THINK WELL

HERU HEALTH ECONOMICS RESEARCH UNIT

KEMRI | Wellcome

Policy Brief, August 2025

Examining the Implementation Experience of Primary Care Networks in Kenya

Summary findings

1. The adoption of primary healthcare (PCN) reforms was a response to longstanding PHC delivery challenges in Kenya, and enabled by strong political support and prioritization.
2. The PCN reform has undergone rapid scale-up across counties in Kenya enabled by a robust legal and policy framework, strong political and stakeholder support at the national and county level, and non-state actor support (donors and development partners).
3. The policy and legal framework supporting PCNs is broad but lacks operational coherence; while multiple national strategies and laws mention PCNs, there is insufficient clarity on governance authority and autonomy.
4. PCNs currently lack legal identity and financial autonomy, which limits their ability to manage funds, coordinate human resources, and control supply chains, critical elements for effective network-based care.
5. The implementation effectiveness of PCNs across the study counties varied. While many counties report 100% establishment of PCNs numerically, full implementation of critical aspects of PCN design such as the establishment of multi-disciplinary teams (MDTs), and the digitization is lacking.
6. PCN implementation effectiveness was undermined by both foundational health system capacity gaps (financing, HR, commodities, information systems) and weak functional integration among facilities, including siloed budgeting, HR management, supply chains, and care coordination.
7. To realize the potential benefits of the PCN reform, Kenya will need to invest in the policy capacity for implementation effectiveness, strengthen foundational aspects of PHC health systems, and iterate the PCN design to incorporate the integration and coordination of key health facility functions.

Introduction

Kenya has prioritized the strengthening of its primary healthcare (PHC) as the foundation of its Universal Health Coverage (UHC) reforms. To enhance PHC service delivery, Kenya introduced Primary Health Care Networks (PCNs) as a model of care reform(The Primary Healthcare Act, 2023). A PCN is a form of network of care, which is a group of healthcare facilities that are administratively interconnected and collaboratively work to provide integrated primary healthcare to the population(GOK, 2021).

The PCN reform aims to enhance health system efficiency, improve service quality, and ensure equitable access across regions (Amboko et al., 2025). Kenya MOH initiated PCN pilots in two counties, Kisumu and Garissa, in early 2020, followed by a progressive scale-up by counties(Opanga et al., 2024). As of February 2025, 221 PCNs had been established across the country.

The adoption of primary healthcare (PCN) reforms was a response to longstanding PHC delivery challenges in Kenya, and enabled by strong political support and prioritization.

1. The PCN reform has undergone rapid scale-up across counties in Kenya enabled by a robust legal and policy framework, strong political and stakeholder support at the national and county level, and non-state actor support (donors and development partners).
2. The policy and legal framework supporting PCNs is broad but lacks operational coherence; while multiple national strategies and laws mention PCNs, there is insufficient clarity on governance authority and autonomy.
3. PCNs currently lack legal identity and financial autonomy, which limits their ability to manage funds, coordinate human resources, and control supply chains, critical elements for effective network-based care.
4. The implementation effectiveness of PCNs across the study counties varied. While many counties report 100% establishment of PCNs numerically, full implementation of critical aspects of PCN design such as the establishment of multi-disciplinary teams (MDTs), and the digitization is lacking.

