Lee et al., 2022). Emphasis by the Kenyan government and international organizations on PHC and Universal Health Coverage (UHC) has forced the development of a workforce capable of delivering appropriate services equitably across different settings (Linley, 2024). Engaging cadres with shorter training, such as clinical officers, to offer essential healthcare services at the PHC level has been shown to produce better outcomes and reduce hospital stay (Donfouet et al., 2024). Each development of the Kenyan health system has gradually increased pressure on established clinical officers' professional boundaries.

The evolution of clinical officer training, clinical competency, and task shifting has created a policy problem concerning whether formal professional boundaries have kept pace with changes in preparation and service delivery. Clinical officers may acquire competencies through evolving educational programmes while their authority and responsibilities remain influenced by legislation, regulation, institutional expectations, and workforce pressures. Evidence from Kenya's advanced-practice nursing and midwifery sector shows that practitioners can be assigned responsibilities that do not reflect their training and skills when appropriate policies, legislation, organisational support, and professional structures are lacking (Ndirangu-Mugo et al., 2024). Similarly, the implementation challenges surrounding Kenya's task-sharing policy demonstrate that expanding professional roles cannot be separated from regulatory and legal considerations (Kinuthia et al., 2022). The central policy question is therefore whether the legal and regulatory boundaries of clinical officer practice are aligned with capabilities, responsibilities, and their actual work.

Aim and Objectives

This paper aims to analyse the current scope of practice of clinical officers in Kenya and identify policy directions for its future development. Specifically, it seeks to: (1) examine the legal and regulatory foundations defining the scope of clinical officers' practice in Kenya; (2) assess the alignment between formal scope, educational preparation and competencies; (3) examine how health-system organization shapes practice boundaries; (4) examine how judicial rulings have interpreted clinical officers competences; (5) identify gaps between formal scope and observed practice and (6) propose policy directions for clinical officer scope development.

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METHODS

Study Design and Analytical Approach

This study employed a policy and regulatory analysis informed by structured document analysis and narrative synthesis. This approach was selected because the current scope of clinical officer practice in Kenya is distributed across legislation, regulatory instruments, professional guidelines, education and competency documents, health-system policies, and empirical evidence rather than being defined by a single instrument. Document analysis provides a structured approach for examining the content, context, implementation implications, and institutional relationships reflected in policy and regulatory documents (Dalglish et al., 2021). The analysis, therefore, considered both the formal definition of clinical officer practice and evidence concerning how roles are implemented within the health system.

A narrative review rather than a systematic review or meta-analysis was chosen because of limitations in content dedicated to the scope of practice and heterogeneity of evidence used for synthesis of the review (Dalglish et al., 2021). The purpose of this narrative review is to integrate different forms of evidence that cannot be pooled together to examine relationships between legal authority, professional regulation, educational preparation, competency, actual practice, and changing health-system requirements.

Sources of Evidence and Document Selection

Evidence was drawn from six principal source categories:

- Kenyan legislation and regulatory instruments;
- Ministry of Health and other government policy and workforce documents;
- Clinical Officers Council and professional documents;
- Education, curriculum, competency, and career-development documents;
- Judicial decisions; and
- Peer-reviewed empirical and review literature concerning clinical officer practice in Kenya.

Primary legal and regulatory documents were given precedence when determining formal professional authority. In particular, the Clinical Officers (Training, Registration and Licensing) Act No. 20 of 2017 establishes the statutory framework for training, registration, licensing, and professional practice, while the 2024 Career Guidelines by the Public Service Commission (PSC) specify recognized qualifications, grading structure, deployment settings, promotional pathways, clinical responsibilities, and specialist pathways.

LITERATURE SEARCH AND SELECTION

Searches of PubMed/MEDLINE were conducted between July and August 2026. These searches were supplemented by searches of government, regulatory, and institutional repositories and web-based scholarly sources. Search terms were developed around the four analytical domains and combined terms relating to ‘clinical officers’, ‘Kenya’, ‘scope of practice’, ‘regulation’, ‘legislation’, ‘licensing, ‘education’, ‘competency’, ‘specialist practice’, ‘task sharing’, ‘primary healthcare’, ‘workforce’, ‘Universal Health Coverage’ and ‘health-systems’.

Judicial decisions were identified through purposive searching of the Kenya Law database using terms relating to ‘clinical officers’, ‘medical evidence’, and ‘competence and clinical practice’. The case-law search was purposive rather than exhaustive, and was directed at decisions in which a court addressed clinical officer competence, authority, or conditions of service.

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Academic studies were included where they examined clinical officer roles, scope, competency, education, specialist practice, task sharing, workforce utilization, or health-system functions in Kenya. Government and regulatory documents were included where they established legal authority, professional standards, training requirements, deployment arrangements, workforce requirements, or policy direction. Documents with no substantive relevance to clinical officer practice, duplicate records, and sources that could not be adequately verified were excluded.

A total of 48 records were screened, and 28 were included: 2 legislative and regulatory instruments, 1 government policy and workforce documents, 3 professional and education documents, 4 judicial decisions, and 20 peer-reviewed studies.

