REPUBLIC OF KENYA

MINISTRY OF HEALTH

KENYA PRIMARY HEALTH CARE STRATEGIC FRAMEWORK

2019-2024

REPUBLIC OF KENYA

MINISTRY OF HEALTH

Kenya Primary Health Care Strategic Framework

2019-2024

KENYA PRIMARY HEALTH CARE

Ministry of Health Kenya. Primary Health Care strategy framework, aims to provide the right services, at the right time, at the right place, at the right cost and by the right provider.

Contents

List of Tables

List of Figures

Hon. Mutahi Kagwe EGH

Foreword

Primary health care became a concept for the world health care system following the Declaration of Alma-Ata in 1978, which gave rise to the global goal of health for all by 2000.The commitment to global improvements in health, especially for the most disadvantaged populations continue to date and is renewed by Nations and organizations every so often in order to maintain the principles of primary health care as defined inthe Declaration and set out in the health-for-all policy.

As a signatory to the Alma Ata Declaration of 1978, Kenya has achieved significant progress in strengthening health systems to align with the principles of Primary Health Care. As we renew our commitments to revitalize primary health care for the 21st century, there is need to review past experiences and refine future roles to meet the complexity of today's health challenges such as Increased inequalities in access to affordable health care, Fragmentation of services and lack of comprehensive approaches to key interventions , demographic shifts like an increasing youthful population at risk of communicable diseases and injuries as well as aging population at risk of non-communicable diseases.

Therefore, as we strive to achieve Universal Health Coverage (UHC) we need to change the way we think about health and move away from hospitals and diseases and towards recognition that health is not only illness and services but also socio-economic and environmental factors that affect the health of individuals and populations.

Towards this end, the Ministry in collaboration with her development partners has finalized the development of a five-year Primary Health Care Strategic Framework 2019-2024 to further enhance the efforts by the government to increase access to primary healthcare services.
The Framework acknowledges global changes and dynamics in the public health sector. These include increased burden of non-communicable diseases and severe resource constraints. It therefore proposes a number of primary health care strategic objectives and interventions with regard to the provision of health care services, leadership and governance, drugs and other medical supplies, financing of Primary health care delivery, the relative roles of each of the main stakeholders involved as well as other health support systems. The Primary Health Care strategic framework will allow greater participation of the communities in the running of health care services, the decisions on their priority health issues, getting involved in the implementation of essential clinical and public health packages.

Finally, the development of the Kenya primary health care strategic framework 2019-2024 has been guided by the Kenyan Constitution, Vision 2030, the Kenya health policy and Universal health Coverage. The ministry acknowledges the fact that the development of this framework has gone through a participatory process by all stakeholders involved in health care delivery. Equally, we look forward to greater participation and cooperation of the Private Sector, Non- Governmental Organizations, Development partners, Governmental ministries, Research and Training institutions, Religious Organizations and the community in implementing the National Primary Health Care Strategic Framework 2019-2024.

Hon. Mutahi Kagwe, EGH
Cabinet secretary,
Ministry of health
NAIROBI

Dr. Rashid A. Aman

Dr. Mercy Mukui Mwangangi

Preface

A health system with strong Primary Health Care delivers better health outcomes with efficiency and improved quality of care compared to other models. Countries with well-functioning PHC programs have better health outcomes at low cost. PHC Programs have better health outcomes and can meet 80-90% of an individual's health needs over the course of their life.

Universal Health Coverage requires a strong primary health care as the foundation of the health system. As Kenya rolls out Universal Health Coverage (UHC), PHC is now more crucial than ever before to tackle the double burden of disease and laying a foundation for sustainable health programs. PHC is where people engage with the health system for the first time, It focuses on promoting health, wellness, preventing disease and the underlying social determinants of ill-health. With the current political commitment through the inclusion of UHC in the 'Big Four' social economic agendas, and equitable distribution of resources through the devolution of health services, the country now has what it takes to show that PHC is the best path towards achieving the goal of Health for All. Therefore, there is need to re-look at measures aimed at strengthening primary health care and shift focus from the costly, and often inaccessible, curative services to preventive services with clear financing mechanisms, "Prevention is better than cure".

The Kenya Primary Health Strategic document is the culmination of extensive consultation with the relevant stakeholders in the health sector. In the initial phase, the first technical meeting was held to create awareness and build consensus to define PHC including the pillars that are essential in making it sustainable in Kenya. The technical team consultatively came up with a concept paper and roadmap to guide the process based on agreed activities. In the exploratory phase, there was an indepth discussion to understand the situation of PHC and the health service delivery systems in general. During this phase, the zero draft of the strategic framework was developed. This was followed by a modelling phase to review the zero draft and incorporate inputs from various stakeholders, to come up with draft one of the PHC strategic framework The last phase was to review draft one in preparation for validation and endorsement.

This strategic framework has identified six strategic directions; leadership and governance, human resource for health, service delivery, health financing, commodity supply and infrastructure, as well as health information, technology and innovations. The six strategic directions together with the implementation model will guide effective implementation of primary health care.

The purpose of this strategic frame work is to provide guidance to national and county governments to effectively and strategically roll out the primary health care essential package.

Chief Administrative Secretary
Ministry of Health

Chief Administrative Secretary
Ministry of Health

Susan N. Mochache, CBS

Acknowledgement

The Ministry of Health sincerely acknowledges the contribution and hard work of the many individuals and organizations that contributed to the development of the strategic framework which was developed through extensive consultations. Team leads and members of different working groups are highly appreciated for the great commitment demonstrated.

In particular, we wish to acknowledge the Department of Family Health led by Dr. Mohamed Sheikh, for providing leadership and stewardship during the primary health care strategy development process. We also acknowledge contributions from colleagues in various divisions in the ministry for their invaluable technical support. The participation and technical contributions of the Non - Government Organizations (NGOs) is highly appreciated.

The development of the strategic framework was made possible through financial assistance from the government and developmental partners.

We look forward to fruitful implementation of this primary health care strategic framework

Principal Secretary,
MINISTRY OF HEALTH

Acronyms

ANC	Antenatal Care
AOPs	Annual Operational Plans
AWP	Annual Work Plan
CHAK	Christian Health Association of Kenya
CHAI	Clinton Health Access Initiative
CHC	Community Health Committee
CHMT	County health management teams
CHEW	Community Health Extension Worker
CHDS	County Director of Health Services
CHU	Community Health Units
CORPs	Community Owned Resource Persons
CSOs	Civil Society Organizations
DALYs	Disability Adjusted Life Years
DHIS	District Health Information System
DFH	Division of Family Health
DHS	Demographic and Health Survey
DPs	Developmental Partners
EMR	Electronic Medical Records
FBOs	Faith Based organizations
FTP	File Transfer Protocol
GDP	Good Dispensing Practices
GoK	Government of Kenya
GP	General Practitioner
GPP	Good Prescribing Practices
HENNET	Health NGO's Network
HFA	Health for All
HFC	Health Facility Committee
HIS	Health Information System
HMIS	Health Management and Information System
HRD	Human Resource Development
HRH	Human Resources for Health
HSCC	Health Sector Coordinating Committee
HSS	Health System Strengthening
HSSC	Health Sector Steering Committee
HSSF	Health Sector Service Fund
HTC	HIV Testing and Counselling
HW	Health Workforce
ICC	Inter-Agency Coordinating Committee
ICT	Information Communication Technology
ICU	Intensive Care Unit
IDSR	Integrated Disease Surveillance and Reporting
IEC	Information Education and Communication
IHRIS	Integrated Human Resource Information System
IMR	Infant Mortality Rate
JICA	Japan International Cooperation Agency

JICC	Joint Inter Agency Coordinating Committee
KAFP	Kenya Association of Family Physician
KDHS	Kenya Demographic Health Survey
KEML	Kenya Essential Medicines List
KEMRI	Kenya Medical Research Institution
KEMSA	Kenya Medical Supplies Agency
KEPH	Kenya Essential Package for Health
KHP	Kenya Health Policy
KHSSP	Kenya Heath Sector Strategic and Investment Plan
KMTC	Kenya Medical Training College
KNH	Kenyatta National Hospital
KRCS	Kenya Red Cross Society
LMIS	Logistic Management and Information System
MCA	Member of County Assembly
MCH	Maternal Child Health
MDT	Multi-Disciplinary Team
MDG's	Millennium Development Goals
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MTP	Medium Term Plan
NCD's	Non-Communicable Diseases
NGOs	Non-Governmental Organization
NHIA	National Health Insurance Authority
NHIF	National Hospital Insurance Fund
NHSSP	National Health Sector Strategic Plan
OPD	Outpatient Department
QOC	Quality of Care
SAGAs	Semi-Autonomous government agencies
SDG's	Sustainable Development Goals
TWG	Technical Working Group
PATH	Programme for Appropriate Technology in Health
PHC	Primary Health Care
RCN	Registered Community Nurses
UHC	Universal Health Coverage
U5MR	Under 5 Mortality Rate
UNDAF	United Nations Development Assistance Fund
UNICEF	United Nations Emergency Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Definition of Terms

Community Health Unit: Is a health service delivery structure within a defined geographical area covering a population of approximately 5000 people each unit is assigned two CHEWs and 10 community health volunteers who offer promotive preventative and basic curative services.

Community Health Volunteer: A trained health worker who is a Government employee and supervises the community health volunteers under the assigned health unit.

Community Health Assistant/Extension Worker: A trained health worker who is a Ministry of Health employee and supervises the community health volunteers under their health unit.

Family Physician: Is a licensed medical practioner; doctor who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis He/ She is concerned with providing comprehensive care to individuals and families by integrating biomedical, behavioral and social sciences. To become primary care physicians, medical school graduates undertake postgraduate training in primary care programs, such as family medicine.

General Practitioner is a physician who does not specialize in one particular area of medicine and are trained to deal holistically (taking into consideration the whole body and environment when offering treatment) with the range of problems a person might have. They also know when and where to refer you if you require further investigations or treatment. They often have regular, long-term patients and provide ongoing medical care to both male and female patients in all age groups.

Medical devices are instruments, apparatus, implement, machine, appliance, implant, reagent for in vitro use, software, material or other similar or related article, intended by the manufacturer to be used, alone or in combination, for human beings, for one or more of the specific medical purpose.

Multi-Disciplinary Team: Is a group of health care workers of different disciplines (professions/cadre) who together make decisions regarding recommended treatment of individual by each providing specific services to the individual, household and community. They co-ordinate services and work together towards a specific set of goals.

Primary Health Care: This is essential heath care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

Polyclinic is a clinic or health care facility that provides both general and specialized examinations and treatments for a wide variety of diseases and injuries to out-patients and is usually independent of a hospital.

Traditional/Alternative Medicine, is a category of medicine that includes a variety of treatment approaches that fall outside the realm of conventional medicine. This concept comprises a range of long-standing and still evolving practices based on diverse beliefs and theories.

Universal Health Coverage: Means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

Vulnerability is the degree to which a population, individual or organization is unable to anticipate, cope with, resist and recover from the impacts of disasters.

Vulnerable population is a group of people such as Children, pregnant women, elderly people, malnourished people, and people who are ill or immunocompromised, socioeconomically disadvantaged who are particularly vulnerable when a disaster strikes, and take a relatively high share of the disease burden associated with emergencies.

Dr. Patrick Omwanda Amoth

Executive summary

The intention of the Government of Kenya to improve the country's health status is in no doubt. Good intentions notwithstanding, various factors have constrained the Ministry of Health's ability to deliver sustainable quality care that is affordable and accessible to all citizens. In response to the daunting challenge, the government responded by developing a PHC Strategic Framework that will spell out the UHC implementation pathway and management of primary health services in the country. The development of the Primary Health Care Strategic Framework (PHCSF) covering the period 2019-2023 is a follow-up to the efforts that the Ministry has made to translate the PHC Alma Ata declaration and the UHC roadmap objectives into an implementable program.

The development of the Kenya Primary Health Care Strategic Framework 2019-2023 is guided by the Kenyan Constitution 2010, Kenya's Vision 2030 and the Kenya Health Policy 2014-2030 which are complemented by the aspirations set out at Global and Regional level. The Constitution gives every Kenyan a right to the highest attainable standard of health (including reproductive health). Article 43- [8]. Articles 53-57 emphasize on human dignity and stipulate attention to the needs and rights of all including special groups with Article 174 further recognizing the right of communities to manage their own affairs and to lead in their development in addition to conferring protection of rights of minorities and marginalized communities.

The spirit of the constitution is well captured in the country's blueprint for Vision 2030 which identifies economic, social and political pillars to drive the country towards realizing the goal. Health firmly constitutes the social pillar and is a key driver in achievement of the vision. Two approaches identified as key in pushing the agenda of an efficient and high quality health care system are (i) devolution of funds and management to the counties and communities, and (ii) shifting the bias of national health from curative to preventive which aligns with the principles that are entrenched in this strategy.

Expounding on the social pillar of the Vision 2030 is the Health Policy 2014-2030 whose main aims are to realize the priorities and flagship set out in Vision 2030, and to move towards making the right to health by all Kenyans a reality. The Policy's primary goal is attainment of universal coverage of critical services that positively contribute to improved health. The policy defines the four tiers of the health system as community, primary care, primary referral and tertiary referral services. This is further implemented at operational level through government strategic planning processes.

Primary Health Care is the first level of contact between the individual and the health system where essential healthcare is provided and forms the basis for other levels of health care services.
A range of approaches can be used, but the emphasis is on developing a multi-model set of interventions tailored to the local context, while simultaneously working to improve the broader health systems environment and culture that supports delivery of quality care.

In any approach, the value of patient and community engagement for quality and safety is emphasized, aiding both alignment with the wider scope of PHC, and effectiveness, accountability, ownership and sustainability of the quality improvement efforts. The goal of PHC is to reduce burden of health needs through universal access to comprehensive health services. The guiding principles are equitable distribution, community participation, inter-sectoral collaboration, appropriate technology and social justice.

The implementation of PHC in the next five years shall be guided by the six identified strategic directions as outlined below which will be achieved through well thought out strategic objectives and interventions

1. Secure and strengthen political/leadership commitment to achieve the primary health care targets
2. Build a strong workforce for health services at all primary health care levels
3. Improve access, availability, safety, efficiency, and equitable service delivery for primary health care at all levels
4. Enhance financing for primary health care
5. Improve systems for the supply chain, medical devices and infrastructure
6. Improve the capacity to use data, research evidence and innovations for decision making

This strategic framework is divided into five chapters.

Chapter 1 has introduction which gives the back ground and overview of the primary health care. The chapter brings out the efforts of the government in improving health status of its citizens through a comprehensive PHC package and the introduction of universal health coverage as a key pillar in the achievement of the President's Big Four Agenda. The chapter further highlights the core principles to be observed during the implementation o f the PHC as well as the elements which the country has been focusing on in response to the Ala Mata declaration of 1978. The gap that informed the development of this strategy is also described

Chapter 2 has the Health Situation Analysis. The chapter provides details of the global, regional and African continent situation analysis of primary health care, , key global and regional commitments in support of PHC. It further describes the evolution of primary health care in Kenya, the Kenyan epidemiological context. The Kenya primary health care system SWOT analysis based on the six WHO health systems building blocks is also described and finally the purpose /justification for primary health care strategic framework and a few appropriate examples of case studies of countries that have successfully implemented PHC programmes are shown.

Chapter 3 has Kenya PHC strategic directions. The chapter outlines the vision, mission, goal and the overall targets for PHC it also proposes what the country should endeavor to focus on in order to achieve the stated targets. It further goes ahead to outline the strategic objectives and key interventions. The chapter finally details the six strategic directions that will guide the implementation of PHC in the next five years as well as the accompanying twenty two and eighty key strategic objectives and interventions respectively

Chapter 4 displays the new arrangements for primary health care implementation framework and approaches that will be used in delivery of PHC services. The rearrangements are in respect to the currently existing Kenyan models vis avis the proposed human resources for health, service delivery, financing and leadership/governance based on the models from countries that have done well in PHC implementation.

Chapter 5 has the Implementation Plan. The plan covers the induction of health related staff on PHC as well as advocacy and communication. The chapter also explains chronologically how the PHC concept shall be implemented in six steps which are: -

Step 1: Setting up of PHC coordinating mechanisms,
Step 2 Feasibility and early adoption,
Step 3: Setting up of PHC Implementing mechanisms,
Step 4: Setting up of PHC learning sites,
Step 5: Monitoring and documentation of PHC implementation
Step 6: Evaluation and analysis of PHC strategy performance in the learning sites.

The implementation matrix with details the strategic directions, objectives and activities to be undertaken by two levels of government including the time lines and estimated cost of implementing the strategy

Chapter 6 is on the monitoring & evaluation framework for primary health care. The chapter provides the rationale for carrying out monitoring and evaluation. The details in the matrix include defined inputs, process and outcome/impact indicators that will be used in the monitoring and evaluation process. The various sources of PHC data, where it will be collected and analyzed is also presented. The chapter ends by explaining how operational and research evidence will be utilized in policy formulation, programming and decision making.

All the sources that have provided information in the development of this strategy are summarized inform of a list of references in APA referencing style.

Ag. Director General,
MINISTRY OF HEALTH

1 INTRODUCTION

Primary Health Care

1.1 Background.

Kenya continues to make significant progress towards improving the health status of its people. Efforts to develop a comprehensive Primary Health Care (PHC) policy started in the 1970s, it was not until the late 1980s that actionable strategies emerged, emphasizing decentralization, intersectoral collaboration and community participation in health. Following two decades of policy changes and learning, the Kenya Essential Package for Health (KEPH) concept was adopted in 2005. However, the country has not had a policy document or guidelines on primary health care. This has led to, among other challenges, a top-bottom approach in designing and implementing health programs where there is no meaningful community participation. Some programs are still vertical and linkage with the community level, a critical platform for preventive and promotive health, has been weak. Given that health services are devolved in Kenya, and with the inclusion of universal health coverage as one of the 'Big Four' agenda in Kenya's socioeconomic transformation, there is need to shift our focus from the costly and often inaccessible curative services to preventive and promotive health services. The PHC Strategy is therefore aimed at renewing the public health focus in the sector, including strengthening the delivery of primary health care services as illustrated in figure 1.

Based on the Alma Ata declaration of 1978, Primary health care (PHC) is defined as essential heath care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.[1]

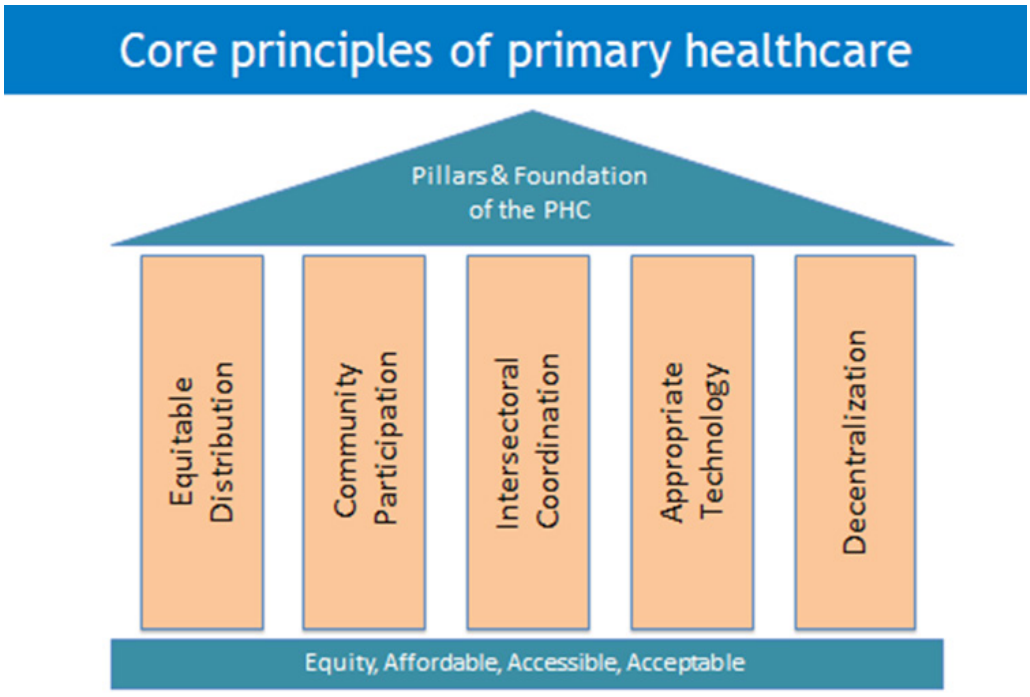


Figure 1 Core principles of primary healthcare

PHC was adopted globally as a means of achieving Health for All (HFA) by the year 2000 as per Alma Ata declaration of 1978. This concept of PHC emphasized the role of community participation, appropriate technology and inter-sectoral collaboration as a means to achieve Universal Health Coverage.