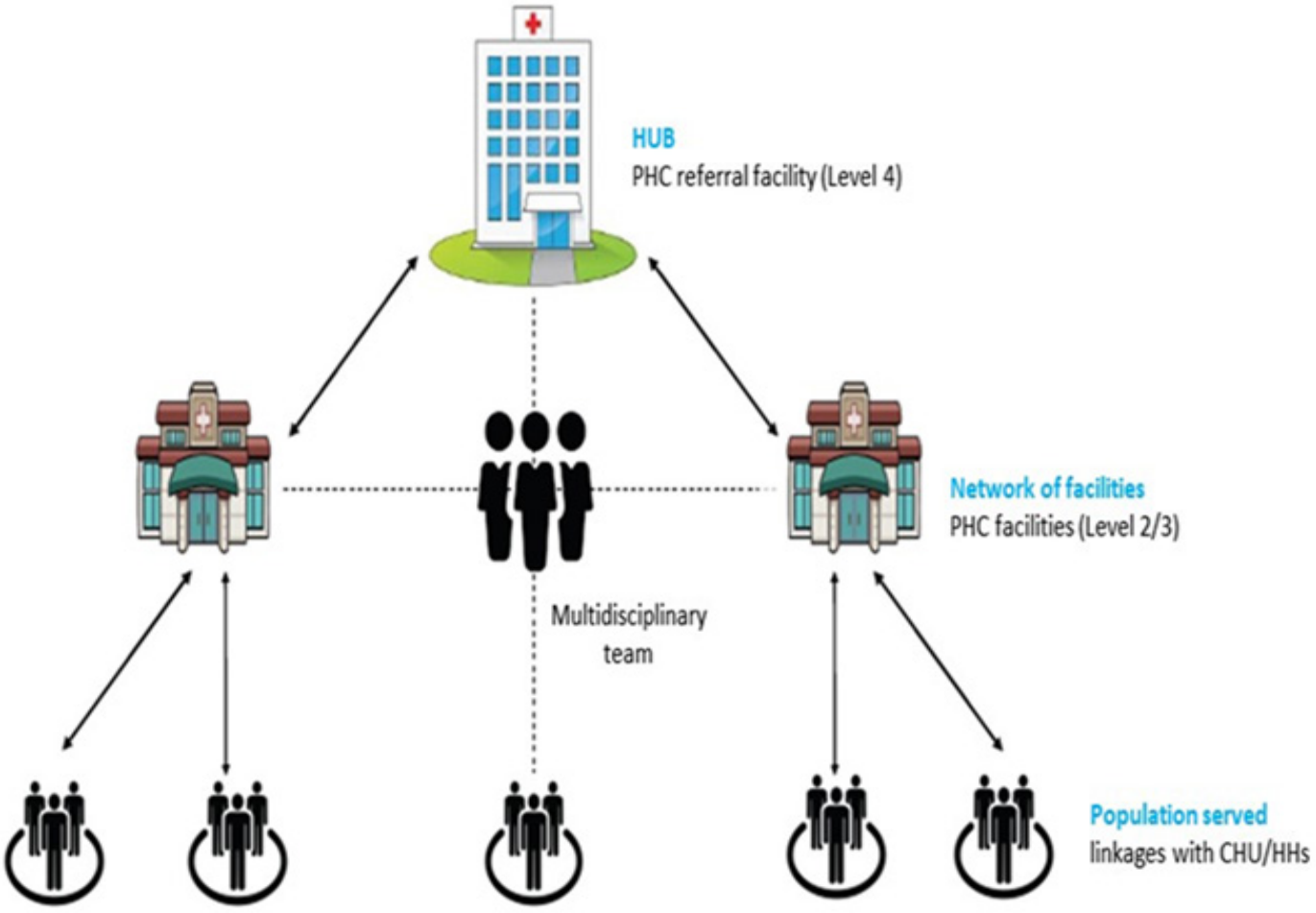

Figure 1: Proposed model of the Primary Health Care Network – 'Hub and spoke model'

The national target is to have at least one PCN per subcounty (total of 315). KEMRI-Wellcome Trust, in collaboration with Thinkwell conducted a study to examine the early implementation experience of PCNs in Kenya. The study collected qualitative data using document reviews and in-depth interviews (n=51) with health sector stakeholders at the national level and in five purposely selected counties between February and June 2024. This policy brief presents key findings from the research as well as recommendations on how to strengthen PCN implementation in Kenya.

PCN establishment steps	County A	County B	County C	County D	County E
1.Sensitisation of key stakeholders					
a. CECs					
b. CHMTs					
c. Partners					
d. Private sector					
e. FBOs					
f. SCHMTs					
g. Facility in-charges					
h. Frontline health workers					
i. CHWs					
j. Community members					
2.Establishment of the governance and coordination structures including MDTs					
a. County PHC TWG					
b. County PHC Advisory Committee					
c. County PHC Coordinators					
d. PCN Committee					
e. Sub-County PCN Coordinators/ SCMOH					
f. MDTs					
g. MedSup at the hub					
h. Community Health Committees (CHCs)					
3. Baseline assessment of;					
a. Health facility needs					
b. Community health units functionality					
c. Client needs					
d. Resources					
e. Partners					
4. County presentation of its PHC implementation					
5. Dissemination of baseline assessment findings					
6. Mapping of the hubs					
7. Mapping of the spokes and CHUs, and linking them to the hubs					
8. Mapping and registration of households					
9. Identification of the financing requirements to establish and manage a PCN					
10. Setting up M&E systems for monitoring the PCNs					
11. Digitisation of PCNs					
a. Telemedicine					
b. Records sharing					
c. E-payments					
d. eCHIS					
12. Gazettement of the PCNs					
	Key:	Done		Not done	

Table 1: PCN establishment steps and progress across study counties

Key findings

1. **Political support and prioritization were key enablers of PCN reforms.**

   The rapid adaptation of PCN reforms in Kenya was facilitated by strong political support. The current government included the strengthening of PHC as one of its key health sector reform agenda in its election campaign manifesto. PCNs were identified as one of the key PHC interventions. PCNs have also received strong political.