Data Extraction and Narrative Synthesis

A structured extraction framework was used to record the source, year, document type, analytical domain, specific issue addressed, principal finding or provision, and relevance to the research objectives (**See Table 1 below**). Evidence was then compared across source types rather than treated as equivalent.

Consistent with the READ approach to health-policy document analysis, extraction and interpretation considered the purpose and context of each document and examined how evidence converged or diverged across sources (Dalglish et al., 2021). Particular attention was given to discrepancies between formal scope, educational preparation, demonstrated competency, and reported practice. Empirical evidence was not used to infer legal authority where legislation or regulatory instruments provided the relevant determination.

Table 1. Data extraction framework

Extraction field	Information recorded
Source	Author, organisation, ministry, or regulatory body,
Year	Year of publication, enactment, issuance, or revision
Document type	Legislation, regulation, policy, guideline, judicial, or empirical study
Analytical domain	One or more of the four domains: legal and regulatory authority; education and competency; judicial precedent; practice and health-system context.
Specific issue addressed	The particular scope, competency, or practice question engaged
Principal finding or provision	The relevant legal provision, policy requirement, or empirical result
Relevance to objectives	How the evidence contributed to the analysis

Rigour and Credibility

Rigour was strengthened through source triangulation. Legal and regulatory claims were based primarily on authoritative Kenyan instruments, whereas claims concerning actual practice were supported by empirical studies and were limited to the settings in which those studies were conducted. For example, prescribing evidence from a single county referral hospital was treated as evidence of practice in that setting rather than as a national estimate. Similarly, evidence of specialist clinical practice was examined alongside training and regulatory documentation, and empirical evidence was not used to infer legal authority. The review consistently distinguished statutory authority, regulatory guidance, employment requirements, and observed practice.

Analytical Framework

The analysis was organized using a deductive four-domain framework developed from the study objectives and informed by scope-of-practice and health-policy literature (**See Figure 1**). Deductive frameworks provide a systematic basis for organizing and comparing information across documents when analytical categories are explicitly defined (Taylor et al., 2024).

01 Legal and regulatory authority	02 Education and competency	03 Practice and health-system context	04 Judicial interpretation
Statutory provisions and regulatory instruments governing clinical officer practice.	Educational preparation, competency development, specialist training, and the relationship between training and responsibility.	Reported service-delivery roles, workforce constraints, supervision, task sharing, organizational expectations, and interprofessional practice	How courts have construed clinical officer competence, authority, and conditions of service.

Figure 1: Domains explaining current boundaries of clinical officer practice in Kenya

This framework allowed the analysis to distinguish between what clinical officers are legally and professionally authorized to do, what they are trained and competent to do, what they are reported to do in practice, and what may be required of the cadre as Kenya's health system evolves (Ndirangu-Mugo et al., 2024; Taylor et al., 2024).

Ethical Considerations

The study used documentary sources and did not collect primary data from human participants. Informed consent and participant confidentiality were therefore not applicable. Transparent attribution and faithful interpretation of the documentary and academic evidence were maintained throughout the analysis.

LIMITATIONS

Four limitations should be noted. First, the review is narrative rather than systematic. Document selection involved judgement about substantive relevance, and a different review team might have assembled a different set of sources. Second, the empirical evidence based on clinical officer practice in Kenya is limited in volume and concentrated in a small number of settings. Several findings rest on single-site studies. These have been bound accordingly, but the available evidence does not support national generalisation about observed practice. Third, judicial decisions were identified purposively rather than exhaustively. The analysis presents the decisions located and does not claim to describe the whole body of relevant case law. Fourth, the legal and policy environment is subject to change. The analysis reflects the current status as of the date of the final search, and readers should verify the current text of any instrument cited.

Findings: Four Domains of Clinical Practice Boundaries

Origins and Purpose of the Clinical Officer Cadre

The development of the clinical officer (CO) cadre in Kenya is linked to the need to expand access to clinical services in a setting where physician numbers are limited. Kenya began training clinical officers in 1928, initially through certificate-level programmes (Couper et al., 2018). These early clinical officers were trained to work under the guidance and supervision of medical doctors in mid-level facilities where health services could not be delivered solely by doctors. This historical origin is important because it helps explain why the CO role has traditionally combined clinical responsibilities with service delivery functions at lower levels of the health system.

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The role of COs subsequently developed beyond a narrowly defined response to physician shortages, and beyond acting as subordinates of medical doctors. Training lengthened and was formalised, statutory regulation was established, specialist pathways emerged, and deployment and regulation increasingly positioned COs to provide clinical services under their own regulator (Githuthi et al., 2026). These developments illustrate an important feature of the profession's development: the formal scope of the CO has evolved, and the current clinical boundaries are far beyond the earlier roles and responsibilities.