Primary Health Care is not just about tackling disease and caring for sick people; it focuses on promoting health, wellness, preventing disease and the underlying social determinants of illhealth that focuses on individual, family and community access to health services.

Primary Health Care is the first level of contact between the individual and the health system where essential healthcare is provided and forms the basis for other levels of health care services (secondary and tertiary). It focuses on the person not the disease while considering all determinants of health (social and behavioral), integrating care and services when there is more than one health need. It is an approach to health beyond the traditional health care system by focusing on health equity and social justice. PHC promotes people centered approach to healthcare and this encompasses promotive, preventative, curative and rehabilitative services through community collaboration and full participation.

During the Alma Ata declaration, it was agreed that PHC was to be implemented in eight elements which are:

1. Education on health problems and how to prevent and control them.
2. Development of effective food supply and proper nutrition.
3. Maternal and child healthcare, including family planning.
4. Adequate and safe water supply and basic sanitation.
5. Immunization against major infectious diseases.
6. Local endemic diseases control.
7. Appropriate treatment of common diseases and injuries.
8. Provision of essential basic medication.

As a country, Kenya added four more elements, which include the following:

1. Dental health
2. Mental health
3. HIV/AIDS
4. Primary eye care
5. Health Management and information systems

Development of the Kenya Primary Health Care Strategy 2019-2024

The development of the PHC strategy was informed by the existing gap that was realized when UHC was announced as one of the 'Big Four Agenda' through a presidential executive order. With the absence of the driver of UHC, then the idea of development of a PHC strategic plan was born. The process commenced through consultative approach with partners and county governments. A team comprising of different departments and divisions in the Ministry of Health together with key stakeholders was brought together. A drafting team was selected and with inputs from all the members, a draft strategy was developed with reference to the Universal Health Coverage roadmap and the Kenya Health Sector Strategic Plan. A broad consultative process on the draft strategy was carried out in a structured manner, and the consultation process done at various levels which included national, counties, health-related ministries, and key health sector partners.

In 2010, Kenya promulgated a new constitution that anchored and guaranteed the citizens the right to the highest, attainable standards of health. The constitution has since contributed to development of various policy documents that provide direction towards the delivery of PHC services. These documents include the Kenya Health Policy 2014-2030; the Kenya Essential Package for Health and Community Health Strategy, the devolved healthcare provision at the county level among other instruments.

Significant achievements have been realized in healthcare service delivery in the last 50 years resulting in improvement of various health indicators. However, Kenya is now faced with the triple burden of

communicable, non-communicable diseases and injuries/road traffic accidents. Despite these challenges the government of Kenya is determined to provide quality, accessible, affordable and acceptable health services for its entire citizenry.

Major strategies include improving access, realizing equity goals and providing quality services as well as strengthening the institutional framework for effective delivery of health services and strengthening primary health care.

PHC is crucial for the roll-out of Universal Health coverage (UHC), to address the triple burden of disease and lay the foundation for sustainable health programs in the country.

2 ANALYSIS

Primary Health Care

2.1 Global situation on primary health care

According to the World Health Organization World Health Statistics 2018, major achievements have been recorded in health globally. However, significant challenges still remain. For instance, 5.4 million children under five died in 2017. After unprecedented global gains in malaria control, progress has stalled because of a range of challenges, including a lack of sustainable and predictable funding. While the risk of dying from cardiovascular disease, chronic respiratory disease, diabetes or cancer has decreased since 2000, an estimated 13 million people under the age of 70 still died due to these diseases in 2016.1 PHC implementation in has faced the following key challenges:

(1) lack of consensus whether PHC should focus on vertical disease programmes where interventions had the most possibility of success or on comprehensive programmes that addressed social, economic and political factors that influenced health improvements;
(2) whether primary care and PHC are interchangeable approaches to health improvements;
(3) how equity and community participation for health improvements would be institutionalised; and (4) how sustainable financing for PHC would be possible.[2]

2.2 Regional primary health care situation in the Africa continent

Within the Africa region, the nature and focus of required health services has evolved significantly with the burden of both communicable and non-communicable diseases challenging health care systems. This is against a backdrop of major threats that include epidemics and outbreaks that in some areas re-emerge and hence continually appear in new areas of the continent, placing significant strain on health systems and resources. Changing climate conditions in many countries are leading to new or re-emerging health threats in the region.

Equitable and sustainable access to properly functioning health systems has not been attained across the Region. There have always been geographical disparities and these have worsened over the last decade. Many people, particularly those in rural areas, often have to travel long distances to receive basic health care. Once they reach a hospital or a clinic, they may only receive health care if they pay for it. Inevitably, many people may forego treatment because they cannot afford it, while those who pay may find the cost ruinous and the quality of service limited. Rapid turnover of people in key positions, lack of continuity in policy, lack of resources, poor management of available resources and poor implementation are seen in many countries as major constraints to improving the health systems.[3]

Because of these contextual global and regional issues, the re-design of health services in the Africa region is built around two areas: Improving health security, and achieving Universal Health Coverage.

2.2.1 Global and regional commitments

African leaders, over the years, have ratified various global and regional PHC commitments towards achieving the agreed health agenda. Some of these commitments include:

- Alma declaration of 1978 on Primary health care
- Bamako initiative of 1988 on increasing availability of essential drugs and other healthcare services
- Abuja Declaration of 2001 that calls for allocation of 15% of the government budget to health
- Maputo declaration of 2003 on agriculture and food security
- Ouagadougou Declaration on Primary Health Care and Health Systems of 2008
- Astana Declaration of 2018 on sustainable development, in pursuit of health for all.

2.3 Evolution of Primary Health care in Kenya

Efforts to develop a comprehensive PHC policy in Kenya started in the 1960s but it was not until the late 1980s that actionable strategies emerged. The summary of the main milestones in the evolution of PHC in Kenya is well documented as per figure 2.

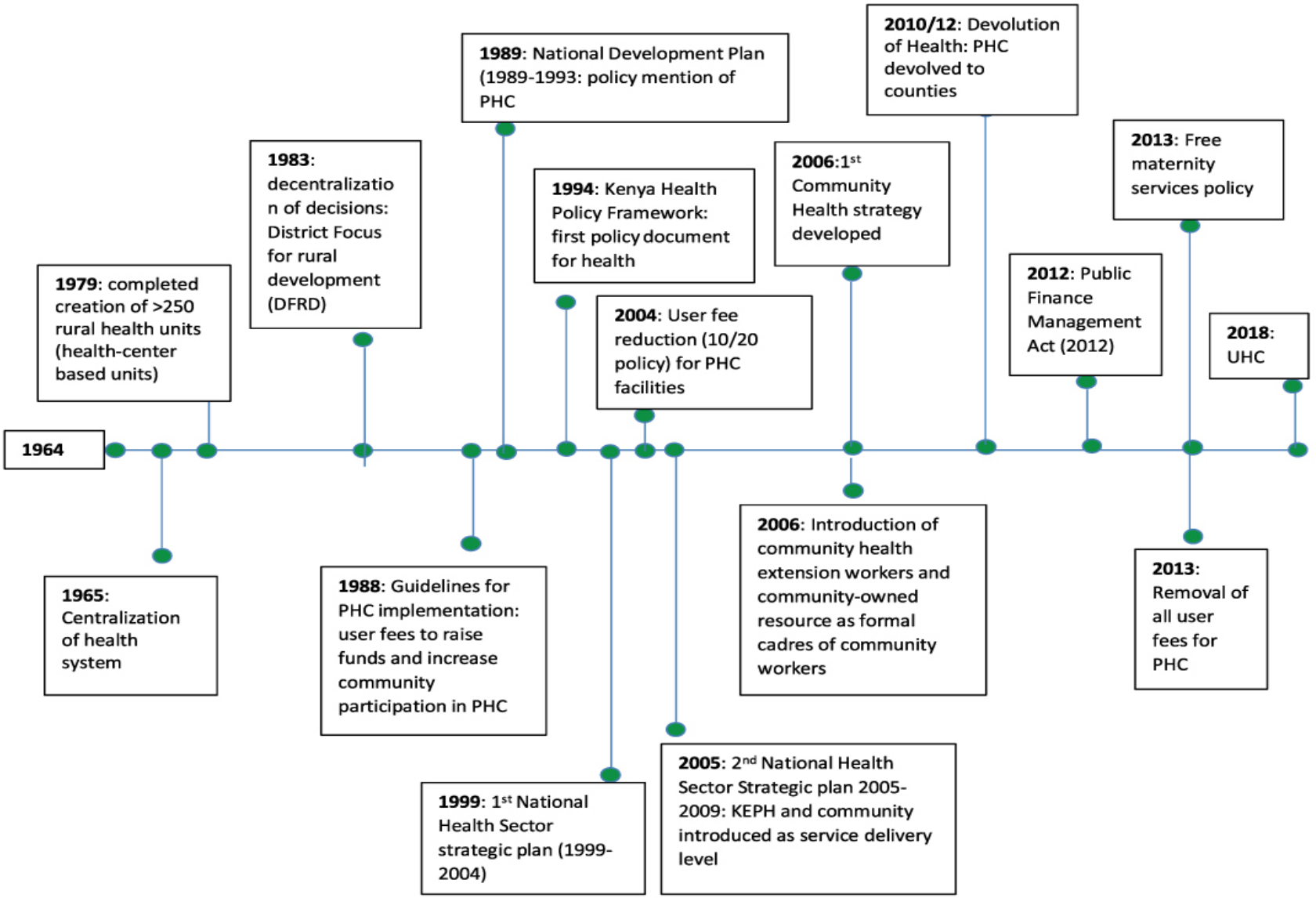


Figure 2: Evolution of Primary Health Care in Kenya

2.4 Kenyan Epidemiological and health services Context

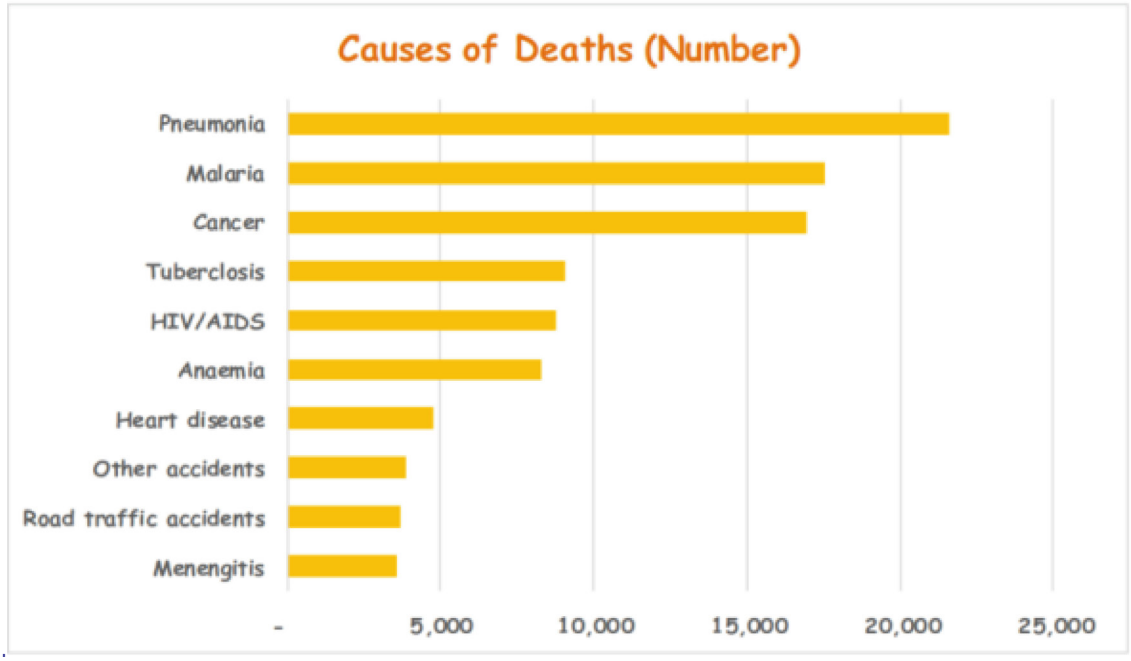
2.4.1 Epidemiological Context

Morbidity

Significant gains have been made in overall health of the Kenyan population with DALYs decreasing from 41,905 to 36,950 per 100,000 population between 2013 and 2017[4].

Mortality

According to the 2018 Economic Survey, the leading causes of death in Kenya are Pneumonia, Malaria, Cancer and Tuberculosis as illustrated in figure 3. Under-Five Mortality decreased from 74 per 1,000 live births in 2013 to 52 per 1,000 live births in 2017 and Infant Mortality from 52 per 1,000 live births to 39 per 1,000 live births in the same period. Maternal mortality also reported decline from 488 in 2013 to 362 per 100,000 live births6 (see figure)



5).

Figure 3: Source: KNBS (2018), Economic Survey

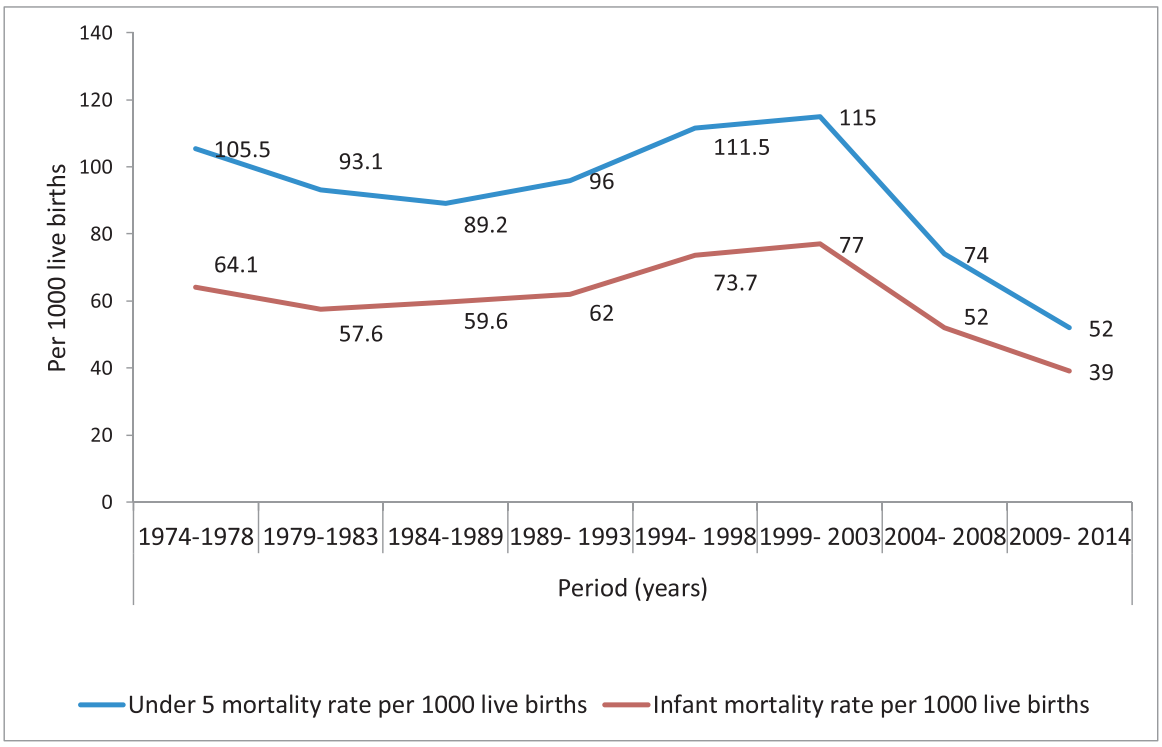


Figure 4: Child Mortality trends in Kenya (KDHS)

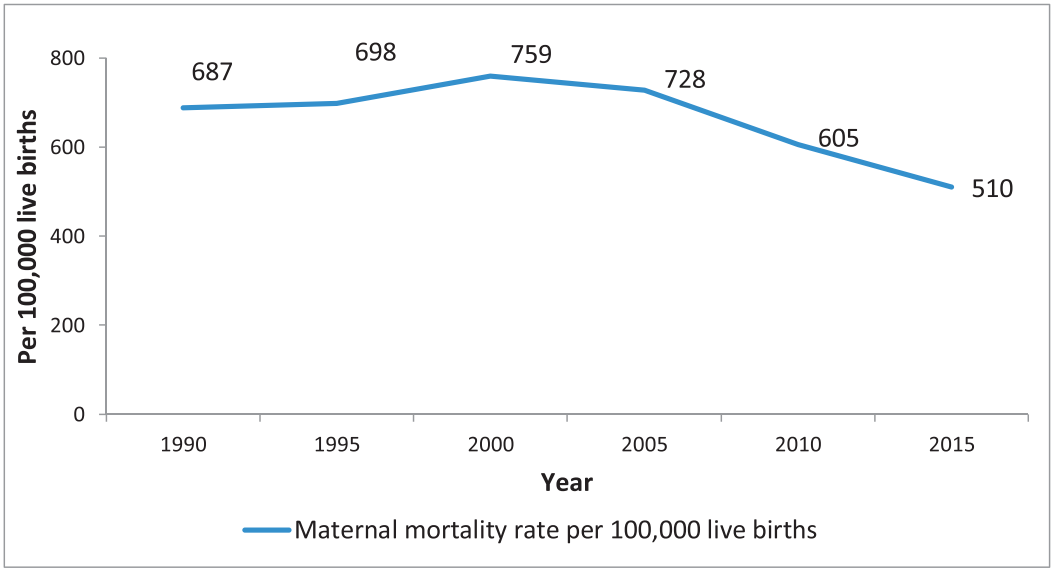


Figure 5: Trends in martenal mortality in Kenya, 1990-2015 (Source: WHO)

Risk factors to health

The main risk factors to health in Kenya include unsafe sex, suboptimal nutrition, unsafe water sources and poor sanitation.[4]

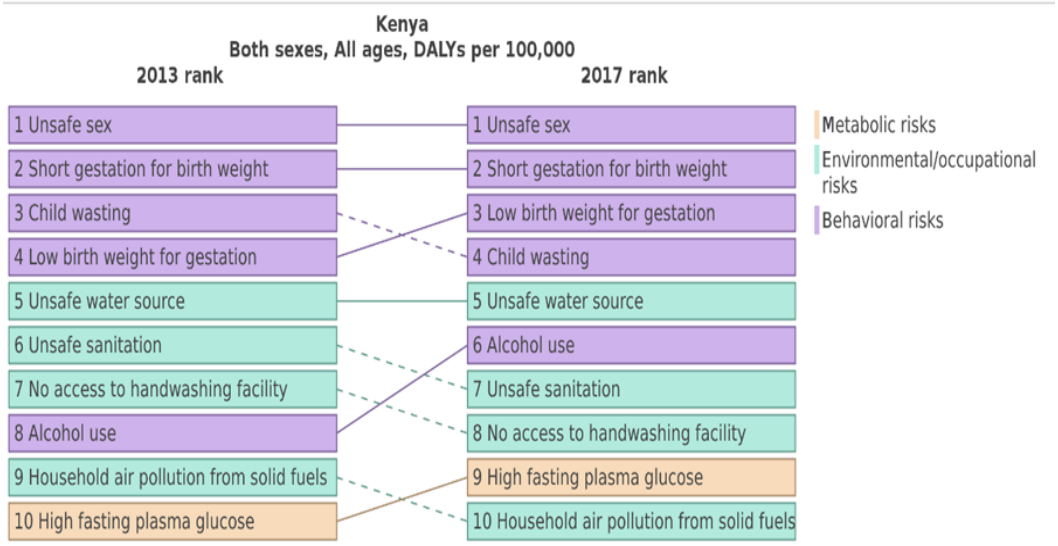


Figure 5: major contributors to disease burden (Source: GBD, 2017)

2.4.2 Health services context
Health Services and Health Status

The percentage of fully immunized child (FIC) at one year dropped from 90% in 2013/14 to 79% in 2016/17.[7] The HIV prevalence among people aged 15-49 is estimated to be 4.8%, a reduction from 5.9% (2015)[8] New HIV infections among adult population has also declined from 71,034 (2015) to 45,000 (2017)[8] New HIV infections among children aged below 14 years slightly increased from 6,613 to 8,000 over the same period 8, [9]. Currently, the country has enrolled 1.1 million people living with HIV on ART, representing 75% ART coverage[9]. It is estimated that 158,000 persons fell ill with TB in 2017, yet only about 85,185 were notified[10]. The country has experienced a decrease in the prevalence of Malaria among children aged 6 months to 14 years in the lake endemic areas, from 38% in 2010 to 27% in 2015 and a slight increase in prevalence in the coast endemic areas, from 4% in 2010 to 8% in 2015[11].