2. **The PCN reform was underpinned by comprehensive legislative and policy frameworks.**

   The PCN reforms in Kenya have been guided by various legislative and policy frameworks. The Kenya Primary Health Care Strategic Framework (PHCSF) 2019-2024 identified PCNs as a key strategy to advance PHC goals in Kenya(MOH, 2019). The Kenya Community Health Policy 2020-2030 and the Kenya Community Health Strategy (KCHS) 2020-2025 provided the policy direction and strategies to strengthen community health services and their linkage to facility based PHC service delivery, which form a key component of PCNs(GOK, 2020). Complementing these overarching PHC and community health services policies and strategies, are specific PCN guidelines, and the Primary Health Care Act 2023, which provided legal and operational directives for establishing and governing PCNs.

3. **PCN implementation in Kenya has been hampered by limited domestic resource allocation and instead relied on non-state partner support.**

   PCN implementation in counties received limited or no budgetary allocation for their implementation. Implementation across study counties relied on financial and technical support from international and local non-state actors (development partners).

4. **The implementation effectiveness of PCN reforms varied across study counties.**

   Table 1 outlines the steps that counties need to undertake to establish PCNs as per the PCN guidelines, and the status of implementation across the study counties. Overall, study counties had made progress in implementing most of the prescribed steps. For instance, counties carried out extensive sensitisation activities and successfully mapped and established connections between their hubs, spokes, and community health units (CHUs). Four of the study counties had fully established their PCNs, while one county had reached 80% completion. This process generally followed the prescribed 12-step sequence, beginning with stakeholder sensitisation, followed by the formation of governance and coordination structures, baseline assessments, county presentations, and the mapping of facilities and households. The process also included identifying financing requirements, setting up monitoring systems, digitising operations, and ultimately gazetting PCNs.

   Despite this progress, notable gaps remained in critical aspects of implementation:

   a) Sensitisation was often concentrated at higher levels of the county health system, with frontline health workers, community health workers, and community members less adequately engaged.

   b) The establishment of governance structures was uneven. For example, multi-disciplinary teams (MDTs) to coordinate team-based care were only functional in three out of the six study counties, while County PHC Technical Working Groups (TWGs) and advisory committees had only been established in one county.

   c) None of the study counties had identified the financial requirements for establishing and managing PCNs.

   d) Monitoring and evaluation systems for PCNs had not been put in place across all study counties.

   e) Counties had also not digitised PCN operations, including telemedicine, electronic records sharing, e-payments, and the electronic Community Health Information System (eCHIS).

5. The functioning of PCNs was undermined by key health system capacity gaps.

While counties made progress in formally establishing PCNs, their functionality was constrained by longstanding weaknesses in health system capacity.In particular, lower-level primary health care facilities such as dispensaries and health centres faced shortages of health workers, medicines, and basic infrastructure.

While counties made progress in formally establishing PCNs, their functionality was constrained by longstanding weaknesses in health system capacity.In particular, lower-level primary health care facilities such as dispensaries and health centres faced shortages of health workers, medicines, and basic infrastructure.

These deficits undermined the ability of PCNs to provide services close to communities, leading patients to bypass primary-level facilities and seek care directly at higher-level hospitals. This pattern reduced efficiency, weakened gatekeeping, and eroded the referral mechanism that PCNs are meant to strengthen.

Digitalisation was another major gap. Although households were being mapped and registered on the electronic Community Health Information System (eCHIS), this was not systematically rolled out or integrated into service delivery. The absence of interoperable systems for telemedicine, electronic records sharing, and digital payment limited both coordination across facilities and the ability to use data for planning and monitoring. Without stronger investments in digital health infrastructure, PCNs risk remaining networks in name only, with limited capacity to deliver on their objectives.