Domain 1: Legal and Regulatory Boundaries

The current scope of clinical officer practice in Kenya is established through an interaction between statutory law, professional regulation, and administrative guidance rather than through a single instrument. The Clinical Officer Act No. 2017 repealed and replaced the Clinical Officer Act (CAP 260) assented in 1988. The Act No. 2017 provides a clear guideline on the governing structure of the Clinical Officer Council (COC)- the regulatory body responsible for training, registration, and licensing. It also provides a clear statutory connection between professional status and clinical practice. Importantly, the Act identifies activities that may be undertaken by a licensed clinical officer. Section 20(9) provides that, in relation to patients, a licensed clinical officer may examine, diagnose, order laboratory or imaging investigations, prescribe treatment, and perform procedures, subject to the qualification that these activities must be undertaken according to the individual's scope of training (Republic of Kenya, 2017). Although this Act establishes a broad statutory framework for clinical practice, it ties practice with education, clinical competency, and preparation. Statutory authority to practise is therefore not equivalent to unrestricted authority to undertake every clinical procedure.

Clinical officers have the autonomy to prescribe medication to sick patients. The statutory framework expressly recognizes prescribing treatment as one of the activities a licensed clinical officer may undertake within the scope of training (Republic of Kenya, 2017). In a retrospective study of outpatient prescriptions at Kapenguria County Referral Hospital, Kayioni et al. (2025) found that clinical officers accounted for 93.3% of prescribers among the 920 prescriptions analysed. This finding demonstrates the substantial role of COs in prescribing within that facility, although it should not be interpreted as a national estimate because the study was conducted at a single county referral hospital and examined prescriptions from 2022.

Professionalization, however, did not eliminate ambiguity concerning the actual role of clinical officers. In their qualitative study, Mbindyo et al. (2013) identified differences between formal policy descriptions of the cadre and how clinical officers, doctors, nurses, and managers understood their responsibilities in practice. The authors particularly identified tensions surrounding prescribing, specialist clinical roles, and the relationship between formal role definitions and day-to-day practice. These findings provide an important historical basis for examining the contemporary scope–practice gap rather than assuming that formal regulation automatically determines actual practice.

The 2024 Career Guidelines issued by PSC provide that the administrative and clinical practice of clinical officers is determined by years of experience and the educational qualifications of clinical officers (Republic of Kenya, 2024). This guideline recognizes clinical officer deployment across levels 2 to level 5 facilities and describes their different roles and responsibilities (Republic of Kenya, 2024). The guideline sets out clinical functions, including history taking, physical examination, investigation, diagnosis, treatment, and referral, and they identify referral and clinical management across levels of care as a central responsibility. The Guidelines also provide for specialized clinical services at different levels- from higher diploma to master’s level- of healthcare delivery where these have been approved by the COC. Thus, the contemporary regulatory environment recognizes both a general clinical officer role and differentiated specialist roles.

The distinction between the Act of Parliament and the Career Guideline is consequential. The Act establishes statutory authority, while the Council regulates professional entry, practice, and standards. The guideline governs public service occupational roles, qualifications, deployment, grading, and progression. These instruments should therefore not be treated as interchangeable sources of legal authority. In particular, a job description or career pathway should not automatically be interpreted as creating an independent statutory scope of practice where the underlying authority rests elsewhere.

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Domain 2: Education and Competency Boundaries.

The development of the CO profession has also involved progressive diversification of educational pathways. The original education pathway was supplemented by higher levels of training and specialization, which developed into graduate and eventually postgraduate studies. A review of mid-level health-worker education in Africa reported that Kenyan clinical officer training had evolved from the original certificate programme to diploma education and subsequently developed specialist training pathways (Couper et al., 2018; Githuthi et al., 2026). This progression has created increasing differentiation within the cadre, with practitioners entering practice with different levels and areas of formal preparation.

Education is a central determinant of the practical boundaries of clinical officer practice. Statutory frameworks have expressed connections between clinical experience gained from practice and school with the scope of practice. The contemporary training structure is increasingly differentiated, encompassing diplomas, degrees, and specializations at master's level. The 2024 Career Guidelines provide evidence that the profession is no longer organized around a single undifferentiated clinical role. This guideline recognizes numerous specialist areas at higher diploma and master's level, including emergency and critical care, anaesthesia, orthopaedics and trauma, ophthalmology, oncology, nephrology, cardiology, mental health and psychiatry, reproductive health, and chronic disease management. Specialist practice represents established components of the professional structure rather than an isolated departure from general clinical officer practice (Republic of Kenya, 2024).

Empirical evidence has demonstrated how these specialists' roles operate in practice. In reproductive health, Darwinkel et al. (2018) documented substantial involvement of clinical officer reproductive-health specialists in emergency obstetric and gynaecological care, including performing 84% of caesarean sections among surveyed participants. Halestrap et al. (2023) described graduates of Kenya's higher diploma programme working in both rural and referral hospitals, with responsibilities extending beyond direct clinical care to leadership and teaching. Interestingly, the development of most of these higher-level specialists' training has been in response to service requirements (Halestrap et al., 2023).

The breadth of specialist practice is also reflected in national workforce documentation. Ajayi et al. (2025) identified clinical officer specialists as a substantial component of Kenya's specialist workforce, with specialist COs distributed across numerous areas of practice. Their document review reported approximately 10% of clinical officers as specialists and identified 20 specialty areas. However, the authors also identified limitations in specialist workforce planning and noted that some specialist curricula lacked non-clinical competencies such as leadership and communication. This highlights the importance of continuous learning and holistic training for specialist clinical officers.