Approximately 13 million school-age children were dewormed while mass treatment of lymphatic filariasis was implemented in 23 endemic sub-counties in 2015 and 2016, whereby 63% treatment coverage was achieved. Targeting 14 million people, the Mass Drug Administration (MDA) for Trachoma achieved national coverage of 79% in 2015. The prevalence of diabetes mellitus among adults is 2%, but only 41% have been diagnosed while effective treatment coverage is 7%. Almost one quarter of the adult population (23%) suffer from raised blood pressure, with 20% having been diagnosed. Effective treatment coverage for hypertension is only 4%[12]. Cancer incidence is estimated at 47,887 cases and resulted in over 32,000 deaths in 2018[13]. Exclusive breastfeeding increased from below 60% in 2013/14 to nearly 80% in 2016/17. The percentage of adolescent pregnancies (10-19 years) reduced slightly from 30% in 2016 /2017 to 28% in 2017/2018 among total pregnancies[14].

The number of health care facilities increased from less than 9,000 in 2013 to 10,000 in 2016, increasing the national average facility density from 1.9 to 2.2 health facilities per 10,000 populations. About 20 million Long Lasting Insecticide Treated Nets (LLITNs) were distributed between 2013 and 2017 or about 63% of

households in Kenya now owning at least one LLITN. About 84% of public health facilities also have diagnostic capacity for malaria. A total of 37 counties are implementing the Community Lead Total Sanitation (CLTS). KEMSA's order fill rate improved from 50% in 2013/14 to the current rate of 86%[7].

2.5 Kenya Primary health care system SWOT analysis

2.5.1 Leadership and Governance

Kenya has a uniform political structure and sound leadership that encourages public participation across all levels of governments. Decentralization has enabled Counties to plan for health services in response to specific needs of the communities and clients. Currently there is political goodwill to operationalize Universal health coverage for all. There is inter-sectoral coordination geared to addressing national health issues. The devolved system of governance face a lot of challenges in ensuring social accountability on resources allocated for health services and the mechanisms to resource mobilization due to lack of policies and regulations to enhance the task. While the national government targeted to establish 10,567 CHUs which translates to Community Health Committees by 2018, only 5,907 was achieved which left a gap of 4,660, while only half of the country HFCs have been 28 Kenya Primary Healthcare, Strategic Framework 2019-2024 trained mostly in the hard to reach regions. The governance provided in most service delivery levels lack capacity to implement their mandates. The enforcement and monitoring of the existing laws and policies on healthcare remains weak and lacks support from decision makers. There is need to strengthen the systems of leadership and governance through capacity building. The opportunity exists to create awareness and promote political leadership and governance support at CHU, Primary Health Facility and Constituency Ward Administration levels.

2.5.2. Service Delivery

Kenya has put in place elaborate strategic plans to ensure that quality primary healthcare services are availed equitably to its people through a wide network of community and primary healthcare facilities.However, access to most service is not optimal as only 52% of Kenyans are able to access health facilities within a 5km radius. Availability and access to services are constrained due to inadequate equitable resource distribution and allocation. Social mobilization as a system and tool to promote awareness and knowledge of citizens on the available health services at each level has not received adequate consideration. The service delivery is well packaged by cohort in the initial KEPH policy document, but emphasis on the implementation guidelines has not institutionalized it.

The Global commitment and ratification of leaders in Astana observed that PHC should provide a comprehensive range of services and care, including but not limited to vaccination; screenings; prevention, control and management of non-communicable and communicable diseases; care and services that promote, maintain and improve maternal, newborn, child and adolescent health; and mental health and sexual and reproductive health[2.] PHC must be accessible, equitable, safe, of high quality, comprehensive, efficient, acceptable, available and affordable, and will deliver continuous, integrated services that are people-centred and gender-sensitive. The policy and political leadership must strive to avoid fragmentation and ensure a functional referral system between primary and other levels of care. Sustainable PHC will enhance health systems' resilience to prevent, detect and respond to infectious diseases and outbreaks[15.]

2.5.3. Financing

Health finance remains critical to the realization of primary healthcare. The government of Kenya has allocated about 7% of its national budget towards healthcare services. Finance allocation is guided by the Public finance management policy to ensure fair allocation to all counties. However, there is lack of adequate financing for PHC services. This is compounded by lack of guidance to the counties on budgetary allocation for health services. Only 11% of the population in the country has health insurance cover.

Primary Health Services demand a sustainable, institutionalized financing innovation in this era of constrained resource availability. The proposed innovation shall be sustained through financial provision that will be harnessed from the National Treasury and stakeholders such as development and implementing partners, the National Hospital Insurance Fund (NHIF), donors, philanthropies, Non-Governmental Organizations (NGOs), Community-Based Organizations (CBOs), Faith-Based Organization (FBOs), private insurances, corporate bodies, cooperatives and saccos. Similarly, prudent financial management structure will be applied at national and county levels for sustainability of this financial model[16].

There is need for continued advocacy to cushion the population from out of pocket spending towards access to health services through increased uptake of health insurance, establishment of a sustainable mechanism to resource mobilization and alignment of existing health insurances to PHC and UHC needs.

2.5.4. Human Resource for Health

The current WHO policy guidelines recommend the creation of decent work and appropriate compensation for health professionals and other health personnel working at the primary health care level to respond effectively to people's health needs in a multidisciplinary context. The document recommends continued investment in education, training, recruitment, development, motivation and retention of the PHC workforce, with an appropriate skill mix. Retention and availability of the PHC workforce in rural, remote and less developed areas is one of the key priorities in the health workforce. Investing in community health workers represents good value for money. And yet, they are often operating at the margins of health systems, without being duly recognized, integrated, supported and rewarded for the crucial role they play[17].

The Kenya Integrated Human Resource Information (IHRIS) system was established to track and manage health workforce to ensure the right health worker is at the right place at the right time. This system needs robust revision to avail the actual gap in the workforce at the primary health care that will support the mechanisms to bridge the gap. Health worker internal and external migration from Public health facilities is significant and must be addressed through elaborate mapping and studies to inform the government on the modalities and preferences for recruitment and retention.

2.5.5. Health Information Management System and Research

The Ministry of Health established HMIS architecture that has improved information completeness. However, the information collected is still limited to a few conditions, and there are weaknesses in its completeness and quality. Additionally, information analysis, dissemination, and use is not well entrenched in the sector[18].

The use of information sources beyond routine health management information remains weak. There is need to strengthen the system from community to national level through innovative approaches and new technologies that capture data at source, upload, process and make the same available and accessible for use by all stakeholders at all levels of primary health care and link referral facilities and institutions of service delivery. Through digital and other technologies, the individuals and communities will be enabled to identify their health needs, participate in the planning and delivery of services and play an active role in maintaining their own health and wellbeing[15]

2.5.6. Health Commodities

Strides have been made in ensuring timely and effective supply of commodities in the health sector for instance the availability of KEMSA Logistics Management and Information System (LMIS). The Kenya Essential

Medicines List (KEML) has played an important role in the effective allocation of commodities to the lowest level. The national government has also partnered with the private sector to ensure availability of health products and technologies such as the Managed Equipment Services (MES). In spite of all this, inadequate supply of medicines, commodities and supplies has been perennial due to weak roll out and utilization of LMIS.

The automation and standardization of the system should be a priority of the government if effective delivery of commodities, medicines and supplies towards increased access to services is expected by the year 2030. Increased resource allocation for procurement and strengthening of the system should be considered by the national and county governments. Innovations that work should be included through a revised policies and guidelines for supply chain systems.

Table 1: SWOT Analysis

SWOT Analysis on Primary Health Care				
	Strength	**Weakness**	**Opportunity**	**Threat**
Political	Drive towards achieving UHC Devolution enabling more community involvement in decision making	knowledge gap by the political leaders and the public on existing policies and guidelines	Anchor strengthening of primary health service as a pathway to achieving UHC. Advocate for political commitment to support strengthening PHC	Political priorities over actual population needs
Financial	Public finance management policy guides national allocation of finances to counties	Low resource allocation to PHC. Lack of guidelines for health care financing to counties. Lack of sustainable community health funding	Increased national and county funding for PHC, develop guidelines for health financing for health. advocate for health insurance mechanisms	Lack of transparency and accountability
Human Resource	Existing norms and standards for HRH, IHRIS in use	Shortage of staff, poor remuneration, high attrition among CHVs	Employ adequate staff, capacity build, Sustainable financing to motivate CHVs: sustainable financing, build MDTs	Lack of consideration for long term gains for investing currently in HRH
Service Delivery	Wide network of PHC systems, and existing community health strategy	Poor linkage of community to PHC facilities, suboptimal emphasis on health promotion	Strengthen and scale up implementation of existing Community Health strategy, strengthen referral and institutionalize QOC	Poor inters sectoral and multisectoral coordination
Commodities	LMIS systems in place, KEMSA has large capacity to supply commodities	Poor quantification and forecasting, LMIS manual, challenges in distribution	Strengthen, automate and standardize LMIS systems, support counties increase capacity for quantification and forecasting	Poor quantification and forecasting, use of alternate suppliers without capacity for procuring large volumes and cannot distribute
HIS	DHIS collecting most of health service delivery data, national Research Policy in place	Incomplete reporting, data quality gaps, Low uptake of data and research for planning	Strengthen DHIS, utilize EMR, use research to inform policy and programming	Parallel data reporting systems

2.6. Purpose /Justification for Primary health care strategic framework

The government of Kenya emphasizes the health of its citizens and the improvement of health service delivery. The Kenya Health Policy, which seeks to contribute to the attainment of Vision 2030 aims to provide equitable and affordable health care of the highest affordable standard to all citizens. Despite the efforts and commitment of the government to improve the health of its population the progress has been slow and still many Kenyans lack access to basic health care, proper sanitation, safe drinking water, and adequate nutrition and many of them die prematurely due to preventable or readily treatable diseases.

The slow progress and challenges in the health sector is further exacerbated by:

- Increasing population with a Demographic shift, Aging population at risk of non -communicable diseases and increasing youthful population at risk of communicable diseases.
- Epidemiological transition and resurgences, emergence of diseases like Ebola,
- Inequity in health care and poor health among disadvantaged groups
- Increased and Escalating health cost
- Globalization, urbanization and modernization of society and changing socio cultural expectations.
- Increased road traffic accident, injuries and violence
- Lack of comprehensive approaches to key interventions.
- High poverty level and economic challenges
- Inadequate information on health matters in the community

Moving forward, deaths from communicable disease are projected to go down while deaths from non-communicable diseases are projected to increase as from 2020 to 2030. The overall deaths in Kenya are expected to increase gradually from 2010 to 2030, as shown in the figure below:

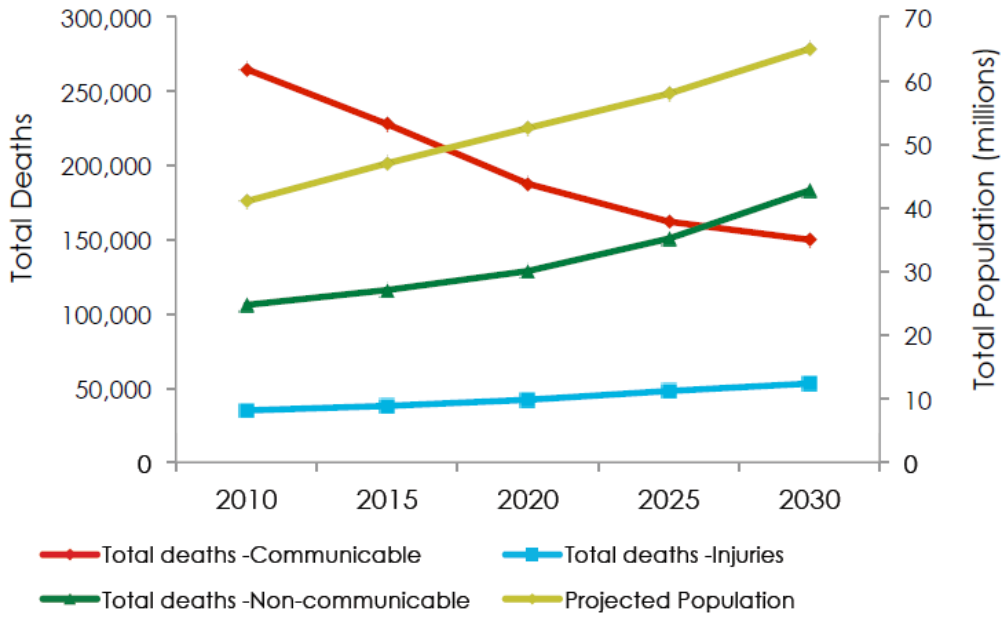


Figure 6: Projection of future mortality drivers

The rising burden of disease, increasing population and global dynamic shift require a sustainable health system that is responsive, efficient and people centered. Public health care allows society and health systems to respond to these challenges. Treating people and communities as key actors in the production of their own health and well-being is critical for understanding and responding to the complexities of the changing context[19].

Universal health coverage requires a renewed focus on primary health care and their importance for individuals, health systems and health for all. Primary Health Care can meet 80-90% of an individual's health needs over the course of their life thus makes Primary Health Care critical towards achievement Universal Health Coverage.

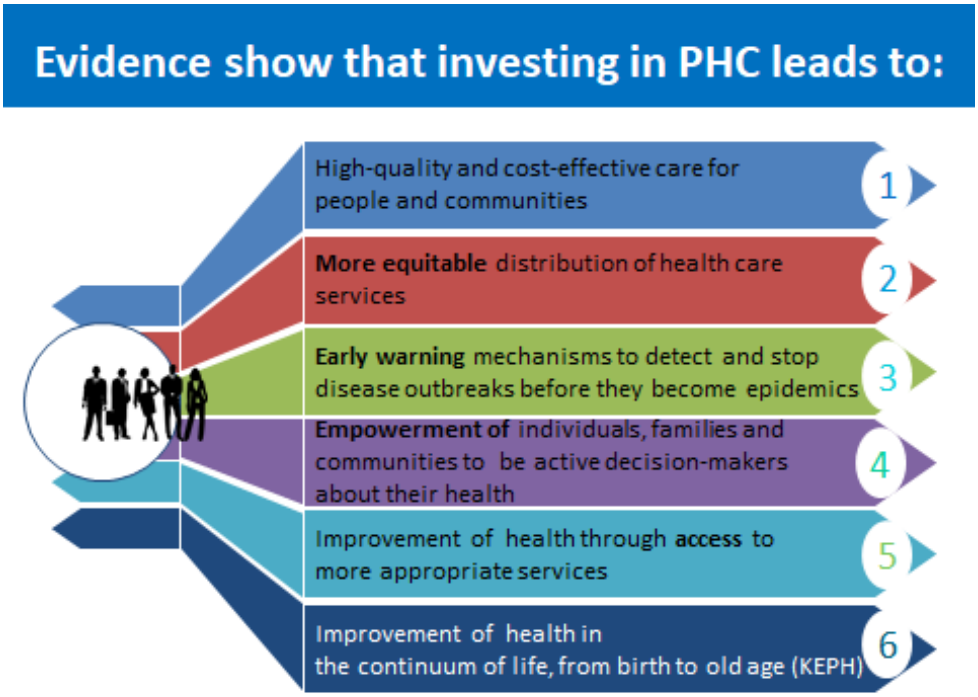


Figure 7: Evidence of investing in primary healthcare

Primary health care is the key to:

- Improving maternal, neonatal , child and adolescent health as well as ensuring appropriate care for the elderly.
- The control of major communicable diseases, including HIV, Tuberculosis and malaria as well as neglected tropical diseases and preventable eye, ear and dental conditions.
- Effectively fighting the epidemic of non-communicable diseases such as cardiovascular diseases, diabetes, respiratory diseases and cancers
- Combating the rapidly rising burden of mental health illness'

We need health systems with strong PHC if we are to achieve universal health coverage.
As outlined in the Astana Declaration 2018, renewing primary health care and placing it at the centre of efforts in the health sector in Kenya is critical for three reasons: (a) the features of primary health care allow the health system to adapt and respond to a complex and rapidly changing world; (b) with its emphasis on promotion and prevention, addressing determinants and a people-centred approach, primary health care has proven to be a highly effective and efficient way to address the main causes of, and risk factors for, poor health, as well as for handling the emerging challenges that may threaten health in the future; and (c) universal health coverage and the health-related Sustainable Development Goals can only be sustainably achieved with a stronger emphasis on primary health care[20].

2.7 Case studies of countries

Evidence shows that countries with strong primary health care have a more efficient health delivery system, have low mortality and morbidity rates and low health inequalities with low health cost. Some countries have implemented primary healthcare models which have not only significantly improved the key health indicators but also managed to provide wide coverage to their populations.

Table 2: Case study of efficient health delivery systems

Country	Improved indicators	PHC Intervention
Rwanda	Life expectancy 64.5 years, Infant mortality rate: 31 per 1000 live births ,Under-5 mortality rate 42 per 1000 live births , Maternal mortality rate 210 per 100 000 live births , Immunization coverage under 1 year 98%,	The ***quality*** *monitored through accreditation, performance-based financing and integrated supportive supervision.* ***Government spending*** support for health sector financing health sector accounts for 16.52% of total government spending. *Community-based health insurance schemes*, which give the majority of the population access to health care services and drugs. Social and private health insurance schemes cover approximately 80% of the population. Total health expenditure as proportion of GDP 16.0%, PHC expenditure as % of total health expenditure 38.0 %.
Thailand	Life expectancy at birth (year) Male 71 Female 77. Total health expenditure as proportion of GDP (%) 7	Three governance models implemented: 1) Region-based health services system to manage and reallocate available resources effectively and efficiently; District health system (DHS): Health management at the district level in order to effectively coordinate and operate through multisectoral collaboration; and Primary care cluster (PCC): Comprehensive health prevention, promotion and other primary care services are provided through family care teams comprising *family physicians and local multidisciplinary teams of health personnel.* Financing: *general taxes, social insurance contributions, private insurance premiums, and direct OOP payments.*
Cuba	Life expectancy improved from 74 years in 1990 to 78 in 2013. IMR from 13.6/1000 in 1990 to 6.2/1000 in 2013. The health coverage improved with at least 4 ANC visits of 100%, birth attended by skilled health personnel at 100% in 2014.	The *PHC model involves Service provision tailored through polyclinics and a community based polyclinics that are the center peace of the Cuban primary health care.* The programme operate with team of family doctors and nurses throughout the country and attend to more than 95% of the population and focus preventive medicine as the cornerstone of health system,"
Ethiopia	Life expectancy: 64 years, IMR: 59/1000, MMR: 353/1000, Immunization coverage: 86.4%, % Total health expenditure as proportion of gross domestic product (GDP)a 2.66%, total public sector expenditure on PHC 26.73%, PHC expenditure as % of total health expenditure 14.69%	Financing sources: including the government Treasury, bilateral and multilateral donors, household out-of-pocket expenditure, international and local nongovernmental organizations (NGOs), private and parastatal employers, and insurance companies. Resource Mobilization Directorate at the Federal Ministry of Health, PHC is one of the pillars of the Growth and Transformation Plan (GTP). Clear governance structure
Eritrea	U5MR reduction from 205 to 58.2 deaths per 1,000 live births, immunisation coverage between the poorest and the wealthiest quintiles reducing by 72%, MMR reduction from 998 per 100,000 live births to around 450. ANC attendance rose from 48.9% to 70.3%	Schools utilized for child health promotion (integration of health and education) Strong Community involvement and outreach programs Community IMCI (C-IMCI), strong political commitment

3 STRATEGIC DIRECTION

Primary Health Care

Vision:

A healthy, productive and globally competitive Nation

Mission:

To ensure progressive, accessible, affordable, resilient, responsive and sustainable primary health care services of the highest standard for all Kenyans.

Goal:

To reduce burden of health needs through Universal access to Comprehensive Health Services.

Overall Targets:

- Reduction of disease burden rate to less than 50% by 2024
- Reduce number of health related mortality by 50%
  To achieve this Kenya needs to:
- Eliminate unmet health needs among all vulnerable and disadvantaged populations
- Reduce PHC related preventable deaths by 80%
- Reduce PHC attributable deaths among infants and children< 5 years by 50%

Kenya Primary Health Care Strategic Directions

The implementation of PHC in the next five years shall be guided by the six identified strategic directions each one developed from the six WHO health systems building blocks. Twenty two strategic objectives and eighty interventions have also been carefully developed in order to contribute in the achievement of each chosen strategic direction.

3.1 Leadership, Management and Governance

Strategic Direction 1: Secure and strengthen political/leadership commitment to achieve the Primary Health Care targets

Strategic Objective 1: Prioritize Primary Health Care as a political agenda for Universal Health Coverage.