6. The functioning of PCNs was undermined by key health system capacity gaps.

Even where PCNs were gazetted, facilities within them continued to operate largely as stand-alone units rather than as coordinated networks. Facilities still prepared their plans and budgets individually, maintained separate commodity supply chains, and managed their own human resources. No county had put in place integrated financial arrangements or a unified health information system across PCN facilities. While some progress had been made in registering households on eCHIS, the system was not yet fully functional across facilities, and data flows were not being used to strengthen linkages or improve referrals.

Gatekeeping mechanisms between levels of care also remained weak, allowing patients to move freely across facilities without referral or coordination. As a result, PCNs were networked on paper but not in practice - linked administratively but functioning with little coordination. Although functional integration is one of the central aims of the PCN approach, this expectation is not clearly spelled out in the current PCN guidelines, which contributed to the lack of systematic implementation across study counties.

Recommendations

The following recommendations should be considered to strengthen the implementation of PCNs in Kenya.

1. **County governments should mobilize and allocate sufficient resources to facilitate PCN implementation.** This would require increased prioritization of PCN in county health budgets, and within these budgets, specific allocations support the set-up and operations. However, resource allocation should be guided by evidence on cost effectiveness, particularly regarding MDTs, to ensure that investments in PCNs are efficient and appropriately balanced with direct support to PHC facilities.
2. **Counties should ensure that all design and operationalization aspects of PCNs are effectively carried out to enhance implementation effectiveness.** These include comprehensive sensitization, the set-up and operationalization of governance and coordination structures such as PCN committees and multi-disciplinary committees (MDTs), and the digitization of PCNs.
3. **Counties should invest in strengthening the foundational aspects of PHC service delivery.** This includes ensuring that PCN health facilities have adequate financing, health workers, health commodities, and infrastructure, and electronic health information systems to support the capacity requirements for PCN service delivery.

4. The national government, in collaboration with county governments, should design and implement functional integration arrangements for PCNs. These include the integration of planning and budgeting of PCN facilities considering public finance management (PFM) frameworks that consider PCNs as a planning, budgeting and expenditure unit. It also includes exploring reimbursement models that consider PCNs as a unit. Further, key facility functions that include commodity supply chains, information systems, and human resource management should be integrated. However, counties should determine whether this model adds value over existing structures, based on local priorities and system capacity. The integration of these functional elements should ultimately facilitate care coordination and integration through the strengthening of gatekeeping and referral mechanisms.

References

Amboko, B., Nzinga, J., Tsofa, B. et al. Evaluating the impact, implementation experience and political economy of primary care networks in Kenya: protocol for a mixed methods study.Health Res Policy Sys 23, 14 (2025). https://doi.org/10.1186/s12961-024-01273-w

GOK. (2014). *Kenya Health Sector Referral Implementation Guideline.*

GOK. (2020). *Kenya Community Health Strategy* 2020-2025. https://www.health.go.ke/

GOK. (2021). *Ministry of Health | Primary Health Care Network Guidelines*.

MOH. (2019). *Kenya Primary Health Care Primary Health Care Strategic Framework.*

Opanga, Y., Kassim, S., Wangalwa, G., Gikunda, A., Musombi, E., Gitimu, A., Ntwiga, I., & Ndirangu, M. (2024). Critical Success Factors for Deployment of Primary Health Care Networks and their Impact in Kenya. *East African Journal of Health and Science*, 7(1), 10–21. https://doi.org/10.37284/EAJHS.7.1.1696

The Primary Healthcare Act (2023). www.kenyalaw.org

About this brief

This brief was developed by the Health Economics Research Unit (HERU), KEMRI-Wellcome Trust Research Programme, and Think-well Global. The brief is based on the following research work that was funded by the Bill and Melinda Gates Foundation.
Beatrice Amboko, Jacinta Nzinga, Anita Musiega, Benjamin Tsofa, Peter Mugo, Rahab Mbau, Anne Musuva, Felix Murira, Ethan Wong, Caitlin Mazzilli, Wangari Ng'ang'a, Brittany Hagedorn, Nirmala Ravishankar, Salim Hussein, Edwine Barasa.

Examining the Implementation Experience of Primary Care Networks (PCNs) in Kenya. 2025. (Forthcoming)

For more information, email Beatrice Amboko **bamboko@kemri-wellcome.org/ indimulib06@gmail.com**

THINK WELL

HERU HEALTH ECONOMICS RESEARCH UNIT

KEMRI | Wellcome