This difference in level of education and specialization means that the term "clinical officer" does not necessarily represent a homogeneous competency profile. A general clinical officer and a clinical officer with additional specialist preparation may share a professional identity but possess different formal educational preparation and competencies. For example, a study by Linley (2024) described the development of a higher diploma for Family Health for Clinical Officers (FHCO) as an important step by the government to address the severe shortage of family health physicians serving the Kenyan population. Graduates from this program subsequently graduate to work in rural and primary healthcare facilities, demonstrating how specialist education is different and creates competencies responsive to specific service requirements.

The existence of specialist pathways nevertheless creates an important regulatory question. A higher qualification establishes additional preparation, but the precise relationship between that qualification, competency, employment designation, and authorized scope remains clear. The Career Guidelines, for example, provide for specialized clinical services subject to Clinical Officers Council approval (Republic of Kenya, 2024). This suggests that specialist practice should be analysed as a structured extension of professional practice rather than an independent speciality. (Elias et al., 2022) found COs trained at a higher diploma in palliative care have a challenge being accredited by the COC due to a lack of recognition, emphasizing the role of regulator engagement in training COs.

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Competency should not be inferred solely from possession of a qualification. The 2024 Career Guidelines define competence in relation to the knowledge, skills, and abilities required to perform assigned functions, while progression within the career structure requires specified qualifications and experience (Republic of Kenya, 2024). According to a study by Njeru et al. (2025), the performance of clinical officer anaesthetists trained at Kenya Medical Training College raised concerns relating to professional development and maintenance of skills. The findings support the need to consider continuing professional development, mentorship, and workplace support alongside initial qualification.

Domain 3: Practices and Health-system Context.

The clinical officer's scope is ultimately exercised within the Kenyan healthcare system, where there are different governing structures at county levels and multiple professional cadres interact. Therefore, formal authority is not necessarily determined by education, legal, or regulatory authorities. Mbindyo et al. (2013) documented this distinction historically, finding discrepancies between formal descriptions of CO roles and the way practitioners and managers understood those roles in different institutional settings. Their findings included role ambiguity and tensions surrounding specialist clinical officer responsibilities. This evidence remains relevant because professional scope operates within organizational arrangements that determine staffing, supervision, referral pathways, and access to equipment and medicines.

The development of the CO scope has occurred alongside major changes in Kenya's healthcare system. For instance, devolution transferred substantial responsibility for health-service delivery to county governments, creating greater variation in how the same professional qualification is deployed (Republic of Kenya, 2024). The 2024 Career Guidelines explicitly assign COs responsibility for clinical services at levels 2–5, while also providing for specialized clinical services at all levels, which were approved by the Clinical Officers Council (Republic of Kenya, 2024). Nyikuri et al. (2015) found sub-county managers preferring to appoint clinical officers over nurses as the managers in charge of health centres due to their level of competency and having a problem determining who between nurses and COs should be in charge of larger dispensaries.

The move towards adopting PHC and UHC has similarly increased demand for appropriately trained clinicians capable of providing a broad range of services close to communities. Clinical officers working in PHC have been at the forefront of implementing policies aimed at moving Kenyans objective of providing UHC to its population. Clinical officers have also been vital in the provision of preventive and promotive medicine and the management of individuals with chronic conditions (Otieno Oginga et al., 2024).

Task sharing has added another layer to this evolution. Kenya developed a national task-sharing policy and guideline as part of efforts to address health-worker shortages and improve access to essential services, including HIV services (Kinuthia et al., 2022). Importantly, task sharing requires alignment between the tasks assigned to health workers, their professional scope, education, and demonstrated competencies. Darwinkel et al. (2018), for example, examined reproductive-health task sharing that enabled specially trained clinical officers to contribute to services traditionally associated with specialist providers. The existence of such arrangements does not mean that every task transferred through a programme automatically becomes part of the unrestricted scope of every clinical officer; rather, task allocation remains dependent on the relevant training, competency, guidelines, and regulatory conditions.

Taken together, these developments show that the Kenyan clinical officer profession has moved from an historically established mid-level clinical cadre toward a regulated, educationally differentiated, and increasingly specialized profession. The 2024 Career Guidelines further recognize clinical officer deployment across multiple service levels and provide for specialist clinical services subject to regulatory approval (Republic of Kenya, 2024). The central issue is therefore no longer simply whether clinical officers have a defined role, but where the boundaries of that role are drawn across law, regulation, education, competency, and actual service delivery.

Domain 4: Judicial Interpretations

Several judicial rulings have stamped the authority on the statutory competence of a clinical officer to render

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medical service, write a medico-legal report, and give a medical expert opinion. These judicial precedents have clarified that clinical officers are not merely 'substitutes' or 'subordinates' of medical doctors, but they are an independent cadre governed by an Act of Parliament, which confers them the authority to clerk, diagnose, and treat patients autonomously within the scope of practice.