Key interventions:

- Launch and disseminate a Kenya Primary Health Care Strategy 2019-2024
- Advocate for legislation of relevant PHC policies, laws and regulations
- Advocate for PHC agenda at all levels
- Incorporate PHC into existing governance and management structures
- Establish multi-sectoral PHC Governance Advisory Council and committees

Strategic Objective 2: Promote good governance, management and administrative accountability in PHC

Key interventions:

- Provide policy guidance to Primary Health care providers
- Strengthen community participation in health policy formulation and decision making in health care

- Strengthen the function of health facility and community management committee's
- Strengthen multi-sectoral collaboration for Primary Health Care

3.2 Human Resource for Health

Strategic Direction 2: Build a strong workforce for health services at all PHC levels.

Strategic Objective 1: Build capacity of health work force to provide quality, efficient and effective service delivery at all PHC levels.

Key Interventions:

- Hire and deploy adequate health workforce in all PHC levels in line with the existing norms and standards as developed using Full Time Equivalent (FTE) tool by Salaries and Remuneration Commission (SRC)
- Capacity build health workforce in all PHC levels to ensure adequate skills to deliver quality services
- Operationalize the scheme of service for Community Health personnel
- Develop and operationalize a scheme of service for medical specialists in Family Medicine

Strategic Objective 2: Establishment of Multi-Disciplinary Teams to provide comprehensive Primary Health Care to a targeted population.

Key Interventions:

- To introduce multi-disciplinary teams lead by family physicians at all PHC levels to enhance service delivery
- Develop guidelines for establishment and management of MDTs for providing PHC services

Strategic Objective 3: Provide mechanisms to ensure availability of ethical and skilled health workforce for the delivery of Primary Health Care services at all levels.

Key interventions:

- Advocate for health workforce pre-service training on customer care
- Advocate for the induction for human resource for health on ethics, integrity and customer care
- Promote mentorship for enhancing skills and competencies for ethical delivery of services
- Enhance the function of regulatory authorities for ethical delivery of PHC services

Strategic Objective 4: Institute performance management and performance contracting.

Key interventions:

- Introduce performance contracting to the health workforce at all Primary Health Care levels
- Capacity building of health workforce on performance contracting
- Link the performance contracting to reward and sanctions

3.3 Service delivery

Strategic Direction 3: Secure and strengthen political/leadership commitment to achievethe Primary Health Care Targets.

Strategic Objective 1: Increase access to functional community units available to provide Primary Health Care services

Key interventions:

- Utilize the facility and community unit assessment report to improve capacity for PHC service provision.
- Expand and increase coverage of CHUs to provide Primary Health Care services.
- Maintain the functionality of CHU, continued mentorship and support supervision of Community Health Volunteers.

Strategic Objective 2: Increase demand and utilization of Primary Health Care services

Key interventions:

- Engage community initiatives to create demand for Primary Health Care interventions and build leadership and community ownership

- Strengthen linkages between facilities and communities through community health fora
- Leverage on appropriate technology for information, education and communication

Strategic Objective 3: Ensure provision of high-quality primary health care services.

Key interventions:

- Increase access to Primary health care services as per the national guidelines
- Institutionalize and operationalize Kenya Quality Model for Health and other Quality Improvement initiatives at all Primary Health Care levels
- Ensure mechanism are in place for gauging client satisfaction and enabling response (service charters, client exit surveys etc.)

Strategic Objective 4: Strengthen Emergency Preparedness and Response System.

Key interventions:

- Strengthen coordination of health surveillance, emergency, disaster preparedness and response at all Primary Health Care levels
- Institutionalize and strengthen integrated health surveillance, outbreaks, epidemic preparedness and response at the community and Primary Health Care levels
- Promote, coordinate a multi-sectoral approach to emergency and disaster response at National and County level.

Strategic Objective 5: Strengthen the referral system at all PHC level.

Key interventions:

- PHC service centers to be the first referral point of entry
- Build capacity of service providers on referral mechanisms
- Strengthen referrals and linkages between public, FBO and private facilities

Strategic Objective 6: Strengthen access to primary health services for vulnerable populations.

Key interventions:

- Develop a health promotion framework for vulnerable population
- Improve linkages between facility-based rehabilitation, palliative care centers, the community and other relevant sectors
- Develop relevant guidelines, policies, standards, SOPs for different vulnerable population
- Establish community rehabilitation, palliative, rescue centers and home based care.

Strategic Objective 7: Mainstream traditional and alternative medicine in the Primary Health Care framework

Key interventions:

- Develop legal framework and guidelines for traditional and alternative medicine for regulation of their practice.
- Integrate traditional and alternative medicine into the health care system.
- Promote research and development of traditional and alternative medicine for Primary Health Care

3.4 Health Financing

Strategic Direction 4: Enhance Financing for Primary Health Care

Strategic Objective 1: Mobilize and Invest Adequate Resources in Primary Health Care

Key interventions

- Advocate for relevant policies, strategies and guidelines for sustainable health care financing mechanism at both national and county level.
- Ring-fence funds for Primary Health care services at all levels.
- Increase domestic financing for Primary Health Care through innovative taxes regimes.

Strategic Objective 2: Expand Health Insurance Coverage In-Line with Primary Health Care Services at all Levels

Key interventions

- Advocate for NHIF scheme to align its strategies with the PHC needs and principles
- Expand private health insurance schemes coverage for PHC services beyond curative services.
- Advocate for community-based health insurance initiatives.

Strategic Objective 3. Establish Innovative Financing Mechanisms at Both Levels Of Governments To Secure Sustainable Domestic Financing For PHC.

Key interventions

- Establish a county-based healthcare financing scheme for PHC
- Scale up sustainable innovative community health and income generating activities to compensate community health workforce
- Establish results-based financing for PHC

Strategic Objective 4. Enhance Financial Planning, Budgeting, Management and Accountability.

Key interventions

- Design an appropriate mechanism for planning and budgeting.
- Facilitate capacity development of the primary health care providers
- Establish efficiency monitoring unit at all Primary Health Care levels.
- Establish financial reporting feedback mechanism

3.5 Commodity Supply Chain and Infrastructure

Strategic Direction 5: Improve Systems For the Supply Chain, Medical Devices and Infrastructure.

Strategic Objective 1: Optimize the supply, distribution and rational use of drugs and commodities.

Key interventions

- Regular update of the Essential lists (Medical, medical lab supplies and reagents, health products and technologies to include Community level) for the improvement of PHC services
- Advocate for local production of commodities, vaccines and supplies
- Strengthen mechanisms and processes for forecasting and quantification of commodities and supplies
- Strengthen the standards and regulations for procurement of commodities and supplies
- Strengthen the tracking systems for storage and distribution of commodities and supplies
- Strengthen systems for rational use of commodities

Strategic Objective 2: Promote Rational Procurement, Placement and Use of Medical Devices.

Key interventions

- Mapping, placement and re-distribution of medical devices for the delivery of Primary Health Care services
- Strengthen the procurement systems for medical devices
- Develop and strengthen the capacity of Human resource for the safe and rational use of medical devices
- Reinforce standards and regulation for medical devices in the supply chain

Strategic Objective 3: Develop and Improve Infrastructure for Delivery of Primary Health Care Services

Key interventions

- Establish an assessment mechanism for evaluating the status of the Primary health care infrastructure
- Ensure the distribution of Primary Health Care infrastructure as per the relevant standards and norms
- Improve existing infrastructure for the delivery of Primary Health Care services.

3.6 Health Information, Technology and Innovation

Strategic Direction 6: Improve the capacity to use data, research evidence and innovations for decision making

Strategic Objective 1: Scale up use of digitized Health Management and Information System to increase utilization of PHC data.

Key interventions

- Advocate for roll out of unique identification for all Kenyans for PHC services
- Create a health profiling platform (healthy, at risk and sick) for targeted interventions
- Create a database for monitoring and evaluating use of resources
- Strengthen DHIS to collect PHC quality data including event based reports

Strategic Objective 2: Promote Research Agenda and Use of Routine Data to Improve PHC Services.

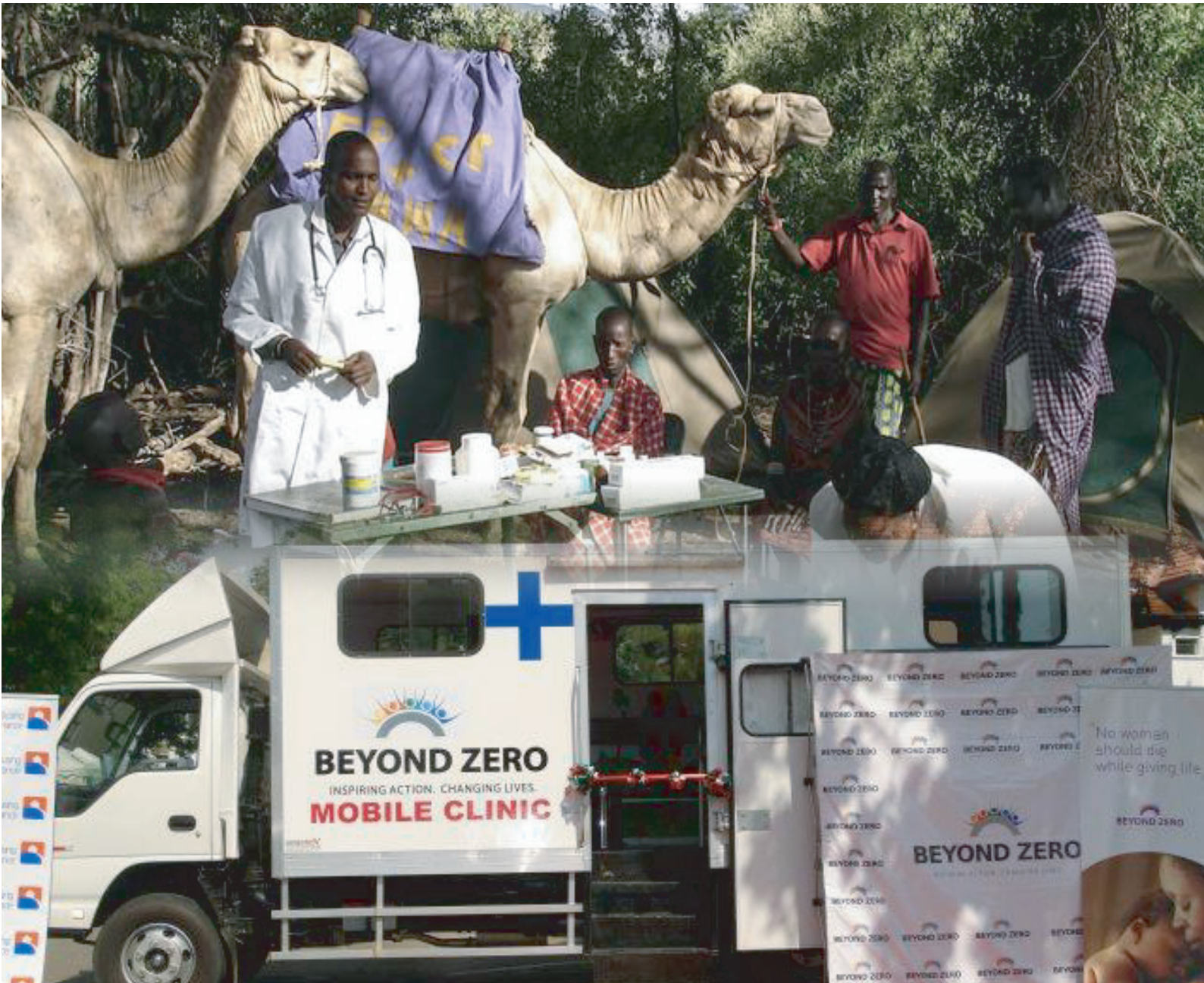
Key interventions

- Conduct research to document best practice, challenges and successes according to the PHC research agenda
- Utilize research findings to inform policy formulation, programming and decision making
- Link PHC data and research to the existing Kenya Health Observatory
- Establish, promote and equip tele-health hub in delivery of PHC.
- Establish PHC centers of excellence in the counties
- Promote interoperability among different health information systems
- Advocate for protection of intellectual property rights for innovations

4

New Arrangements for Primary Health Care

Primary Health Care



4.1 Improvement of service delivery, human resource, infrastructure and commodity management

4. 1.1 Re-organisation of primary health care service delivery

Primary health care forms the basis for other levels of health care and focuses on the person not the disease while considering all other determinants of health (social and behavioural), integrating care and services when there is more than one health need.

In order to achieve effective, sustainable universal health coverage service delivery, there is need to shift the way health services is delivered or organized in the country and adopt different strategies and models.

Table 3: Primary Health Care Delivery Models From selected Countries

S.N	Model	Description/highlight of the model	Applicability of the model	Country being applied
1.	Multi-disciplinary teams (MDTs)	A team of health professionals, working together to provide comprehensive and continuous person centered health care services for individuals, families and communities. Looks at the community when addressing other determinants of health	Primary health facility, Across all population	Brazil and Cuba
2.	Polyclinics	Facilities staffed with variable professionals providing both primary, specialized and auxiliary services	Densely populated, urban and informal settlement	Cuba
3.	General Practitioners	GPs are medical officers that are the first stop for any resident who seeks health care services. GPs refer patients for specialized care. Useful for community outreaches.	Urban areas	Britain
4.	Mobile clinics/outreaches	Based on the remoteness of an area and lack of health care services in certain areas.	Nomadic areas and special populations(IDPs, refugees, migrants)	Saudi Arabia
4.	Community midwifery	Encompasses care of women during pregnancy, labour, and postpartum period,	Both urban and Rural Nomadic areas	Japan

Moving forward, It is envisaged that the delivery of primary health care services in Kenya transforms from the current pre-dominant disease-centred care approach to a people centred care approach. People-centred care is the transformation of current disease approach to more provider client interactions.

Table 4: Proposed healthcare delivery transformation

Tally	Feature	Current health care	Proposed health care
1	Focus	Focusing on illness and cure	focussing on the health needs
2	Relationships	Relationships being limited to the moment of consultation	being long lasting enduring personal relation
3	Continuity	Episodic curative care	comprehensive, continuous and person centred care
4	Responsibility	Responsibility limited to the effective and safe advice to the patient at the moment of consultation	responsibility to the health of all in the community along the life cycles and responsibility for tackling determinants of ill-health
5	Partnership	Users being consumers of the care they purchase	people being partners in managing their own health and that of their community

It is anticipated that the level 2, 3 and 4 health care facilities are going to be the focus of the Primary Care network. The Level 2 facilities will be strengthened and enriched to deliver the same level of service as a level 3 facility (current health center). These facilities shall be known as the Primary health care facilities. Each primary care facility shall organize its primary health care services in a people centered model. In the people centered model, a team of health workers (the multidisciplinary team –MDT) will be prescribed population in a predetermined geographical area (The Community PHC zone).

Each delineated community PHC zone will have the prescribed number of community units (CU) which shall be linked to the Primary Health Care Facilities. It is envisioned that in order to facilitate access to PHC services in the PHC zone, all persons in the area will be registered and zoned into community health units. The registry will be updated every 6 months as per the community health strategy.

The Community Health Units shall be made operational as per the MOH community health strategy guidelines (with modifications as per geographical setting and population density).
The primary health care will be the frontline health care for the Kenya health system. It will be provided in the home, PHC centers, private clinics, community level, outreaches and medical camps. Different primary health care models suited to specific populations may be used to deliver care to the community. These include but not limited to the following:

- Multi-disciplinary Team model
- Polyclinics (equivalent to Kenyan Medical Centers and level 4 facilities)
- Mobile clinics and Outreaches model
- Community Midwifery model

*For the HRH to provide primary health care services conforming to health for ALL they will have to undergo an induction training in order to transform the provider client interaction

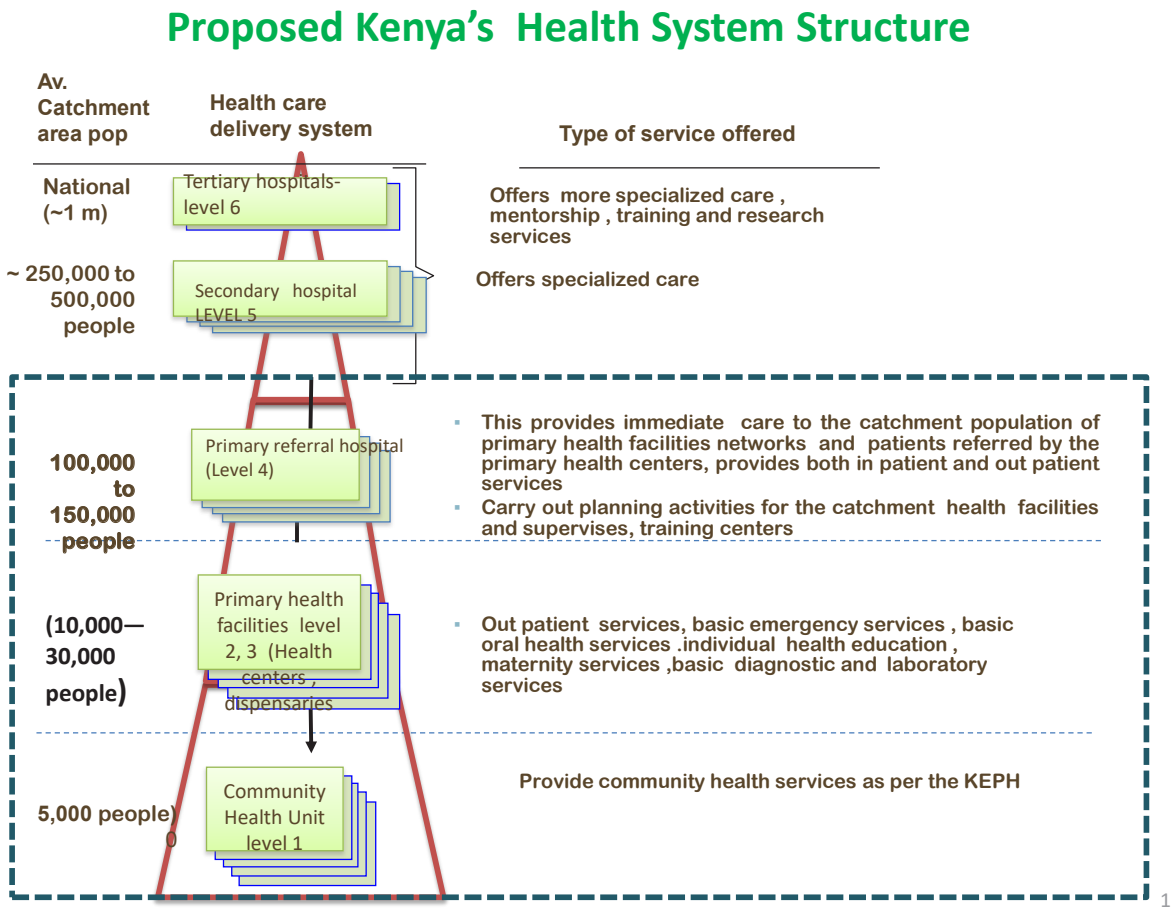


Figure 8 : Proposed health system structure

4.1.2 Re-organization of Human Resource for Health

Establishment of Health teams referred as Primary Health Care teams (PHC teams or Multi-Disciplinary Team (MDTs)

The central attributes of Primary Health Care are: First contact (accessibility), longitudinally (person focused, preventative and curative overtime), patient center comprehensive care and coordination (referral towards secondary and tertiary level). The World Health Organization resolution on Primary Health Care (2009) reiterates the importance to reorganize disease- or heath problem specific (vertical) actions through comprehensive (Horizontal) Primary Health Care. The focus of this is to train and retain adequate numbers of health workers, with appropriate skill mix, including primary health care nurses, midwives, clinical officers, allied health professionals and family physician, able to work in a multidisciplinary modus in cooperation with community health workers in order to respond effectively to people's needs.

The role of front line workers like Primary Health Care teams/multidisciplinary teams is important in the delivery of quality health care. They will work to promote wellness, provide services, respond to health needs of the population and work with other sectors and are the principle entry route health services from the community to other levels of care.
The PHC team/ MDT model shall deliberately deploy HRH to the primary health care level and further ensure that adequate staffing and the required mix of health disciplines is readily available over time. The MDT will be comprised of staff in primary health care services that will provide services suitable to

the different geographical landscape and socio economical and cultural population. The emphasis is on the provision of multimodal suite of interventions tailored to the local context, while at the same time working to improve the broader health of the community

The composition of multidisciplinary teams (MDTs) should adapt to the specific characteristic of the system and the community.

