HERU
HEALTH ECONOMICS RESEARCH UNIT

KEMRI | Wellcome Trust
POLICY BRIEF
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Examining the Implementation Experience of Primary Care Networks in Kenya

Summary findings

- 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
- 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
- The implementation effectiveness of PCNs across the study counties varied, with critical aspects of PCN design such as the establishment of multi-disciplinary teams (MDTs), and the digitization of PCNs inadequately implemented
- The effectiveness of PCNs was compromised by capacity gaps in key foundational aspects of PHC health systems including financing, human resources, health commodities, and information systems
- PCN effectiveness was further undermined by the limited integration of key health facility functions – financing, human resource management, health commodity supply chains, information systems, and care coordination.
- To realise 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 primary healthcare (PHC) as the foundation of its Universal Health Coverage (UHC) reforms. To enhance PHC service delivery, Kenya introduced Primary Care Networks (PCNs) as a model of care reform. 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. The PCN reform aims to enhance health system efficiency, improve service quality, and ensure equitable access across regions. Kenya MOH initiated PCN pilots in two counties, Kisumu and Garissa, in early 2020, followed by a progressive scale-up by counties. At the time of writing this brief (October 2024), 195 PCNs had been fully established across the country.

Primary care networks in kenya

The design and implementation of PCNs in Kenya is guided by the PCN guidelines, and the Primary Healthcare Act 2023. A PCN uses a hub and spoke model and consists of a PHC referral facility, serving as the hub, and several PHC facilities functioning as spokes (Figure 1). The hubs serve as the first level of referral, providing both technical and resource support to the spokes. A multi-disciplinary team (MDT), led by a family physician with a mix of different health professionals oversee the activities of the hub, as well as linkages with the spokes. A PCN is expected to include at least one sub-county hospital, three health centers or dispensaries and five Community Health Units (CHUs) in a sub-county, responsible for delivering PHC to the population within its catchment area.