One of the landmark interpretations is from the Court of Appeal ruling on the defilement case of Raphael Kavoi vs Republic (Criminal Appeal 198 of 2008) [2010] eKLR. This ruling affirmed that clinical officers are competent and autonomous medical practitioners who can render medical services, write and give medical evidence as stipulated in Section 77 of the Evidence Act. The Court extensively cited the Clinical Officer Act to justify its ruling, breathing judicial life into this Act (Kenya Law, n.d.).

In the matter Gakuo vs Mwanzia (Civil Appeal E112 of 2025) (2026) KEHC 7352 (KLR), the judge of the high court overturned a ruling by a magistrate who had rejected a medical report of a person injured, simply because it was not from a clinical officer or a medical doctor (Kenya Law, n.d.). This judgement emphasizes that the clinical officer profession is an autonomous medical profession capable of writing a medical report. It also stated that COs are professionals with a clear scope, statutes, regulations, and often provide autonomous medical services in PHC facilities.

In another matter of a murder case, Republic v Kiura (Criminal Case E023 of 2021) [2023] KEHC 19850 (KLR), the accused person had challenged that the witness was a specialist clinical officer with a higher diploma in mental health; therefore, they did not qualify as an expert witness to testify as a competent medical practitioner. However, this matter was dismissed, and the above Raphael Kavoi v The Republic 2010 386 KLR was extensively quoted to support the competency of a clinical officer to give medical evidence (Kenya Law, n.d.).

In addition, employment and labour relations courts have also reinforced the role, responsibilities, and career pathways of clinical officers. In the case of County Government of Machakos v Kenya Union of Clinical Officers (2024) KEELRC 13567 (KLR), the court ruled that clinical officers are essential healthcare workers within the Kenyan ecosystem, their rights must be protected, and the county must implement the 2024 Career Guideline developed by the Public Service Commission (Kenya Law, n.d.). This guideline clearly states the promotion, specialization, and grading of clinical officers.

Taken together, these decisions indicate judicial recognition of clinical officers as authorised practitioners competent to render medical services and to give medical evidence, and judicial willingness to enforce the career framework governing their employment. The decisions confirm that competence derived from statute is authoritative, sound, and legally binding.

Summary of the Domains of Clinical Practice Boundaries.

In conclusion, the current scope of practice should therefore be understood as a layered construct rather than a single list of permitted activities (**See Table 2**).

Table 2: Summary of domains that determines the clinical officers clinical practice boundaries

Domain	**Focus on how**	**Current status of Clinical Practices**
Legal and Regulatory Boundaries	Laws and regulations defining clinical officers' authority to practice.	Clinical officers are authorized to examine, diagnose, investigate, prescribe and perform procedures within the training (Section 20(9), Clinical Officers Act (2017)
Education and Competency Boundaries	Qualifications, specialist training and competence determine practice.	Specialists' clinical officers are allowed to practice within the scope of specialty. For instances, Clinical officers reproductive-health specialists perform

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		caesarean sections (Darwinkel et al. 2018)
Practice and Health-System Context	Staffing, resources, task-sharing and health-sysem influence practice.	Clinical Officers have taken up leadership roles as sub- county and health centre managers (Nyikuri et al. 2015)
Judicial Interpretations	Court decisions clarify clinical officers' professional authority and responsibilities.	Courts have affirmed clinical officers' competence to provide medical services (Raphael Kavoi v Republic, 2010)

This layered structure also explains why a gap can emerge between formal scope and observed practice. A clinical officer may perform a procedure because of service demand, local delegation, previous experience, or specialist preparation, while the legal and educational basis for that activity may require separate examination. Conversely, a formally recognized competency may remain underused because the facility lacks equipment, medicines, mentorship, patient volume, or an appropriate referral pathway. The central analytical question is therefore not simply "What do clinical officers do?", but "What are they legally authorised, trained or employed to do? versus, what are they actually doing?".

Scope–Practice Gap

Formal Scope versus Actual Practice

A central finding emerging from the evidence is that the formal scope of clinical officers and their actual pattern of practice are not necessarily identical (**See Table 3**). The statutory framework establishes a broad clinical role, but qualifies the exercise of the functions according to the practitioner's scope of training (Republic of Kenya, 2017). The 2024 Career Guidelines similarly describe clinical officers' wider specialized scope, subject to COC approval (Republic of Kenya, 2024). The existence of these broad formal functions does not establish CO's authority to perform all of them. Darwinkel et al. (2018) found that reproductive-health clinical officers were extensively involved in emergency obstetric and gynaecological care, with 41 of 49 surveyed practitioners reporting that they performed caesarean sections. Importantly, the study reported instances in which clinical officers performed procedures beyond their formal training. The finding demonstrates how actual service delivery can extend beyond documented training boundaries in particular settings. The evidence, therefore, suggests that the scope–practice gap should not automatically be interpreted as evidence of inappropriate practice. In some circumstances, differences may reflect specialist preparation, competency acquired after qualification, service necessity, or legitimate task sharing. The critical policy issue is consequently whether the reason for divergence is identifiable, regulated, and supported by appropriate competency, rather than whether divergence exists alone.