The MDT shall be charged with responding to the community health needs in its identified population (the primary health care zone) in which the link CHUs lie. The MDT will plan community outreach/ in reach activities in response to the community needs and disease burden. The MDT will also work with the CHVs to ensure appropriate referral of clients from the community unit to the link PHC Facility. The MDT shall also refer clients who need specialized care to the secondary level health facilities. To facilitate the MDTs work, additional support including provision with appropriate means of transport and mobile medical kits will be required.

The MDT will be led by a Family Physician; in the absence of which a specialist such as the Physician or Pediatrician will suffice.

Key health personnel in the MDT are;

- Medical Officer
- Clinical Officer
- Pharmaceutical officer/ technician
- Nursing Officer/ Community health nurse
- Public health officer/ technician
- Nutritionist/ Dietician
- Health Promotion Officer
- Health Records and Information Officer
- Laboratory and Imaging specialist

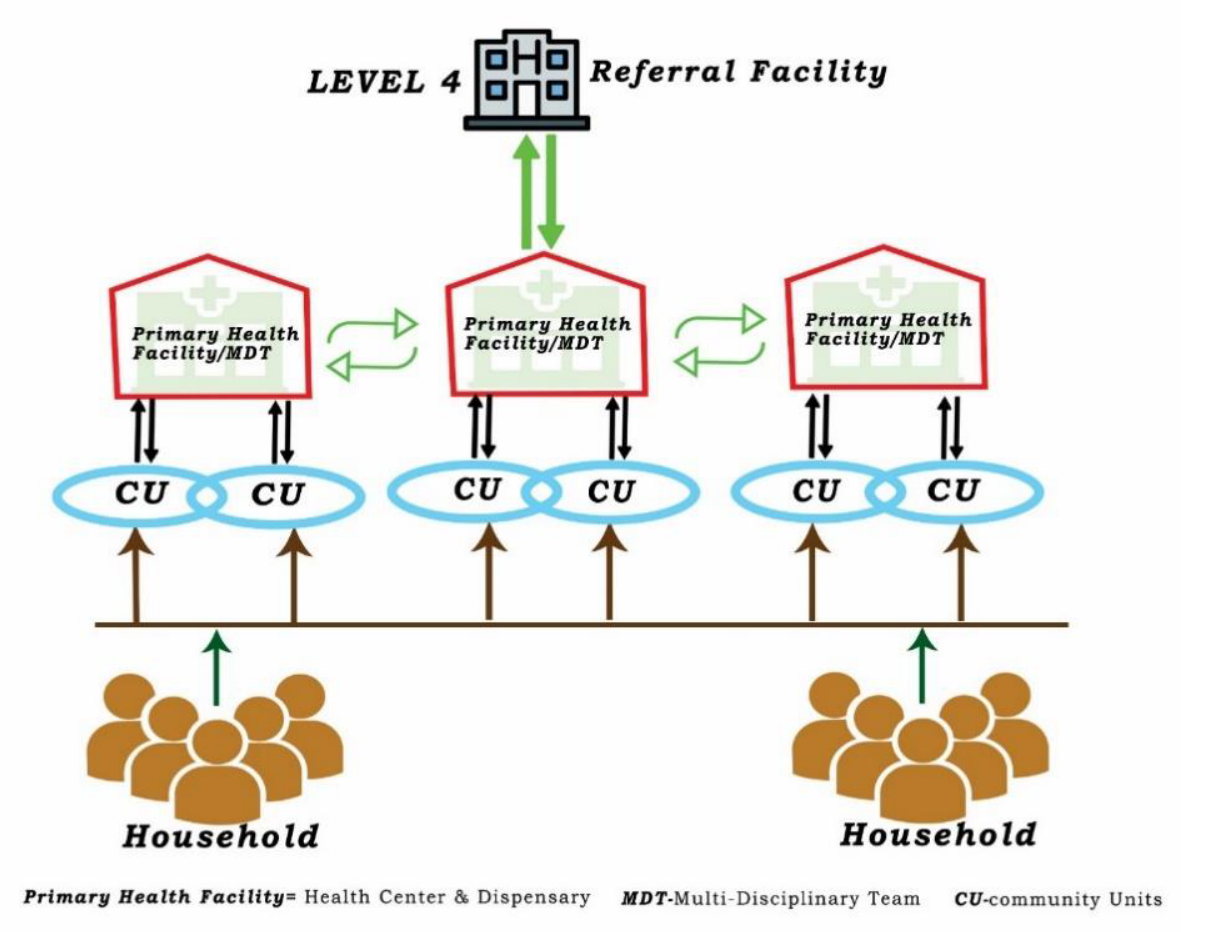


Figure 9: Multi disciplinary Team Model

Community Midwifery and Nursing homes

Midwives are the primary providers of care in many ANC settings (1). In Midwifery Led Community Care (MLCC) models, a known and trusted midwife (caseload midwifery), or small group of known midwives (team midwifery), supports a woman throughout the antenatal, intra-partum and postnatal period, to facilitate a healthy pregnancy, childbirth, and healthy parenting practices

In midwife-led care, the emphasis is on normality, continuity of care and being cared for by a known, trusted midwife during labour. Midwife-led continuity of care is delivered in a multi-disciplinary network of consultation and referral with other care providers.

This model requires that well trained midwives are available in sufficient numbers for mothers throughout pregnancy and during childbirth. It may therefore require a shift in resources to ensure that the health system has access to a sufficient number of midwives with reasonable caseloads.

To implement this model, the National and County governments should consider training of practicing midwives and scaling up the number to create an enabling environment for CHVs and CHEWs as frontline personnel for linkage of mothers to other PHC services. This model should be considered for implementation in hard to reach counties/ regions with high perinatal and maternal mortality

Polyclinics

These are medical centers/clinics or health care facilities that provide both general and specialist examinations and treatment for a wide variety of diseases and injuries to outpatients

Polyclinics are a "one-stop shop" health care facility where various health disciplines are in place. The polyclinic aims at ensuring access to primary health care services and they are ideal in densely populated areas such as slums and urban regions. Polyclinics can refer to each other (horizontal referrals) depending on various circumstances like availability of specialized cadre or proximity to each other. This suits very well in urban and highly populated sets ups.

Mobile clinics and Outreaches services

Making health services readily available and make accessible to nomadic, migrating and hard to reach population in areas outside the areas covered by the statics health facilities

General practitioners (GPs)

General practitioners or GP can be contracted by the government and private institutions to cover or take care of specific population in a defined area with a defined referral system.

4.1.3 Primary Health Care Commodities and Infrastructure

A solid primary health care system requires functional systems that ensure sustainable and equitable access to essential commodities, equipment and infrastructure to facilitate administration of first line and preventive treatment, access to timely and early diagnosis of conditions as well as the referral of cases to higher level facilities for further specialized attention.

A Standard a package of essential commodities, equipment and infrastructure need to be readily available to provide primary health care services for the implementation of PHC model in the Country

4.2. Governance and Leadership for Primary Healthcare

4.2.1. Primary Health Care Institutionalization and Co-ordination

To implement the Kenya PHC Strategy, there will be urgent need for restructuring, reorganizing and strengthening of institutions and organizations at both levels of government involved in health service delivery and financing to ensure that the proposed Primary Health Care governance, service delivery reforms and financing strategies are in place with full instruments of administration that further strengthen sustainability of PHC in the Country.

This strategic framework realizes that effective partnership, governance, stewardship and regulatory frameworks are the main vehicles through which set targets can be achieved. It allows all health sector stakeholders to collaborate and coordinate their actions, recognizing each one's specific responsibilities. The Governance obligations are outlined in the Country's legal framework. It is therefore necessary that operations be harmonized and aligned to the current Constitution. The renewed emphasis on primary health care calls for dedicated and strengthened coordination at both National and County levels. There already exists a functional health system management and coordination structures for the PHC strategic plan to leverage on.

Primary Health Care is the key driver for achieving UHC.

The PHC Strategic Framework together with UHC national roadmap form the platform for a coordinated effort by implementing partners in the Health sector. Therefore, at National level, PHC Department shall be housed in the MOH, Directorate of Medical Services, and Preventive & Promotive Health Services. At county level, the County health management teams will coordinate implementation through the incorporation of PHC explicit targets and interventions in Annual Operational Plans (AOPs). A PHC coordinator shall be appointed to lead the implementation of the framework at County and Sub County Levels.

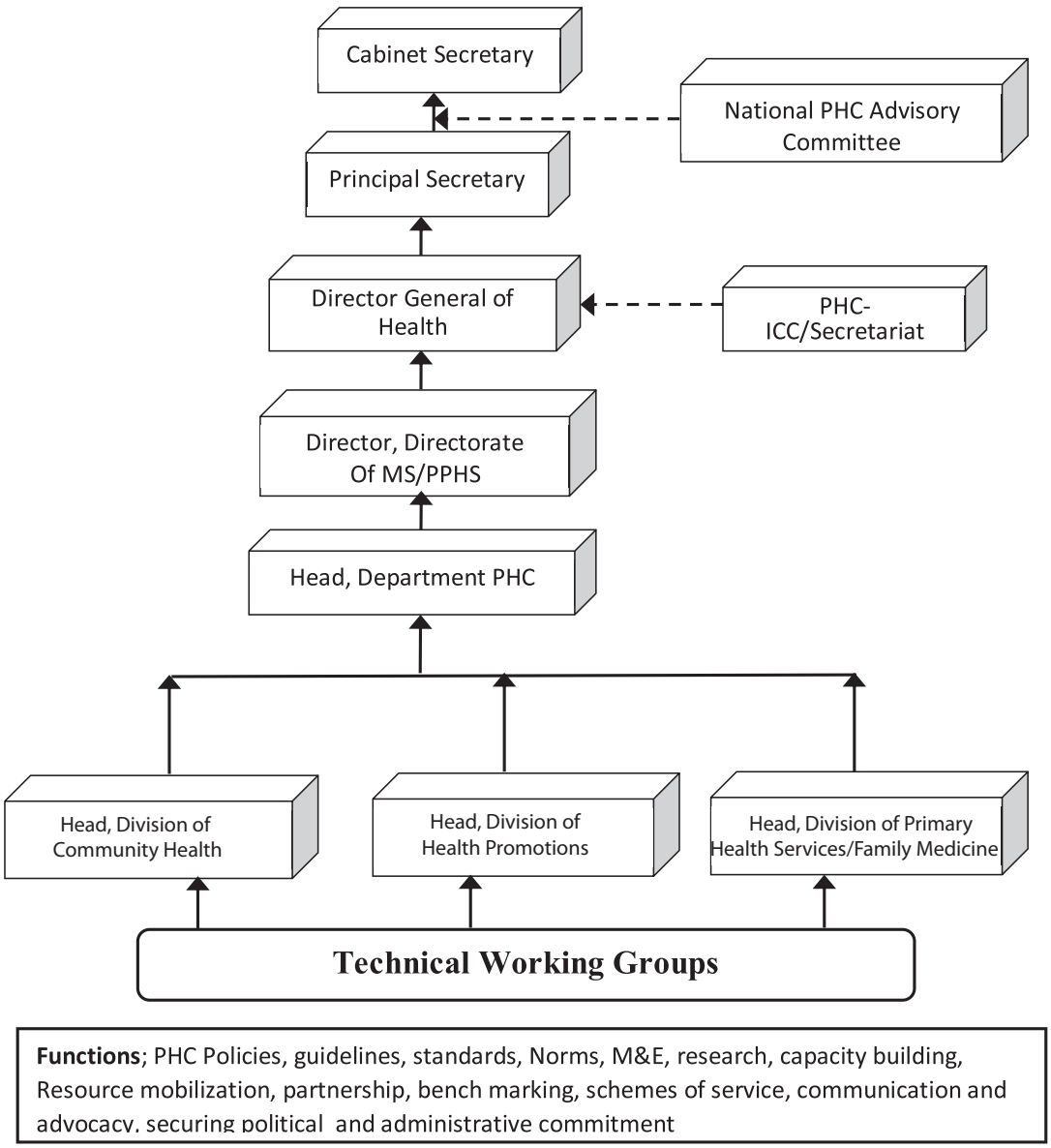
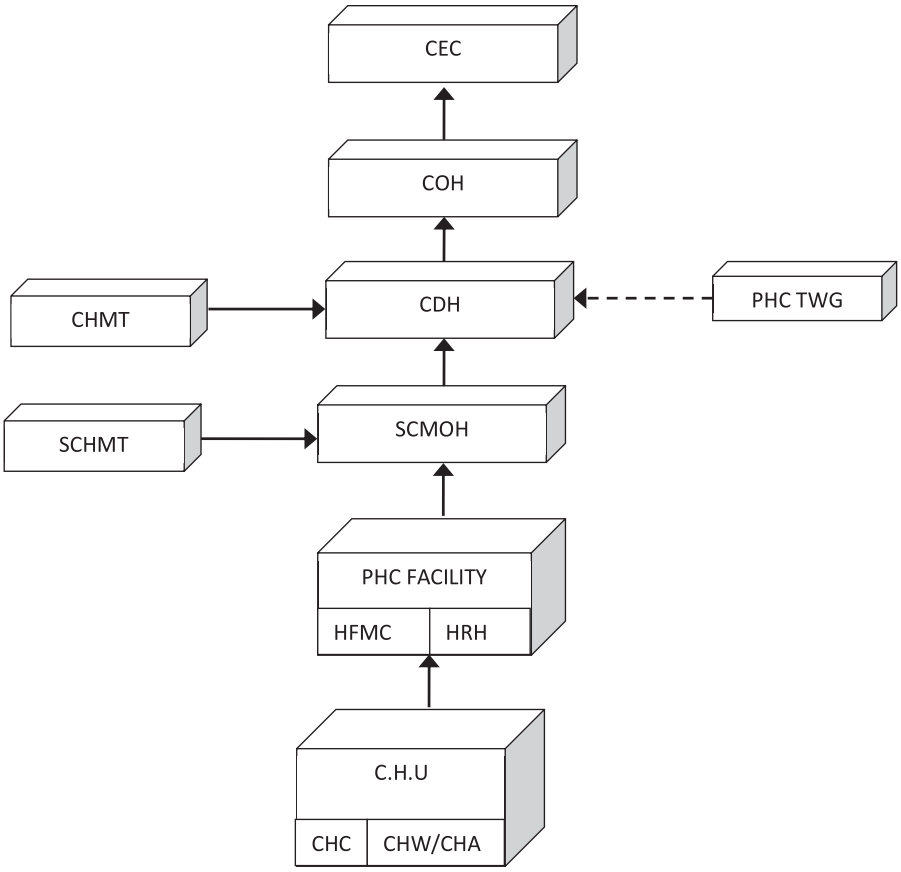


Figure 10: National PHC Structure



Functions; Resource mobilization, health facility services, community health services, community engagement advocacy, M&E, capacity building of staff, supervision, bench marking, partner coordination, infrastructure development, personnel matters, supply chain management, securing political and administrative commitment

Figure 11: County PHC Structure

Note: The PHC coordinator will be appointed by the CEC as advised by the CDH. The primary purpose of the PHC coordinator is to strengthen the integration of all PHC components. The PHC coordinator at the County will be reporting to the County Director of Health responsible for PHC matters. The PHC Coordinator will be coordinating all PHC matters relating to community level and primary health care facilities. There shall be a community health focal person at the sub county who will be answerable to the SCMOH/ SCPHC coordinator and will take charge of all PHC matters at community and PHC facilities level.

4.2.2. Inter-sectoral collaboration

One of the key principles of PHC is inter-sectoral collaboration and should be emphasized amongst key stakeholders in health sector such as agriculture, water, industry, education, housing , works etc .

Primary Health Care is the foundation of an effective national health system. To attain the desired health outcomes, concerted efforts of the primary, secondary and tertiary levels of health care are necessary.

4.2.3. Community participation and engagement

Communities are not only recipients of health services but also a critical part of decisions making organ about their own health. Utilization of health services depends strongly on community ownership which comes through community participation. Alma-Ata declaration identified community participation as the process by which individuals, families and communities assume responsibility for their own health and welfare, and develop the capacity to contribute to their community development (WHO-UNICEF, 1978). Community participation in terms of needs identification and implementation should be encouraged at all level of service delivery through creation of community health committees.

4.2.4. Health partnerships

Creation of a strong health partnership framework is key in provision of a successful PHC system The non-public health sector is a key player in primary health care policy formulation, services provision, monitoring and evaluation. Currently a big proportion of the population obtains health care services from nonpublic health sector and therefore the need to strengthen and sustain health partnerships. This will be achieved through ensuring active partner involvement in decision making and implementation processes.

Table 5: Stakeholders Roles and Responsibilities

National Ministry of Health	• Oversee and facilitate the implementation of the PHC services initiative • Complete, disseminate and operationalize the PHC implementation framework • Regular review meetings at national and county levels to monitor progress in implementation of the PHC framework • Strengthen HRH • Define and implement an integration package for each level of health care system to ensure the PHC packages are implemented at all levels • Streamline and strengthen supply chain management of PHC commodities, laboratory support • Develop policies and strategies for task shifting with appropriate supervision and support mechanism to ensure quality, safety and equity. • Strengthen Community health Strategy, • Strengthen health promotions on PHC activities • Standardize and harmonize the scope of work for CHWs and other lay cadres, including link to facilities and inclusion of NGOs/CBOs to support PHC • Roll out a communication strategy for PHC. • Resource mobilization • Strengthen M& E frameworks
MOH Program Units	• Advocacy and Resource mobilization • Preparation of information use plans • Monitoring of the implementation
County Government Department of Health	• Service delivery • Infrastructure development • Regular review meetings at county levels to monitor progress in implementation of the PHC framework • Define and implement an integration package for each level of health care system to ensure the PHC packages are implemented at all levels • HRH matters • Advocacy and Resource mobilization • Supervision • Partners collaboration • Implement Community health Strategy • Implement health promotions on PHC activities • Implement communication strategy for PHC. • Preparation of work plans • Monitoring of the implementation
Other Line Ministries	They Include: Planning and National Development; Finance; Public Service; Education; Youth and Sports; Information and Communication; Gender; Office of the President; Urbanization and Housing; Works; Roads; Home Affairs; Agriculture; Water; Special programs **Roles:** • Policy coherence • Joint Advocacy and Resource Mobilization • Human Resource Management and Development • Infrastructure and sustainable financing for PHC
Development Partners	• Provide Technical oversight to the PHC services initiative • Influence policy formulation and implementation • Resource mobilization for PHC services • Monitoring and evaluation of the PHC services initiative
Implementing Partners and Civil Society Organization	• Support implementation of the PHC initiative at different levels-national, sub national and at health facilities • Monitoring progress of the PHC services initiative • Advocacy, communication and social mobilization • Resource mobilization for PHC services
Community health workers and informal caregiver	• Advocacy, social mobilization and resource mobilization • Service provision • Program Development Input
Training Institution and referral facilities	• Research and Evidence-Based Interventions • Pre-service and In-service training of HW on PHC and improved service delivery
FBOs, Private facilities and organizations	• Implementation of PHC services • Public-Private partnership
Media	• Advocacy and communication

4.3. Financing for Primary Health Care in Kenya:

4.3.1. Resource Mobilization for Sustainability

Leverage of efficiency gains and advocate for adequate, predictable and structured funding to support primary healthcare service delivery.

Counties are at liberty to pick any of the proposed models or come up with their own based on their socio-demographic and economic dynamics.