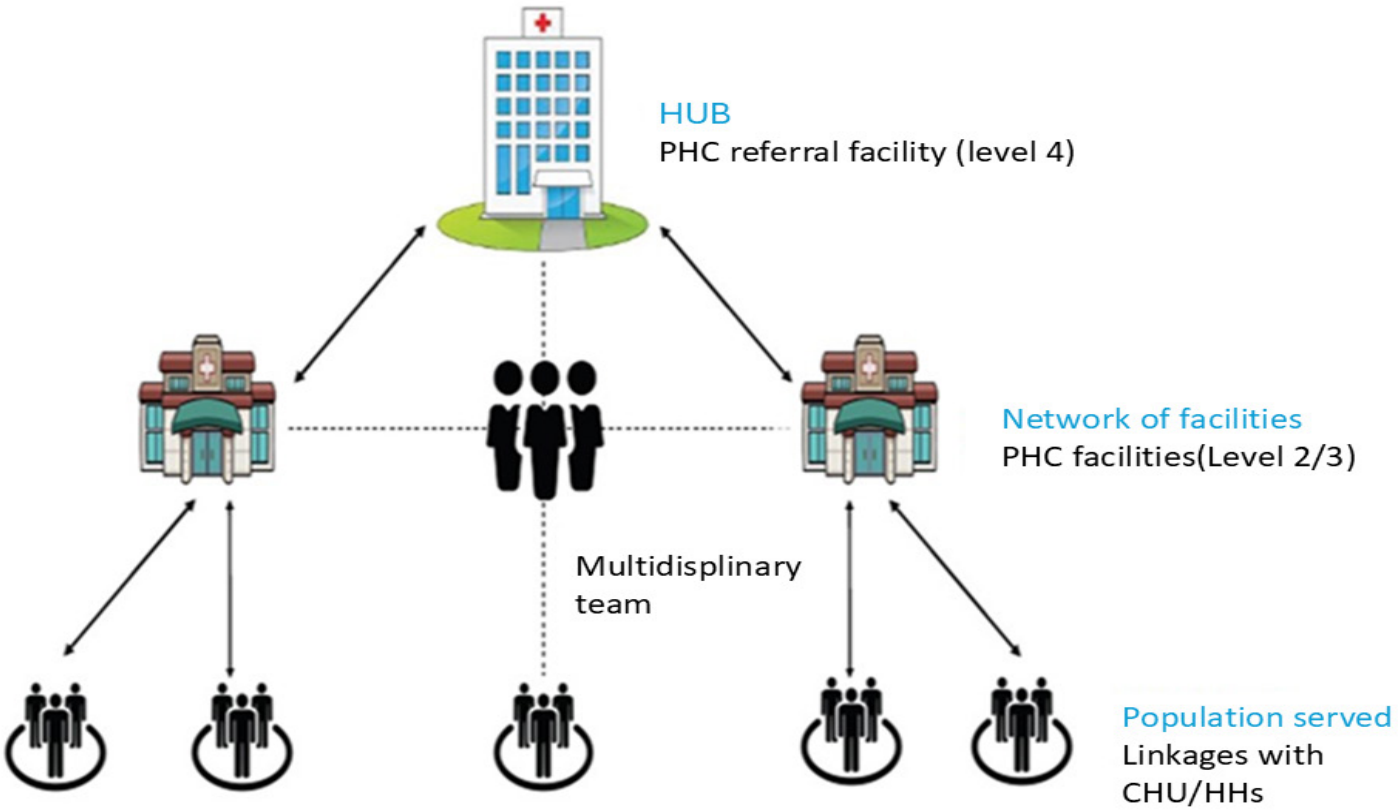

Figure 1: Proposed model of the Primary Health Care Network – 'Hub and spoke model'

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 support at the county level.

2. **The PCN reform was underpinned by comprehensive legislative and policy framework.** The PCN reforms in Kenya have been guided by a robust legislative and policy framework. The Kenya Primary Health Care Strategic Framework (PHCSF) 2019-2024 identified PCNs as a key strategy to advance PHC goals in Kenya. 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. 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, and the status of implementation across the study counties. Study counties had made progress in implementing most of the prescribed implementation steps. For instance, counties carried out extensive sensitization, and successfully mapped and established connections between their hubs, spokes, and CHUs. However, gaps existed in critical aspects of implementation:

a. There was inadequate sensitization of frontline health workers, community health workers, and community members. Sensitization was more extensive at the higher levels of the county health system.

b. There were gaps in the establishment of PCN governance structures across the study counties. The establishment of multi-disciplinary teams (MDTs) to coordinate team-based care in the PCNs was only achieved in three out of the six study counties, while the establishment of County PHC technical working groups (TWGs), and County PHC advisory committees were only achieved in one out of the 5 study counties.

c. None of the study counties reported identifying the financial requirements for establishing and managing PCNs.

d. There was also a lack of established monitoring and evaluation systems for PCNs across all the study counties.

e. Study counties had not digitized the operations of PCNs

5. **The functioning of PCNs was undermined by key health system capacity gaps.** Across the study counties PCN implementation revealed inadequate investments in foundational aspects of health system capacity such as health workers, medicines, and infrastructure. Capacity gaps were especially pronounced in lower level PHC facilities (health centers and dispensaries). This led patients to bypass lower-level facilities to seek basic care in higher level facilities, undermining the intention of PCNs to promote efficiency by strengthening the referral mechanism.

6. **There was limited to no functional integration among health facilities within PCNs.** Health facilities within PCNs continued to plan and budget individually and had no financial relationship. They also continued to manage their commodity supply chains and human resources individually. PCN facilities did not have an integrated health information system. Further, there was no effective gate keeping mechanism between the levels of care within PCNs. The fact that these functions were not integrated meant that PCNs were networked *de jure* but operated with little or no coordination *de facto*.

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 implementation of PCNs as a key PHC intervention.

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 PCN 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 and 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. The integration of these functional elements should ultimately facilitate care coordination and integration through the strengthening of gatekeeping and referral mechanisms.

About this brief

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