Table 3: Summary of the scope-gaps on the key thematic areas determining clinical officers' practice.

#	Theme Area	Function	Actual Practice (From Published Studies)	Notes On Gap / Alignment
1	**Formal Scope (Statutory / 2024 Career Guidelines)** Explicitly authorised as per training and skill	Treatment of common ailments (outpatient/inpatient) Minor surgical procedures	Routinely performed across levels of health facilities in Kenya	Generally aligned varies by health facilities
2	**Prescribing Medicines**	Prescribing of essential medicines and other medicine within scope of	Routinely done across health facilities in Kenya	Generally aligned varies depending

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	Authorised as per training (expanded under 2017 Act)	training.		with health facilities
3	**Leadership / Management / Supervision Roles** Inclusion at senior management of health service	Provide clinical leadership and supervision of junior staff Manage facility or unit in-charge	Many senior COs hold clinical leadership positions frequency and formality vary by county	Generally aligned; varies depending with different settings
4	**Specialist practice** Linked to specific qualifications, experience, COC recognition & employment designation	Performance of specialty-specific high-risk procedures (e.g. advanced reproductive health (RH), anaesthesia, orthopedics) Complex clinical decision-making according to scope	Specialists are 10% of all COs (Ajayi et al. 2025). Perform procedure depending with training e.g., Caesarean sections are performed by RH COs (Darwinkel et al. 2018)	Partially aligned; credentialing gap remains a policy priority
5	**Education and Competency Development** Higher diplomas & master's specialist expand competencies (2024 Career Guidelines)	Make complex decision and perform advance surgical procedure according to their training and scope of practice.	Training improves knowledge and management (Ouma et al. 2026) Sustained implementation depends on technical support and supervision.	Partially aligned; formal qualification must be linked to specific scope.

Education and Competency Versus Service Expectations

A second source of tension arises from the relationship between what clinical officers are trained to do and what health facilities expect them to do (**See Table 3**). The development of higher diplomas and master's specialist pathways has expanded the competencies available within the cadre (Republic of Kenya, 2024), but educational expansion does not necessarily guarantee uniform competency across practitioners or facilities. However, it creates opportunities to align practitioner preparation with service requirements. At the same time, it makes the traditional use of the generic label "clinical officer" increasingly inadequate for describing the competencies available within the profession.

Additional training does not remove the need for continuing competency development. Ouma et al. (2026) found that training primary healthcare workers in Kisumu County improved knowledge and short-term management of diabetes and hypertension, but sustained implementation was affected by the availability of technical support. Their findings demonstrate that training alone does not determine whether a newly acquired competency can be translated into sustained clinical practice. Facility supervision and organizational support can either enable or constrain the exercise of competence.

Therefore, the relationship between education and scope should not be conceptualized as a simple qualification-based entitlement. A more defensible model is one in which a formal qualification model links permitted activity to demonstrated competency, maintained over time and regularly assessed rather than assumed.

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Specialist Practice and Credentialing

The expansion of specialist clinical officer practice creates a further scope–practice challenge because specialist practice introduces differentiated levels of competency within the same professional cadre. The existence of multiple specialist pathways increases the need for clear credentialing and differentiation between general and specialist practice. Ajayi et al. (2025) identified approximately 10% of Kenya's clinical officers as specialists and documented 20 specialty areas. These findings suggest that specialist workforce development is occurring, but that the growth of specialist cadres needs to remain connected to workforce planning, service-delivery requirements, and appropriate role definition.

The issue of credentialing is therefore not simply whether specialist qualifications should exist, but whether there is sufficient clarity regarding the relationship between qualification, registration, specialist recognition, competence, employment designation, and permitted clinical functions. This matter is extremely important because specialized COs perform high-risk procedures and complex clinical decisions. The Career Guidelines require specialised COs to have certain specific qualifications and professional experience for progression and recognition (Republic of Kenya, 2024). Although the guideline provides the basis for employment and promotion of specialist COs, continued alignment between specialist education, regulatory recognition, and actual deployment remains necessary.

Devolution and Organizational Variation

Devolution introduces another dimension to the scope–practice gap because the same professional qualifications are implemented within different county health systems. The 2024 Career Guidelines describe clinical officer functions across county health-service levels 2–5 (Republic of Kenya, 2024). However, the existence of a common professional framework does not mean that all countries have identical staffing structures, facility capabilities, or service demands.

Historical evidence also demonstrates that organizational context can influence professional roles. Mbindyo et al. (2013) found differences in how clinical officer roles were understood across health-system actors and institutional settings. Their findings suggest that professional boundaries are shaped not only by formal regulation but also by management expectations and relationships with other cadres. This creates an important distinction between national professional scope and facility-level scope of employment. A clinical officer may be legally qualified to undertake a particular function but not be authorized by a particular county management team or manager to perform it because the facility lacks the necessary equipment, supervision, staffing, or service mandate. Conversely, an organizational demand for a service should not by itself create professional authority where the practitioner lacks the required training or regulatory basis.