The Financing model for PHC will consider the ultimate goals of UHC which are:

1. Access
2. Quality
3. Financial protection and
4. Equity

In order to come up with a comprehensive financing model there are three aspects that need to be considered:

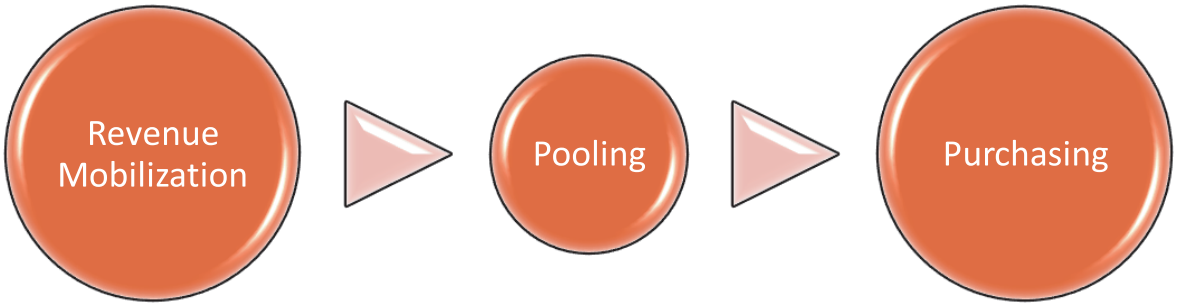


Figure 12: Financing model structure

The financing model for PHC services looks into three key areas of health financing:

- Resource mobilization: This deals with mobilizing resources required to provide the primary health services
- Resource pooling: Mobilized resources are managed by different institutional units (financing agents), who make decisions about where the funds will be allocated to
- Purchasing health services: This involves purchasing the defined PHC benefit package from public health providers

4.3.1.1. Revenue Mobilization

The current sources of funding for health in Kenya are:

- Out of pocket payments (OOP)
- User fees
- Government
- Donor funds
- NHIF contributions from the formal and informal sector
- Private insurance

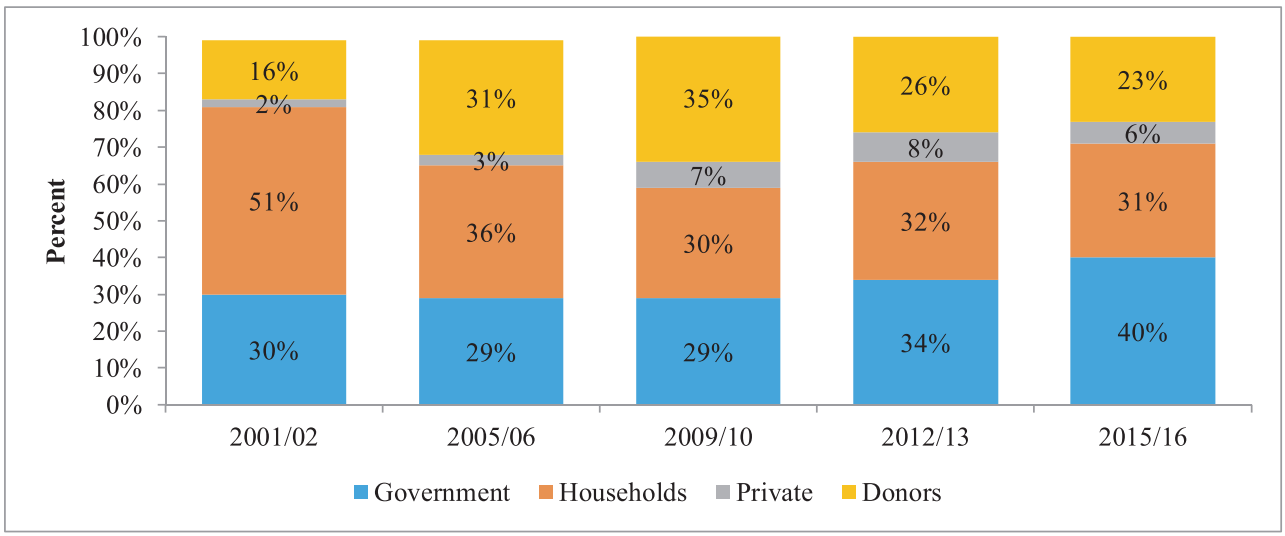


Figure 13: Sources of health financing in Kenya
(Source: National Health Accounts (Ministry of Health, 2017)

4.3.1.2. Proposals for revenue mobilization for PHC services

1. The system needs to focus less on health insurance as the answer for UHC/PHC due to the informal nature of employment
2. The system needs to rely more on funding from government taxes to fund PHC services:
   - This is shown to work in developed countries with better health indicators: UK, Norway, Finland
   - Treasury should gradually increase allocation from the current 6% towards the Abuja declaration of allocating 15% of the government budget, with the increase being targeted mainly to PHC
   - Earmark part of sin taxes and Sports Funds for PHC (Tobacco, Alcohol and Gambling/ betting)
   - Advocate for review of the PFM act (2012): Funding for healthcare should be "ring-fenced" specifically to health and not less than 35% of the county budget. At least 25% of county health budget should be sent to facilities directly from exchequer.
3. Copayments by individuals
   - Retain the copayment system for specialized PHC services since copayments minimizes waste but special groups in the community are exempted (children under 5 years, pregnant mothers, those 60 years old and above) Other countries have retained this system e.g. UK and Norway
4. Development partners' contribution should support integrated health services and public health functions. Partners should direct funds to one ring-fenced pool e.g. Rwanda. To operationalize this, MOH shall establish a Donor Project Implementation and M & E unit at the Ministry of Health. Adequate consultations with donors need to take place and inculcate in the pooling system a self-monitoring, automatic electronic systems which are temper proof - Rwanda has implemented this system
5. Establish a conditional grant for counties tied to performance (performance/outcome based budget)
   - Establish a matching fund at county level contribution of 25% of health funds to PHC. – Justification to include then how the government should match funds
6. Institutionalize Community PHC zones or CUs income generating activities to raise funds to facilitate community PHC and other related activities, e.g. green houses for horticulture,

community livestock auctions, community water vending, community H/hold goods wholesalers and retailers, etc.; each advised by community participation and resource mobilization at all levels

4.3.1.3. Resource Pooling

Pooling is important for cross subsidization. The current pooling mechanism in the country

- Linda mama
- Civil servants' scheme
- Super cover
- HISP/ social protection
- Secondary school scheme
- County schemes
- Vertical programs by Partners
- Private insurance
- CBHI schemes

NHIF

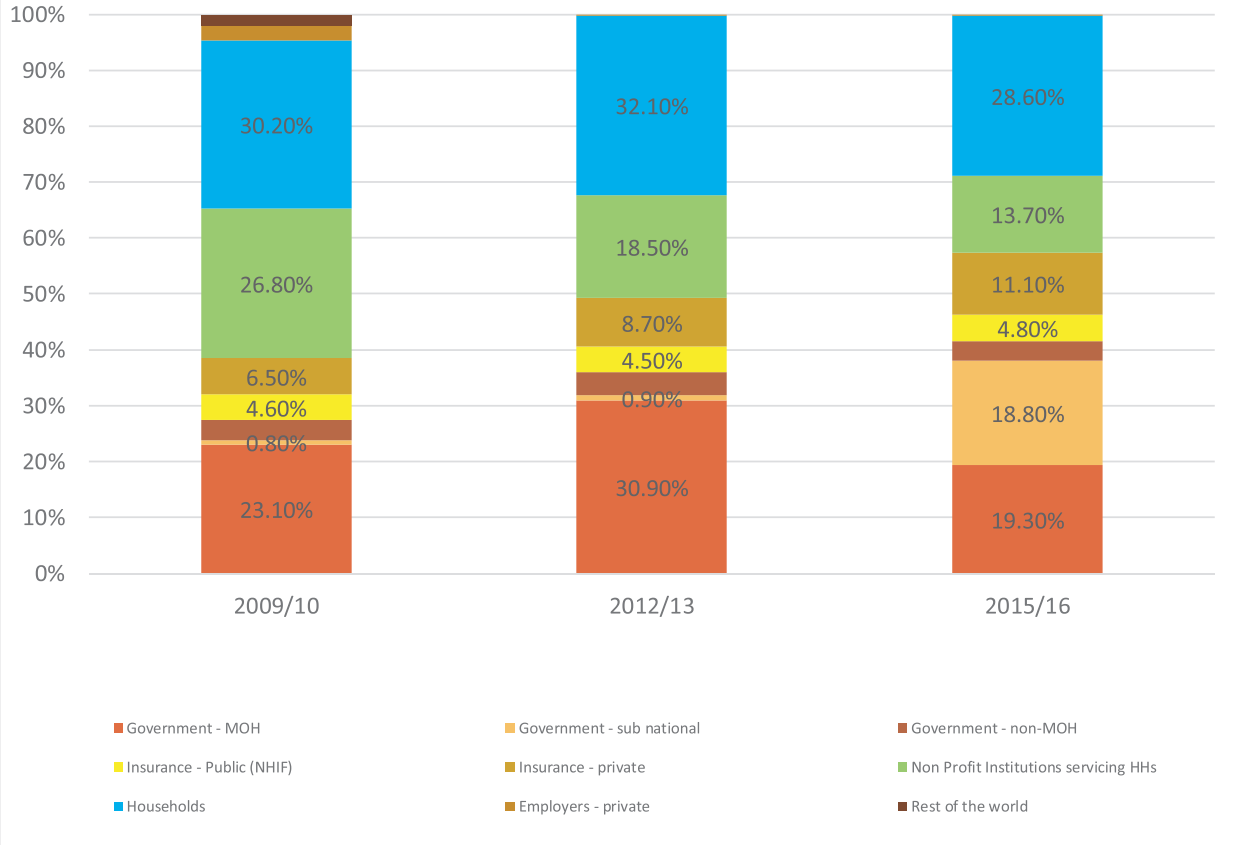


Figure 14: Manager of current health expenditures in Kenya, 2009/10 to 2015/16
Source: National Health Accounts (Ministry of Health, 2017)

4.3.1.4. Proposals for pooling mechanisms for PHC services

1. Review NHIF's mandate from hospitals/health facility based to cover all health providers (to cover preventive and promotive services-the pillars for PHC)
2. Minimize pools since they are cost effective and easier to manage
3. Pooling should remain both public and private: two scenarios
   - The county allocation for health (35% of county budget) goes to the NHIF pool, copayments stay in the facility (25% of FIF and NHIF should finance PHC services), donor funds go into the NHIF pool
   - The county allocation for health (35% of county budget) remains in the county, copayments stay in the facility (25% of copayments and county budget allocation should finance PHC services), donor funds go into a pool

4.3.1.5. Purchasing of health services

The current purchasing of health services in the country is:

- Capitation by NHIF
- Out of pocket payments by individuals
- User fees
- Government
- Private insurance

4.3.1.6. Proposals for purchasing

1. Provider payments should be tied to performance: develop the scorecard to measure performance to unlock funding for conditional grants
2. Strategic payments to PHC services e.g. pay more for Promotive and preventive services relative to other services
3. Pay higher rates for the lower level facilities to increase utilization: alternatively Pay same rates across all levels of care for PHC services
4. Strengthen the accreditation mechanism (inspection) to improve the quality of the services
5. Affirmative action for PHC workers in terms of remuneration for attraction and retention

Sustainable financing innovative approaches to support PHC

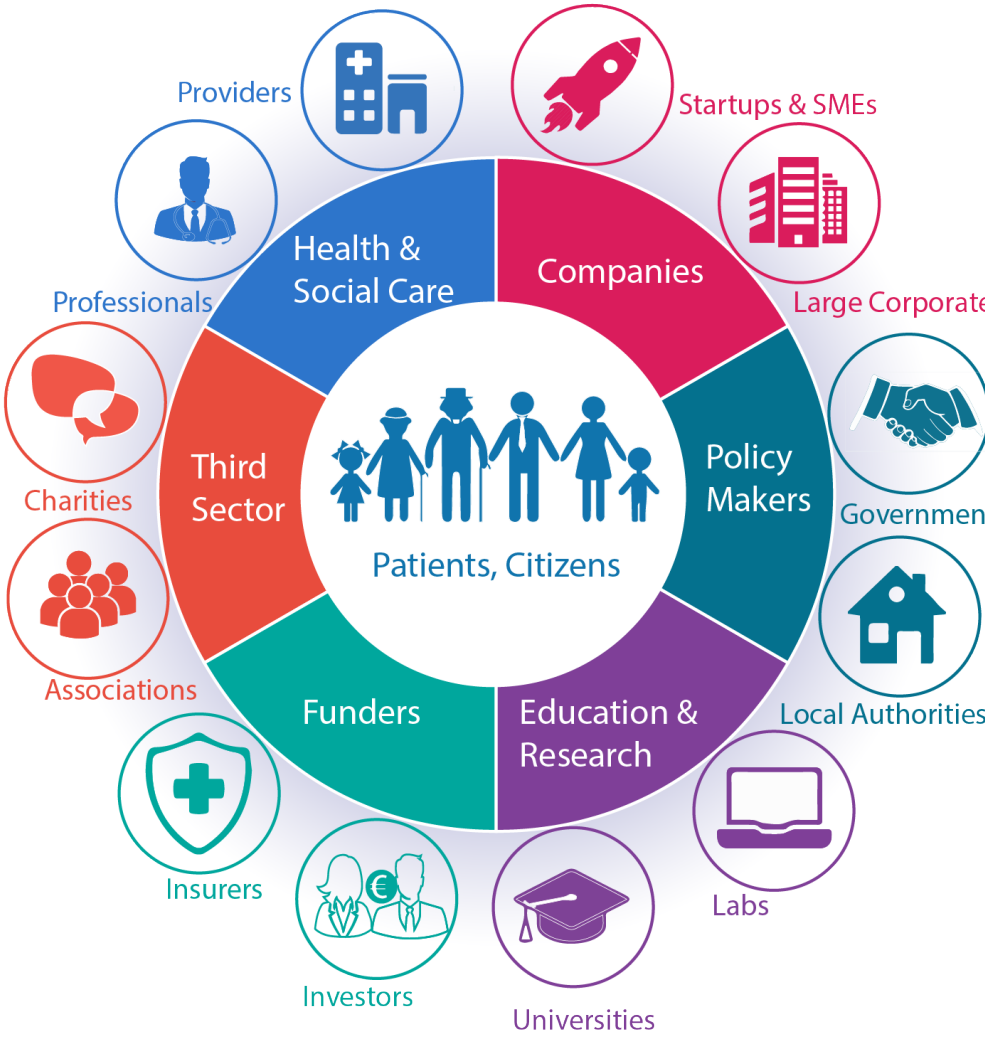
1. Create a pay for performance system against which payments can be made to CHWs and CHEW
2. Set up an entrepreneurship model to supplement the community health worker income
3. Additional resource mobilization through PPPs for all health building blocks

4.3.1.7. Benefits package design for PHC

The financing model for PHC will ensure that everyone is able to access PHC benefits package at all levels for free. If the first point of contact is level 4, having by passed the PHC facility, then the client shall be required to pay for services as per the institution's policy.

5 Implementation Plan

Primary Health Care



5.1 IMPLEMENTATION OF THE PHC STRATEGY 2019-2024.

The PHC Strategy shall be launched and all counties will be encouraged to adopt the approach and support to set up the sites within counties shall be provided by the national teams.
Sensitization on the PHC concept will be provided in all counties with an emphasis on the PHC models namely: multidisciplinary teams (MDTs), Family medicine, Community midwifery, mobile clinics, poly clinics) for the county specific contextualization. Key activities which shall take place throughout the entire implementation shall include:

1. Induction of Staff on PHC
2. Advocacy and Communication

5.1.1. Induction of Staff

An important aspect of the implementation phase will be completing of comprehensive induction for the human resource for health on the PHC concept. An adequate, well distributed, motivated and supported health workforce is required for strengthening PHC and progressing towards universal health coverage. The main aim of inducting this teams will be to ensure institutionalization of the PHC concept and its processes and the expected roles of staff. The Proposed models will require human resource for health as per the norms and standards.

5.1.2. Advocacy and communication

In addition, advocacy and communication will be provided to the health teams at all levels and the stakeholders. An advocacy and communication strategy will be developed with clear messaging targeting all groups. This is with a view of increasing awareness and improve buy in by all stakeholders on the need to support and prioritize PHC implementation.

5.2. Implementation steps

The implementation of the PHC concept will be conducted as outlines below:

5.2.1. Step 1: Setting up of PHC Coordinating Mechanisms

The PHC coordinating mechanism will be responsible for governance and leadership of PHC. In order to ensure this, the following will be completed:

1. Operationalize coordination arrangements for PHC at National and County level
2. Formation of Joint intersectoral implementation teams at National and County level
3. Development of PHC Implementation Guidelines

5.2.2. Step 2 Feasibility and Early Adoption

This step will include the following:
Feasibility and PHC service readiness assessment in counties

a) Review current PHC implementation in the counties.
b) Review capacity of counties to deliver PHC.
c) Review of legal, regulatory and financing frameworks at National and County levels to initiate PHC reforms

This review will be done against a standardized tool that will assess all the dimensions of the PHC across the Strategic direction domains and other additional information. A comprehensive report with key actionable recommendations will be drafted for adoption and implementation. PHC Strategy shall then be mainstreamed in fiscal budgetary processes including annual work planning

5.2.3. Step 3: Setting up of PHC Implementing Mechanisms

1. Definition of the PHC essential health service package
2. Development of the PHC Implementation tool kit. This will include a checklist of resources (financing, infrastructure, commodities, basic equipment, HRH, and PHC services) which need to be in place in order to implement effective PHC services. It shall also include work plan and budget templates, reporting templates, guidelines for teams' composition and roles for implementing PHC at different levels. The counties shall be guided by these documents and shall adapt them to their specific settings.
3. Formation of Multi-disciplinary teams and Setting up Primary health care networks in the Counties

5.2.4. Step 4: Setting up of PHC Learning sites

As counties are implementing PHC strategy, specific sites in counties shall be purposively selected as learning sites for PHC. This shall comprise of sites in both current UHC pilot and non-pilot counties. There shall be close monitoring, evaluation, documentation of lessons learnt and sharing to enable implement lessons learnt to other counties.

5.2.5. Step 5: Monitoring and documentation of PHC implementation.

Monitoring and evaluation shall be continuous to ensure the primary health care services are provided as per the essential benefits package. Regular support supervision, evaluations and quality audits shall be done to ensure the quality of health services is maintained. There shall be frequent stake holder engagement meetings to address emerging gaps and share best practices.

5.2.6. Step 6: Evaluation and Analysis of PHC Strategy Performance in the Learning sites

Quarterly county performance PHC evaluations shall take place to review progress in the counties and shall be consolidated into a national report. This shall be shared in stakeholders' consultative meetings to address the challenges experienced in the PHC implementation. The successes, lessons learnt, and innovations shall also be shared to improve performance across counties. This shall be done quarterly in the counties and bi- annually at the national level.

The existing tools, guidelines and structures used in the initial steps shall be regularly updated as per the findings in the ongoing implementation process.