Task Sharing and Professional Boundaries

Task sharing represents perhaps the clearest example of how health-system needs can interact with professional boundaries. Kenya has used task sharing to redistribute selected health-service responsibilities among cadres in response to workforce shortages and access gaps. The development of national task-sharing policy involved efforts to clarify which tasks could be redistributed, to whom, and under what conditions (Kinuthia et al., 2022).

As set out in section 3.4, a task-shared activity is bounded by the conditions of its allocation. The policy risk is that repeated allocation of a task under service pressure comes to be treated as a formal extension of scope, without the training, supervision, and assessment that a formal extension would require, as illustrated by reproductive-health literature by Darwinkel et al. (2018). Task sharing is particularly relevant to PHC and UHC because workforce shortages are unlikely to be resolved through physician expansion alone. However, redistribution of responsibilities without corresponding attention to training, supervision, credentialing, and accountability can create uncertainty regarding professional responsibility. The policy objective should therefore not be task sharing for its own sake, but safe redistribution of appropriate tasks to appropriately trained and competent practitioners within clearly defined regulatory arrangements**.**

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Overall, the evidence indicates that Kenya's scope–practice gap is multidimensional. It arises from differences between formal legal authority and observed practice, variation in educational preparation and competency, expansion of specialist roles, county-level organizational differences, and task-sharing arrangements.

The 2024 Career Guidelines attempt to provide greater structure by linking qualifications, career progression, deployment, and clinical responsibilities (Republic of Kenya, 2024). Nevertheless, the evidence indicates that a formal definition alone cannot resolve the gap. Effective scope governance requires continuous alignment between law, regulation, education, competency, employment arrangements, and population health needs.

Future Directions

In the future, the clinical officer's scope of practice is likely to be influenced by a myriad of emerging and re-emerging factors, as summarized in **Table 3** below.

Table 3: Potential factors which will influence clinical officer scope of practices

Themes	Key Points	Implications for Clinical Officers
5.1 Primary Healthcare & Universal Health Coverage	Kenya's push toward PHC and UHC increases the role of Clinical Officers at levels 2–5. The 2024 Career Guidelines already position COs to work in the PHC facilities (Republic of Kenya, 2024). Development of a Higher Diploma in Family for COs to work in PHC is a good example of potential opportunities for COs (Linley et al., 2024). Adoption of COs practice in PHC requires resources and technical support, not training alone (Ouma et al., 2026).	Clinical officers should align competencies with PHC priorities. They should advance their training in areas essential for PHC and UHC. Ensure deployment and support systems match the expanded frontline role needed for PHC and UHC.
5.2 Changing Disease Burden: NCDs & Multimorbidity	The rising burden of non-communicable diseases (NCDs) requires knowledge and skills in continuity of care, monitoring, treatment, and long-term risk management. Training of COs improves short-term knowledge and management of hypertension by primary health workers (Ouma et al., 2026). The Career Guidelines already recognize specialist pathways in chronic disease management (Republic of Kenya, 2024).	Shift from acute care management to chronic-disease management. Strengthen competencies in the prevention and management of chronic diseases. Advocate for the employment of specialized COs to manage NCDs at PHC facilities.
5.3 Specialist & Advanced Practice	Approximately 10% of Kenyan COs have some specialization (Ajayi et al., 2025). Currently, there are specializations for	Clarify training, competencies, regulatory, and employment functions for specialists.

	higher-diploma and master's pathways (Republic of Kenya, 2024). Specialist production must be linked to actual service needs rather than educational supply alone.	Clarify specialist COs' roles and responsibilities. Develop a competency maintenance plan.
5.4 Digital Health & Emerging Technologies	Telemedicine, electronic health records, digital referral systems, and clinical decision-support tools can improve access and continuity of care. Artificial intelligence adds the need for competencies in interpreting algorithmic outputs (World Health Organization, 2021). Digital tools support but do not themselves expand a practitioner's legal professional scope.	Prepare COs to use digital tools safely and ethically and to verify outputs before use. Integrate digital competencies into the training of COs and professional standards. Innovative health solutions using AI and digital health platforms

Overall, the future of clinical officer practice in Kenya is likely to involve greater differentiation rather than simple expansion. Any developments of this profession should remain governed by the same underlying principle: a clinical function should be assigned and maintained where there is an identifiable health-system need, appropriate education, demonstrated competence, regulatory authority, and capacity to deliver the service safely.

POLICY RECOMMENDATIONS

The evidence reviewed indicates that the principal policy challenge is not simply whether the scope of clinical officer practice should be expanded. Rather, Kenya requires a more coherent policy to determine whether clinical practices offered by clinical officers should be maintained, expanded, modified, exercised, or reviewed. These functions should be developed by key stakeholders of the Kenyan healthcare system (**See Table 4**)

Table 4: Policy recommendations to improve policies governing clinical officer practices

No	Recommendation	Responsible institutions
1	**Harmonize legislation, regulation, education, and practice.** By aligning the statutory framework, council requirements, curricula, career guidelines, and service-delivery expectations	- Ministry of Health - Clinical Officer Council - Public Service Commission - Training institutions
2	**Establish a national competency-based scope framework.** Distinguishing general, specialist, and advanced practice, so that a single professional title is not read as a uniform competency profile	- Clinical Officers Council - Ministry of Health
3	**Strengthen specialist and advanced-practice credentialing,** Establish clear specialization linking to registration, training, competency assessment, employment, and authorised functions.	- Clinical Officers Council - Ministry of Health - Training institutions - Employers (County

		representatives and private sector)
4	**Introduce periodic, evidence-informed scope review.** Develop a clear scope of practice, review existing guidelines informed by population health needs, workforce distribution, new qualifications, competency evidence, service outcomes, technological development, and patient safety data	- Public Service Commission, - Ministry of Health - Clinical Officers Council
5	**Workforce planning and alignment with populations** Training should be based on available workers and population. Specialist training should correspond with service demand, deployment opportunities and supporting resources. Scope development should be considered as part of health-system planning and organized around dynamic cycle (**See Figure 2**)	- Ministry of Health - Training Institutions - Clinical Officer Council - Employers (County representatives and private sector)

The overarching policy principle should therefore be that the clinical officer's scope is expanded, maintained, or modified according to demonstrated competence, appropriate education, regulatory authority, population needs, health-system capacity, and patient safety. This approach avoids both an unnecessarily restrictive scope that fails to utilise available competencies and an uncontrolled expansion of responsibilities unsupported by adequate preparation or regulatory safeguards.

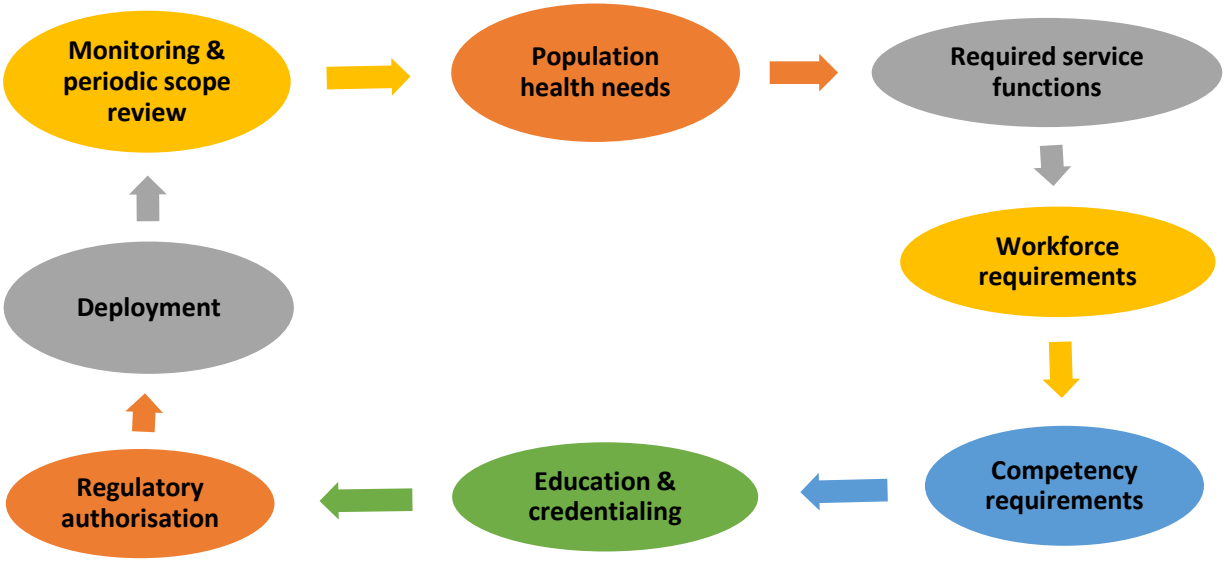


Figure 2: Proposed framework for developing the scope of practices.

CONCLUSION

Clinical officer practice in Kenya has evolved from a health-system response to limited medical workforce capacity into a regulated and increasingly specialised profession. This review demonstrates that the boundaries of practice are shaped by legislation, professional regulation, education, competency, and the realities of service delivery. The evidence also demonstrates a continuing gap between formal scope and actual practice.

The central policy issue is therefore not simply whether the clinical officer's scope should be expanded. Scope should instead be maintained, expanded, or modified according to demonstrated competence, appropriate education, regulatory authority, population needs, health-system capacity, and patient safety. A

clearer competency-based framework, better alignment between education and regulation, and periodic review of scope are necessary to reduce ambiguity and support appropriate professional development.

Ultimately, defining the boundary of clinical officer practice require dynamic approach that recognizes both the capabilities of the profession and the safeguards patients are entitled to expect. A competency-based framework, explicit specialist credentialing, and periodic evidence-informed review offer a more durable settlement than any fixed list of permitted activities.

Author Contributions

GG and CSO conceptualized, designed, and wrote the first draft. DB supervised and reviewed the manuscript. All authors read and approved the final copy of this manuscript.

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Competing Interests.

The other authors declare no competing interests.

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