5.3. Implementation Matrix

Key (N-National, C- County, B-Both)

Intervention	Activities	Responsible party	Years				
			2019/20	2020/21	2021/22	2022/23	2023/24
Leadership and Governance: Strategic Direction 1: Secure and strengthen political/leadership commitment to achieve the Primary Health Care targets							
Strategic Objective 1.1: Prioritize Primary Health Care as a political agenda for Universal Health Coverage							
Launch and disseminate a Kenya Primary Health Care Strategy 2019-2023.	Hold two prelaunch meetings	B	x				
	Hold a national launch breakfast meeting with key stakeholders	N	x				
	Dissemination meetings for national stakeholders	N	x				
	Hold 10 regional multi-sectoral dissemination meetings	N	x				
	Hold county level multi-sectoral dissemination meetings	C	x				
Advocate for legislation of relevant PHC policies, laws and regulations	Hold quarterly stakeholders meeting	B	x	x	x	x	x
	Hold two meetings with legislatures to discuss enabling legislative frameworks	B	x				
	Review existing guidelines including training manuals to accommodate PHC component	N	x	x	x	x	x
	Print and Disseminate guidelines for PHC providers	N	x	x	x	x	x
Advocate for PHC agenda at all levels	Hold retreats to develop policy and guidelines for mainstreaming PHC into governance and management	B	x	x	x	x	x
	Hold stakeholder workshops to validate the policies and guidelines	B	x	x	x	x	x
	Disseminate policies and guidelines to all stakeholders through MOH circular	B	x				
Incorporate PHC into existing governance and management structures	Accessibility mapping and desk review of existing PHC services	N	x	x	x	x	x
	Establish healthcare governance structure with prominence to PHC at national and county level	B	x	x	x	x	x
Establish multi-sectoral PHC Governance Advisory Council and committees	Review & Strengthen the function of health management & committee's guidelines of 2002	N	x				
	Enforce compliance to the health facility management committee guidelines	N	x				
	Strengthen stewardship role of the health ministry in respect of non-State actors	N	x				
Objective 1.2 Promote good governance, management and administrative accountability in PHC							
Provide policy guidance to Primary Health care providers	Sensitization of PHC providers on policy	N	x				

Intervention	Activities	Respon-sible party	Years				
			2019/20	2020/21	2021/22	2022/23	2023/24
Strengthen community participation in health policy formulation and decision making in health care	Conduct PHC Advocacy and policy forums	B	x				
	Conduct 10 regional stakeholders forum to give feedback and make appropriate decisions	B	x	x	x	x	X
Strengthen the function of health Facility and Community management committees	Conduct trainings for committees based on needs identified in the facility and community unit assessment report	B	x				
	Gazette the committees	B	x				
Strengthen multi-sectoral collaboration for Primary Health Care	Conduct national semi-annual stakeholders forum	N	x				
	Conduct semi- annual stakeholders forum in the 47 counties	C	x	x	x	x	X
Human Resource for Health: Strategic Direction 2: Build a strong workforce for health services at all PHC levels							
Objective 2.1: Build capacity of health work force to provide quality, efficient and effective service delivery at all PHC levels							
Work with HRH on a result based framework for PHC services	Develop result-based framework for HRH for PHC services	N	x				
Use tools e.g. the WLISN - Work Load Indicators of staffing Needs "full time equivalent" tool to assess the staff needs and staffing levels per facility	Create the posts of the required health care workers	B	x				
Hire and deploy adequate health workforce in all PHC levels in line with the existing norms and standards	Identify HRH gaps – conduct a HRH gap analysis	B	x				
	Develop county specific HRH management plans to address the gaps	C	x	x	x	x	x
	Update iHRIS to include PHC including in cooperation of level 1	C	x	x	x	x	x
	Training health care workers on the essential PHC package	C	x	x	x	x	x
	Advertise the posts	C	x	x	x	x	x
	Shortlist the applicants	C					x
	Conduct interviews	C	x	x	x	x	x
	Appoint successful applicants	C	x	x	x	x	x
	Deploy the appointed health work force	C	x	x	x	x	x
Capacity build health workforce in all PHC levels to ensure adequate skills to deliver quality services.	Induction of the newly appointed health workers	B	x				
	Carry out a training needs assessment	B	x	x	x	x	x
	Develop sensitization/training package on the role of MDTs in the delivery of PHC services	B	x	x	x	x	x
	Training of the national PHC strategy trainers of trainers (master trainers)	N	x				

Intervention	Activities	Respon-sible party	Years				
			2019/20	2020/21	2021/22	2022/23	2023/24
	Supervision of health care workers on PHC services	B	x	x	x	x	x
	Provide job aids and other IEC materials	B	x				
Operationalize the scheme of service for Community Health Workers/personnel at all levels	Advocate for the implementation of the CHWs scheme of service	B	x				
	Adhere to the CHW scheme of service in the recruitment	B	x				
	Review CHW scheme of service	B	x				
	Sensitization on HRH for PHC to CoG and county executives including county assemblies	B	x	x	x	x	X
	Periodic review and assess performance of county HRH	B	x				
Develop guidelines for establishment and management of MDTs for providing PHC services	Convene PHC working group to develop concept, ToRs for guiding the development of guidelines for establishment and management of MDTs	N	x	x	x	x	X
	Sensitize CHMTs/SCHMTs on the need for establishment of MDTs	B	x	x	x	x	X
	Develop guidelines for establishment and management of MDTs through workshops and retreats	B	x	x	x	x	X
	Convene stakeholders meetings for validation of the guidelines for establishment and management of MDTs	B	x	x	x	x	X
	Disseminate the guidelines for establishment and management of MDTs	B	x	x	x	x	X
	Distribute the guidelines for establishment and management of MDTs	B	x				
Objective 2.2 Provide mechanisms to ensure availability of ethical and skilled health workforce for the delivery of Primary Health Care services at all levels							
Advocate for health workforce pre-service training on customer care	Sensitize the training institutions of health workers to include pre-service training on customer care	C	x	x	x	x	X
Advocate for the induction for human resource for health on ethics, integrity and customer care	Induct HRH on ethics integrity and customer care	B	x	x	x	x	X
	Identify champions on ethics and integrity	B	x	x	x	x	X
	Link the champions with health care workers	B	x	x	x	x	X
	Monitor the mentorship progress	N	x	x	x	x	x
Engagement with the health sector learning institution to include in their curriculum the PHC concept (work ethics, discipline and training on health needs and not diseases only)	Meetings with health sector learning institutions	N	x				
Promote mentorship for enhancing skills and competencies for ethical delivery of services	Meetings to develop mentorship guidelines and networks	N	x				

Intervention	Activities	Respon-sible party	Years				
			2019/20	2020/21	2021/22	2022/23	2023/24
Enhance the function of regulatory authorities for ethical delivery of PHC services	Identify the relevant regulatory authorities	B	x	x	x	x	x
	Sensitize the relevant regulatory authorities on their role in PHC services	B	x	x			
	Involve the regulatory authorities in the implementation of PHC services	B	x	x	x	x	x
Objective 2.3 Institute performance management and performance contracting							
Introduce performance contracting to the health workforce at all PHC levels	Develop PHC performance contracts	B	x	x	x	x	x
	Sign the performance contract with the health workforce	B	x	x	x	x	x
	Monitor performance of the health workforce	B	x	x	x	x	x
Implement the health act and establish HRH professional oversight authority to address industrial actions	Meetings held with health unions and HRH professional authority	N	x	x	x	x	x
Capacity building of health workforce on performance contracting	Sensitize the health workforce on the contracts at KSG	B	x		x		x
Link the performance contracting to reward and sanctions	Reward or sanction based on performance	B	x	x	x	x	x
Streamline paying salaries for the health work force undergoing training	Meetings held with relevant parties	N	x	x	x	x	x
Service Delivery: Strategic Direction 3: Institutionalize and improve service delivery at all PHC levels							
Objective 3.1 Increase the access to functional community units available to provide PHC services							
Utilize the facility and community unit assessment report to address identified gaps to improve capacity for PHC service provision.	Establish community health units in areas with no CHUs to increase coverage	C	x	x	x	x	x
	Ensure all CHUs are functional-provide CHV kits	C	x	x	x	x	x
	Develop incentives for the maintenance of CHVs	C	x	x			
	Develop IGAs among CHVs for their sustainability	C	x	x			
	Operationalize the scheme of service for community health workforce	C	x	x			
	Conduct community dialogues	C	x	x	x	x	x
	Hold joint health facility/community meetings (governance meetings, management meetings e.t.c)	C	x	x	x	x	x
	Joint health facility community planning	C	x	x	x	x	
	Conduct action days (e.g. outreaches)	C	x	x	x	x	x
	Conduct regular review meetings between CHWs and Facility teams	C	x	x	x	x	x

Intervention	Activities	Responsible party	Years				
			2019/20	2020/21	2021/22	2022/23	2023/24
	Conduct assessment using the PHC Assessment tool to identfy gaps in providing PHC (involves training teams on the tools, actual data collection, compiling reports of assessmnet, designing improvement plans and disseminating findings and next steps to the teams for implementation)	B	x	x	x	x	X
	Provision and implementation of full package of PHC for all levels (skilled and adequate HRH, supplies and equipment and other support)	C	x	x	x	x	x
	Mobilize resources for capacity improvement on PHC service provision	C	x	x	x	x	x
	Design and adopt a data dash board to collect PHC data	C	x	x	x	x	x
	Train the CHEWs and other users on the data collection tools	C	x	x	x	x	x
Counties to provide resources to support implementation of PHC	County planning meetings	C	x	x	x	x	x
Engage partners in their contributions (pooling resources) in the support of PHC services	Conduct stakeholders engagement meeting	C	x	x	x	x	x
Objective 3.2: Increase demand and utilization of primary health care services							
Organize routine county and wards PHC stakeholders/communities advocacy forums, media engagement with the local vernacular station	Conduct advocacy meetings	B	x	x	x	x	x
	Advertisements	B	x	x	x	x	x
Expand and increase coverage of CHUs to provide PHC services	Mapping of CHUs in the area	C	x	x	x	x	x
	Employment of CHEWs	C	x	x	x	x	x
	Annual Functionality assessment	C	x	x	x	x	x
Engage community initiatives to create demand for PHC interventions and build leadership and community ownership.	Identify community groups and resource persons	C	x	x	x	x	x
	Sensitize the communities through the community groups on the availability of PHC services	C	x	x	x	x	x
Strengthen linkages between facilities and communities through community health fora	Sensitize the community through community health fora on availability of PHC services in health facilities	C	x	x	x	x	x
	Facilitate the registration of community members to the health facilities	C	x	x	x	x	x
	Sensitize the community on the available referral mechanisms	B	x	x	x	x	x
Leverage on ICT for information, education and communication	Identify the available IEC materials for community sensitization of PHC	N	x				

Intervention	Activities	Responsible party	Years				
			2019/20	2020/21	2021/22	2022/23	2023/24
	Identify the appropriate ICT channels for communication	C	x				
	Develop and package the IEC materials according to the target audience	B	x	x	x	x	x
	Disseminate the IEC materials through the appropriate ICT channel to the community	C	x	x	x	x	x
Defined populations, individuals, families should be mapped/registered to a particular Multidisplinary team (MDTs) to increase utilization PHC services	Conduct national mapping	B	x				
Assign defined individual, families and communities to specific MDTs (to take care of their health and not their "sickness")	Constitute MDTs and assign households to MDTs	C	x	x	x	x	x
Visits by MDTs to designate homesteads as advised by the CHVs	Conduct home visits	C	x	x	x	x	x
Objective 3.3: Ensure provision of high-quality primary healthcare services							
Institutionalize and operationalize Kenya Quality Model for Health and other Quality Improvement initiatives at all PHC levels	Sensitize the PHC management team on KQMH and QI	B	x	x	x	x	X
	Disseminate KQMH and other relevant QI initiatives	B	x				
	Build capacity of health facility managers and HCPs including community level	C	x				
	QI team formation for managers and Work Improovement Teams (WITs) for service providers	C	x		x		x
	Conduct regular assessments (Internal and external)	B	x	x	x	x	X
	Establish a recognition mechanism (star rating system)	N	x	x	x	x	x
Ensure mechanisms are in place for gauging client satisfaction and enabling response(service charters, client exit surveys etc.)	Provide service charters at all PHC service delivery points	C	x	x	x	x	X
	Develop customer feedback mechanisms	B	x	x	x	x	X
	Develop client satisfaction tools (exit interviews, community scorecards, suggestion boxes and other dashboards including anonymous hotlines)	C	x	x	x	x	X
	Conduct client satisfaction checks	C	x	x	x	x	X
	Analyze the customer feedback and take the necessary action	C	x	x	x	x	x

Intervention	Activities	Responsible party	Years				
			2019/20	2020/21	2021/22	2022/23	2023/24
Objective 3.4: Strengthen emergency preparedness and response system							
Strengthen coordination of health surveillance, emergency, disaster preparedness and response at all PHC levels	Provide mechanisms for surveillance of any PHC related events (SOP development)	N	x	x	x	x	x
	Conduct surveys to establish the level of emergency response	N	x	x	x	x	x
	Prepare disaster preparedness response plan and costing	N	x	x	x	x	x
	Conduct drills to establish the level of disaster preparedness and response	B	x	x	x	x	x
	Link PHC response team with the other disaster response teams	B	x	x	x	x	x
Institutionalize and strengthen integrated health surveillance, outbreaks, epidemic preparedness and response at the community PHC levels	Provide mechanisms for surveillance of outbreaks and epidemics of PHC related events	B	x	x	x	x	x
	Conduct surveys to establish the level of outbreak or epidemic	B	x	x	x	x	x
	Prepare outbreak and epidemic preparedness and response plan	B	x	x			
	Link PHC response team with the other outbreak and epidemic response teams	B	x				
Promote, coordinate a multi-sectoral approach to emergency and disaster response in every county	Sensitize the county management from different sectors on the need for multi-sector approach to emergency and disaster response	B	x	x	x	x	x
	Provide mechanisms for coordinated multi-sectorial response	B	x	x	x	x	x
Objective 3.5: Strengthen the referral system at all PHC Level							
PHC service centers to be the first referral point of entry	Provide mechanisms for the referral in PHC services	B	x	x	x	x	x
	Set the criteria for downward referral – should be in the KEPH---curative division and programs. E.g. well controlled NCDs, – Revise the criteria for upward referrals to ensure on the justified case get referred to higher levels of care	N	x	x	x	x	X
Build capacity of service providers on referral mechanisms	Train PHC services providers on the referral mechanisms	C	x	x	x	x	X
Strengthen referrals and linkages between public, FBO and private facilities	Sensitize all the health care providers on the available referral mechanisms	C	x	x	x	x	X
	Engage FBO/Private sector facilities for partnership in PHC (including referrals)	B	x	x	x	x	X
	Catalogue the capabilities of FBO/Private hospitals and develop a referral strategy (defining when to refer and which cases to refer)	B	x	x	x	x	x
	Sensitize communities and PHC facilities on available referral services in FBO/facilities in their locality	C	x	x	x	x	X

Intervention	Activities	Responsible party	Years				
			2019/20	2020/21	2021/22	2022/23	2023/24
	Engage with NHIF to cover participating FBO/private sector facilities for referrals	C	x	x	x	x	X
	Provide the necessary referral mechanisms between PHC public facilities, FBOs and Private facilities	C	x	x	x	x	X
	Build the capacity of health care workers to manage patients referred downwards	C	x	x	x	x	X
Objective 3.6: Strengthen access to health services for vulnerable populations							
Improve linkages between facility-based rehabilitation, palliative care and the community	Provide referral mechanisms from the community to the facility based rehabilitative and palliative care services	C	x	x			
	Disseminate guidelines for community palliative care	C	x	x	x	x	X
Increase the number of community rehabilitation centers	Sensitize the management on establishment of community rehabilitation centers	C	x	x	x	x	x
	Advocate for establishment of community rehabilitation centers	N	x	x			
	Train health care providers on community based rehabilitation	C	x				
Strengthen home based care	Sensitize CHVs and MDT on home based care	C	x	x	x	x	x
	Provide referral mechanisms for home based care from PHC facilities	C	x	x	x	x	x
	Provide essential supplies to the CHVs and other home-based caretakers	C	x	x	x	x	x
Develop a health promotion framework for vulnerable groups	Convene PHC working group to develop concept, ToRs for guiding the development of health promotion framework for vulnerable groups	B	x	x	x	x	x
	Develop health promotion framework for vulnerable groups through workshops and retreats	B	x	x	x	x	x
	Convene stakeholders meetings for validation of the health promotion framework for vulnerable groups	B	x	x	x	x	x
	Disseminate the health promotion framework for vulnerable groups	B	x	x	x	x	x
Objective 3.7: Mainstream alternative medicine in the PHC framework							
Identify practitioners in alternative medicine and their services	Sensitize the county management on alternative medicine and their services	N	x	x	x	x	x
	Develop tools for identification of the practitioners in alternative medicine and their services	N	x	x	x	x	x
	Collect the data on the practitioners in alternative medicine and their services	B	x				x
	Prepare report on the practitioners in alternative medicine and their services	C	x	x	x	x	x
Capacity build practitioners in alternative medicine to support service delivery for PHC	Train the identified practitioners in alternative medicine on the importance of PHC and their roles in PHC	C	x	x	x	x	x

Intervention	Activities	Responsible party	Years				
			2019/20	2020/21	2021/22	2022/23	2023/24
Health Financing: Strategic Direction 4: Enhance Financing for Primary Health Care **Objective 4.1 Mobilize and Invest adequate resources in Primary Health Care**							
Increase domestic financing for PHC through innovative taxes regimes.	Hold 3 workshops to develop PHC domestic resource mobilization strategy	N	x				
	Conduct 1 national and 4 regional forums to disseminate resource mobilization strategy	B	x	x	x	x	x
	Conduct 3 retreats to develop legislative framework for local taxation in support of PHC	N	x	x	x	x	x
	Conduct 47 primary health care financing advocacy meetings	B	x	x	x	x	x
Develop and disseminate PHC resource mobilization strategy at National and county levels	Hold 8 TWG meetings to develop financial management guidelines for PHC	N	x				
	Disseminate guidelines through MOH circular	N	x				
Develop health care financing guidelines for PHC.	Draft proposals for review of PFM Act to allow for ring fencing of PHC funds	N	x	x	x	x	X
	Hold 4 quarterly breakfast meetings with Parliament to discuss ring fencing of PHC funds	N	x	x	x	x	X
Establish a structure for health economics at national and county level	Recruit 47 Health Economists	B	x	x	x	x	x
Increase domestic financing for PHC through innovative tax regimes	Develop county legislative mechanisms for innovative tax regimes	B	x				
Allocate adequate resources to improve access to primary health care services based on the country context	Advocate for adequate resources to improve access to PHC services based on the country context	B	x	x	x	x	X
Objective 4.2: Expand health insurance coverage in-line with UHC aspirations							
Advocate for NHIF scheme to align its strategies with the PHC needs and principles	Conduct 3 meetings to develop a uniform service package for PHC and UHC	N	x	x	x	x	x
	Conduct 4 quarterly meetings with private health insurance schemes to finance PHC	N	x	x	x	x	x
Increase private health insurance schemes coverage for PHC services	Conduct 1 meeting to advocate for review of the NHIF scheme in order to align with the PHC needs and essential package	N					
Advocate for community-based health insurance schemes	Conduct regular meetings to advocate for community-based health insurance schemes	C	x				
	Conduct 2 workshops and recruit a consultant to development of a comprehensive national health care financing policy	N	x				
Objective 4.3: Establish innovative financing mechanisms at both levels of Governments to secure sustainable domestic financing for PHC							
Establish a county-based healthcare financing scheme for PHC	Develop and maintain county PHC financing scheme	B	x	x	x	x	x

Intervention	Activities	Responsible party	Years				
			2019/20	2020/21	2021/22	2022/23	2023/24
Scale up sustainable innovative community health and income generating activities to compensate community health workforce	Conduct meetings to advocate for scale up of sustainable innovative community health and income generating activities to compensate community health workforce	C	x				
Strengthen results-based financing for PHC	Conduct 8 regional trainings on results based financing	N	x				
	Conduct county annual results based financing review meetings	C	x	x	x	x	x
Objective 4.4: Enhance financial planning, budgeting, management and accountability							
Design an appropriate mechanism for planning and budgeting.	Conduct 2 meetings to harmonise planning and budgetting tools	N	x	x	x	x	X
Facilitate capacity development of the primary health care management time	Conduct 8 regional trainings on planning and budgetting	N	x				
Establish financial reporting feedback mechanism	Develop a dashboard for financial reporting	N	x				
Commodity supply and infrastructure: Strategic direction 5: Improve systems for the supply chain, medical devices and infrastructure.							
Objective 5.1: Optimize the supply, distribution and use of drugs and commodities							
Advocate for the update of the Essential lists (Medical, medical lab supplies and reagents, health products and technologies to include Community level) for the improvement of PHC services	2 Advocacy meetings for a standing budget line for nutrition commodities and equipment and increased allocation for procurement and distribution of nutrition commodities at national and county level	N	x				
	Disseminate the Essential Medicines List to counties and all health facilities	C	x				
Advocate for local production of commodities, vaccines and supplies	Pre-qualification of local producers to increase the production base	C	x	x	x	x	X
	Partnerships to strengthen capacity of local producers	C	x	x	x	x	x
Scale up mechanisms and processes for forecasting and quantification of commodities and supplies	Refresh / build capacity of Forecasting and quantification teams	C	x	x	x	x	x
	Build capacity on LMIS	N	x	x	x	x	x
	Roll out LMIS	N	x	x	x	x	x
	Conduct annual forecasting and quantification exercise for all commodities	B	x	x	x	x	x
Strengthen the standards and regulations for procurement of commodities and supplies	Conduct a National assessment of the supply chain procurement system	N	x				
	Workshop to Develop/ review SOPs on procurement for integrated health commodities, supplies, medical equipment and allied devices	N	x				
	Disseminate SOPs on procurement for integrated health commodity and supplies	N	x				
	Conduct 1 Quality assurance missions annually	N	x	x	x	x	x
	Convene Bi annual stakeholders forum on supply chain	N	x	x	x	x	x

Intervention	Activities	Responsible party	Years				
			2019/20	2020/21	2021/22	2022/23	2023/24
Strengthen the tracking systems for storage and distribution of commodities and supplies	Develop/review SOPs for warehousing , storage and distribution of commodities and supplies	N	x	x			
	Conduct assessments on warehousing and distribution capacity of prequalified suppliers	B	x	x	x	x	x
	Conduct assessments on warehousing and distribution capacity of counties, sub counties and facilities	C	x				
	Optimize capacity for warehousing and distribution at all levels	C	x				
Strengthen systems for rational use of commodities	Develop SOPs on rational use of commodities	N	x				
	Dissemination of SOPs on rational use of commodities	N	x				
	Train health providers on rational use of commodities	N	x	x	x	x	x
Improve on monitoring evaluation and surveillance of commodities and supplies stock status through LMIS	Roll out LMIS across all facilities	C	x	x	x	x	x
	Conduct quality assurance missions annually	N	x	x	x	x	x
	Conduct annual audits at facility level	C	x				
	Conduct community level audits	C	x	x	x	x	x
	Hold review meetings on supply chain management	B	x				
Develop Quality improvement model for supply chain	Develop a score card for supply chain management	N	x				
	Dissemination of Score card	N	x				
	Orientation of teams on score card	N	x				
Objective 5.2: Promote rational procurement and placement of medical devices							
Facilitate the mapping of the status of medical devices for the delivery of PHC services	Develop a checklist for mapping medical and allied equipment	N	x				
	Conduct mappingof medical devices at facilities across tiers	N	x				
	Dissemination of mapping findings	N	x	x	x	x	x
Strengthen the procurement systems for medical devices	Bi-annual advocacy meetings for use of guidelines for procurement and rational use of medical devices	N	x	x	x	x	x
Strengthen the systems for rational use of medical devices	Form TWGs/ quarterly meetings to strengthen systems	N	x	x	x	x	x

Intervention	Activities	Responsible party	Years				
			2019/20	2020/21	2021/22	2022/23	2023/24
Objective 5.3: Improve infrastructure for delivery of PHC services							
Design an assessment mechanism for evaluation of the status of the health care infrastructure	Develop an integrated checklist for mapping PHC infrastructure at National and County level	N	x				
Determine the status of health care infrastructure for PHC services	Conduct PHC Infrastructure assessments at National and County level	N	x				
Advocate for improvement of the infrastructure for the delivery of PHC services	Development of a costed PHC Infrastructure improvement plan	B	x				
	Dissemination of costed PHC infrastructure improvement plan	N	x				
	Monitor implementation of the PHC Infrastructure improvement plan	N	x	x	x	x	x
Health information, technology and innovations: Strategic Direction 6: Improve the capacity to uptake data, research evidence and innovations for decision making							
Objective 6.1: Scale up use of digitized Health Management and Information System to increase utilization of PHC data							
Advocate for roll out of unique identification for all Kenyans for PHC services	2 Advocacy meetings for roll out of unique identification for all Kenyans for PHC services	N	x				
Create a database for monitoring and evaluating use of resources	3 meetings Development of National and county specific VSPs	N	x	x	x	x	x
	Dissemination of VSP profiles	B	x				
	3 Workshop meetings to develop PHC/UHC inputs and process dashboard and an action tracker	N	x				
	Integrate RMNCAH scorecard to include PHC outcome Indicators	N	x				
Strengthen KHIS to collect PHC quality data including event based reports	Development of minimum inputs/requirement/Standards for sustainable PHC county implementation- including quality standards Link to Service	N	x				
	Development of assessment/Monitoring and evaluation tools (including check lists) for PHC	N	x				
	Quarterly support and Monitoring and evaluation field visits	B	x	x	x	x	x
	Quarterly stakeholder progress review meetings	B	x	x	x	x	x
	Annual County and National PHC reports	B	x	x	x	x	x
	Annual National stakeholder progress review meetings	B	x	x	x	x	x

Intervention	Activities	Responsible party	Years				
			2019/20	2020/21	2021/22	2022/23	2023/24
Objective 6.2 Promote research agenda and use of routine data to improve PHC services							
Creation of a PHC Institute		N			x	x	x
Conduct research to document best practice, challenges and successes according to the PHC research agenda	2 day meeting to define PHC research agenda/priorities	B	x	x	x	x	x
	Conduct research on the identified priorities	B	x	x	x	x	x
Utilize research findings to inform policy formulation, programming and decision making	Conduct regional trainings on evidence to inform policy making	B	x	x	x	x	x
	Conduct selected science cafes on PHC	B	x	x	x	x	x
	Develop selected elevator pitches	B	x	x	x	x	x
	Develop policy briefs	N	x	x	x	x	x
Link PHC data and research to the existing Kenya Health Observatory	Generate and upload monthly PHC policy briefs in the observatory	N	x	x	x	x	x
	Sensitization and training on how to link PHC data and research to the existing MOH observatory	N	x				
	Conduct capacity building at county level on research and utilization of the findings	B	x				
Objective 6.3: Scale up successful innovations and technology to improve PHC							
Promote and equip tele-health in delivery of PHC by establishing functional tele-health hubs	Developing a criteria and requirements for establishing tele-health -2 day meeting	N	x				
	Select tele health hubs based on the identified criteria	N	x				
Planning and costing for establishment of telehub centers	Develop the criteria and requirements for establishing the centers of excellence	N	x				
	Mapping of potential tele hub centers	N	x				
	Planning and costing for equiping of telehub centers	N	x				
Promote interoperability among different health information systems	2 workshop meetings between HIS, LMIS, KEMSA, IHRIS	N	x				
TOTAL							

N- National C-County B-Both National And County level

6

Monitoring & Evaluation Framework

Primary Health Care

6.1. Rationale

A comprehensive M&E framework shall be the basis for:

- Guiding decision making in the Kenya Primary Healthcare Strategic Framework 2019-2024, by characterizing the implications of progress (or lack of it) being made
- Guiding implementation of services by providing information on the outputs of actions being carried out
- Guide the information dissemination and use by the sector amongst its stakeholders and with the public that it serves.
- Providing a unified approach to monitoring progress by different planning elements that make up the sector – national government, counties, programs, SAGA's, and others

6.2. Stewardship Goals

The overall purpose of the M&E framework is to improve the accountability of the PHC Strategy. This shall be achieved through a focus on strengthening capacity for information generation, validation, analysis, dissemination and use.

The stewardship goals for the PHC Strategy framework are:

a) Strengthening the PHC data architecture
b) Improving the performance monitoring and review processes for PHC
c) Enhancing sharing of data and promoting information use

6.3. Strengthening PHC data architecture

A common data architecture is needed to ensure coordinated information generation, data and information sharing and efficiencies are maximized in data and information management. M & E unit will carry the mandate of strengthening and overseeing the common data architecture. The health sector has identified sector indicators for monitoring and evaluating the implementation of Kenya Health Sector Strategic and Investment Plan 2019-2023 which will be used to monitor PHC services.

During the implementation phase the process indicators will be measured through routine monitoring using existing systems which shall need to be strengthened to assess the overall contribution of primary health care services to the overall health sector performance. The indicators mapped will measure inputs and processes, activities, outputs and outcomes and ultimately impact. These indicators are derived from the WHO 100 Core indicators and the Primary Health Care Vital signs profile and contextualized to the Kenyan context as shown in figure 15.

Input and Processes	Output	Outcome	Impact
Health financing and governance	**Service access and availability**	**Coverage of interventions**	**Health Status**
1 Total current expenditure on health as % GDP 2 PHC Expenditure as percent of Current Health Expenditure 3 PHC Expenditure per capita (USD) 4 Domestic government PHC expenditure % domestic government health expenditure 5 Activity and financial reports to track the progress 6 Domestic government PHC expenditure % PHC expenditure 7 Qualified PHC focal person at County & Sub county level 8 Availability of annual work plan for PHC 9 Number of quarterly expenditure review meeting done 10 Support supervision to PHC facilities 11 Public participation forums for health-related matters for social accountability 12 Facility Management committee 13 Quality Improvement Team	1 Percentage of households registered for UHC card 2 Population accessing PHC health services within 5km radius 3 Service utilization (DPT1, 1st ANC) 4 BEmONC and CEmONC availability and readiness 5 Availability of essential medicines and commodities 6 Facilities with functional labs as per basic min requirement 7 Functional CHUs 8 Coverage of CHU 9 Number of CHU that report on the household health data	1 Demand for family planning satisfied with modern methods 2 4th Antenatal care coverage 3 Skilled birth attendance 4 Care seeking for Pneumonia 5 Children with diarrhoea receiving oral rehydration solution 6 Vitamin A supplementation coverage 7 DPT3 Coverage 8 Antiretroviral Therapy (ART) Coverage 9 TB case detection rate 10 Number of people screened for hypertension / diabetes 11 Number of women screened for cervical cancer 12 Number of new referrals for ANC visits 13 Number of new referrals for immunization 14 Defaulter tracing for ANC clinic 15 Treatment Interrupters referred for management of TB 16 Number of community referrals made to a link facility	1 Life expectancy at birth 2 Under 5 mortality rate 3 Infant mortality rate 4 Neonatal mortality rate 5 Maternal mortality rate 6 TB mortality rate 7 HIV / AIDS mortality rate 8 Malaria Incidence rate 9 HIV Incidence rate 10 TB Incidence rate 11 TB notification rate 12 TB prevalence rate 13 % of Deaths from NCD's (Cardiovascular, Cancer, Diabetes, Chronic respiratory Diseases)
Infrastructure	**Service quality and safety**	**Risk Factors**	**Financial risk protection**
1 No. of PHC facilities per County 2 Population to PHC Facility ratio 3 Facilities with electricity 4 Facilities with water 5 Hospital bed density (Inpatient) beds per capita 6 Ambulance Per S/C for referral	1 Institutional maternal mortality ratio 2 Maternal death reviews done 3 ART retention rate 4 TB treatment success rate 5 Second line treatment coverage among MDR-TB cases 6 Malaria mortality rates in endemic regions	1 Exclusive breastfeeding rate 0-5 months of age 2 Stunting in children Under 5 3 % of households using improved sanitation facilities 4 % of households using improved safe water facilities	1 Out-of-pocket payment for health as a share of total current expenditure on health 2 Incidence of catastrophic health expenditure Incidence of impoverishment due to ODP

Health workforce
1 Health worker density and distribution per cadre

Health Information
1 Availability of reporting tools 2 Timeliness of reporting 3 Completeness of reporting in DHIS 4 Proportion of PHC services provided in PHC facilities 5 RDQA conducted quarterly 6 Data Review conducted quarterly

Figure 15: M & E implementation process indicators

6.4. Routine Data Collection and Management

This shall be done thorough existing data collection systems. Health Management Information System (HMIS) is used to collect health services delivery data. Currently, data is relayed from community, facility to county level using the monthly paper-based system where it is subsequently entered into a web-based HMIS portal. To enable measurement of PHC performance specifically, HMIS data will need to be disaggregated by level of facility to enable differentiation of data from the community services and primary health facilities from secondary and tertiary health facilities/services. Development of a PHC dashboard will be critical to monitor performance of PHC and use the visualization to communicate performance to the leaders. This will help promote data use for decision making.

Logistics Management Information System (LMIS) is used to collect commodities ordering, supply and utilization information from health facilities. Through the PHC strategic framework rollout, support will be provided to targeted counties and facilities to strengthen the LMIS system including the planned consolidation in KEMSA (Kenya Medical Supplies Agency).

Community-based Health Information System (CBHIS) is used to collect routine health interventions data at community level. Monitoring of community health strategies will be strengthened by ensuring adequate tools to the CHVs, and linkage to the health facility to ensure PHC data is from the CHWs is collected and relayed to the National level. Gaps have been noted in data collection at the community especially deaths occurring in the community. There is need to strengthen Civil and Vital Registration and Statistics and link this to community health data. There is need to strengthen reporting of private facilities to the KHIS to enable capture of all service delivery data in primary health care facilities.

Table 6: PHC Indicator Matrix

PHC Indicator Matrix

Expected Results	INDICATOR	Baseline 2017/18	2018/19	2019/2020	2020/2021	2021/2022	2022/2023	Data source	Frequency	Responsible person
Health Status	Life expectancy at birth	63			66		68	KDHS 2014	5 years	MOH/KNBS
	Under 5 mortality rates	52			45		40	KDHS 2014	5 years	MOH/KNBS
	Infant mortality rate	39			31		28	KDHS 2014	5 years	MOH/KNBS
	Neonatal mortality rate	22			17		15	KDHS 2014	5 years	MOH/KNBS
	Maternal mortality ratio	362			230		200	KDHS 2014	5 years	MOH/KNBS
	TB mortality rate	38			25		19	Annual WHO Global Report/	Annual	MOH/ WHO
	HIV/AIDS mortality rate	-								
	Malaria Mortality Rate	5.6			4.5		4	MIS 2015	5 years	MOH/KNBS
	% of deaths from NCD's (Cardiovascular, Cancer, Diabetes, Chronic respiratory diseases)	55			35		20	STEPS 2015	5 Years	MOH/KNBS/ WHO
	Cancer mortality Rate	3			2.6		2.5	DHIS2/STEPS 2016	Annual	MOH
	Mortality attributable to dietary risk factors (per 100,000)	41.5			26		26	GBD 2017	Yearly	
	Malaria incidence rate	166			150		130			
	HIV incidence rate	0.19								
	TB incidence rate	292			234		146	Annual WHO Global Report	Annual	MOH/ WHO
	Hypertension incidence rate (per 100,000)	2557	2853	2903	2953	3003	3053	KHIS	Monthly	MOH
	TB case notification rate (per 100,00)	171	192	200	207	207	210	TIBU	Annual	MOH
Financial Risk Protection	Out –of –pocket payment for health as a share of total current expenditure on health	31.5	25			15		NHA (2015/16)	3 years	
	Incidence of catastrophic health expenditure	4.9			2		2	KHHEUS 2018	5 years	

Outcome Indicators

	INDICATOR	Baseline 2017/18	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	Data source	Frequency	Responsible
Coverage of interven-tions	Demand for family planning satisfied with modern methods	53	N/A	N/A	65	N/A	N/A	KDHS	5 Years	KNBS/ MOH
	4th Antenatal care coverage	49	51	53	55	57	59	DHIS 2	Monthly	MOH
	Skilled birth attendance	59	65	67	70	73	75	DHIS 2	Monthly	MOH
	Children under five with diarrhea treated with ORS & Zinc	25	50	60	65	70	75	DHIS2	Monthly	MOH
	Vitamin A supplementation coverage	45%	46%	47%	68%	69%	65%	KHIS/Kenya Micronutri-ent Survey)	Monthly /Biennial)	MOH
	Penta 3/HIB/Hib coverage	80	83	87	90	92	95	DHIS2	Monthly	MOH
	Antiretroviral Therapy (ART) coverage Adult)	67	70	72	74	75	77	DHIS2	Monthly	MOH
	Antiretroviral Therapy (ART) coverage Children)	84	85	88	89	90	93	KHIS2	Monthly	MOH
	Proportion of diabetes cases attended at primary level facilities	59	63	66	69	72	75	KHIS	Yearly	MOH
	Proportion of hypertensive cases attended at primary level facilities	69%	65%	66%	6A%	67%	AB%	KHIS	Yearly	MOH
	% of women aged 15 –49 years screened for cervical cancer	89%	C5%	DB%	5B%	55%	4B%	STEPS	5 years	MOH
Risk Factors	Exclusive breast-feeding rate 0-5m (<6 m) months of age	48%	4C%	45%	46%	47%	6B%	KDHS	5 years	MOH/KNBS
	Stunting in children under 5	26	24	22	20	18	17	KDHS	5 Years	MOH/KNBS
	% of households using improved sanitation facilities	52	55	60	65	68	70	KMIS 2015/KDHS	5 years	MOH, KNBS
	% of households using improved safe water facilities	71	73	75	78	79	80	KMIS, KDHS,	5 years	MOH, KNBS
	% households with access to latrines	-								MOH,KNBS
	% households with adequate ventilation	-								MOH,KNBS
Wellness	Current tobacco users (men)	C9%	22	21	20	19	18	STEPS	5 Years	MOH
	Proportion of population with BMI >25	CA%	26	24	22	21	20	STEPS	5 years	MOH

Output Indicators/Access

Expected results	INDICATOR	Baseline 2017/18	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023	Data source	Frequency	Responsible
Service access and availability	Percentage of households registered by CHVs	-	60	70	80	90	100	KHIS	Annually	MOH
	Proportion of the population with 5 km to a health facility	62	69	75	82	88	95	Access modelling	Annually	MOH
	Utilization service (1 st ANC)	86.5	88	90	92	94	95	KHIS	Annually	MOH
	BMONC availability and readiness in PHC facilities	9	12	15	20	25	30	KHFA	Annually	MOH
	Proportion of facilities/(level 3) providing Cervical cancer screening(VIA/VILLI) (Offers cervical cancer diagnosis)	22	24	27	31	35	38	KHFA	Annually	MOH
	Average availability of essential medicines in PHC facilities	41	45	55	65	75	80	KHFA	Yearly	MOH
	Average availability of basic diagnostic tracer items in PHC facilities	45	50	55	60	65	70	KHFA	Annually	Access
	Proportion of level 4 facilities with mapped PCNs	-	-	-	30	50	70	County Data	Annually	Access
	Number of PCNs conducting at least 1 community health and promotion outreach	-	-	60	70	90	100	KHIS in future	Monthly	Access
	Proportion of community health units established	55	65	70	80	90	100	KMCUL	Annually	MOH
	Proportion of fully functional Community units	66	70	85	90	95	100	KMCUL	Annually	Access
	Percentage of community health units submitting timely information	61	65	70	75	80	85	DHIS	Monthly	MOH
Service quality and safety	Facility maternal mortality ratio	102	95	92	89	86	83	KHIS	Monthly	MOH
	Proportion of facility Maternal death review /audit done	80.4	82	85	87	90	94	KHIS	Monthly	MOH
	TB treatment success rate	83	90	90	90	90	90	TIBU	Quarterly /annual	MOH
	Satisfaction among FP clients (dispensaries)	79.7	82	84	86	88	90	SDI Survey/ Customer Satisfaction Survey	5 Yearly / Annual	MOH
	Adherence to clinical guidelines (Proportion of relevant history and examination questions asked by the provider, of those that should be asked)	43.5			55		70	SDI Survey/ Customer Satisfaction Survey	5 Yearly	MOH
	Diagnostic accuracy (Proportion of cases correctly diagnosed out of the number of patients examined, as observed through clinical vignettes on multiple common conditions)	67.5			75		90	SDI Survey/ Customer Satisfaction Survey	5 Yearly	MOH
	Proportion of rooms with all infection control items (Proportion of rooms (FP, sick child, ANC and NCD) where all infection control tracer items are present)	12			35		50	SDI Survey/ Customer Satisfaction Survey	5 Yearly	MOH
	Adequate waste disposal (Average score (out of 3) on adherence to standards for disposing of medical and hazardous waste, sharps, and having guidelines for waste disposal in place)	64			75		90	SDI Survey/ Customer Satisfaction Survey	5 Yearly	MOH

Input and Processes Indicators

	INDICATORS	2017/18 Baseline	2018/19	2019/20	2020/21	2021/22	2022/2023	Data source	Frequency	Responsible person
Health financing and Governance	Total expenditure on health as % of GDP	2.5(2015/16)	3	N/A	N/A	5	N/A	NHA	Annually	MOH
Health Financing	PHC expenditure as % of Current Health Expenditure	24.1	30	40	45	50	55	NHA	3 years	MOH
	Government PHC per capita health spending (US$)	$11.42			$18		$25	NHA	3 years	MOH
	Share of domestic government health spending allocated to PHC	9.6			15		20	NHA	3 years	MOH
	Domestic government PHC spending as % of current PHC spending	64			70		75	NHA	3 years	MOH
Governance	PHC focal person at County	-			47		47	PHC Survey	Annually	MOH
	Availability of county annual work plan for PHC	-			47		47	PHC Survey	Annually	MOH
	Activity and financial reports to track PHC progress (APR report)	-			47		47	PHC Survey	Annually	MOH
	Proportion of PHC facilities having external support supervision	97.4			99		100	PHC Survey/KHFA	Annually	MOH
	Counties with public participation forums for health-related matters for social accountability	-			47		47	PHC Survey	Annually	MOH
	Bi annual -National PHC Stakeholders engagement meeting	1			2		2	National APR report	Annually	MOH
Infrastructure	Population to PHC facility ratio (per 10,000 population)	1.1			1.3		1.5	KMFL	Annually	MOH
	% of Health facilities access to source of power	71	75	80	85	87	90	KHFA	3-5 Years	MOH/KNBS/WHO
	% of primary health facilities with access to source of improved water source	85	88	90	92	94	96	KHFA	Annually	MOH
	% of primary facilities with internet connectivity	22	27	32	37	42	45	KHFA	Annually	MOH
	% of primary facilities with accessible road network	-	50	55	60	65	70	Future KHFA	Annually	MOH
	Proportion of primary facilities with access to an ambulance for emergency referral services within 15 minutes	87	90	92	94	96	98	Joint Assessment Report 2018	2 years	MOH
	% of primary health facilities with a package of basic equipment by level of care	20.20	25	35	40	45	50	KHHFA /SDI	Survey	MOH

Input and Processes Indicators

	INDICATORS	2017/18 Baseline	2018/19	2019/20	2020/21	2021/22	2022/2023	Data source	Frequency	Responsible person
	basic equipment by level of care									
Human Resource	Number of clinical officers per 10,000 population	3	3.2	3.4	3.5	3.6	3.7	KHFA	Yearly	MOH
	Number of Nurses per population ratio (per 10,000 population)	10	11	12	12.5	13	14	iHRIS 2018/KHFA	Yearly	MOH
	Number of CHVs in the country	60850	72,021	85,266	90,534	95,802	101,070	KMCUL	Yearly	MOH
	Density of community health volunteers (per 5 000 population)	7.8	8	8.2	8.4	8.6	10	KMCUL	Yearly	MOH
Health Information	% of health facilities submitting complete information (completeness of reports)	89	85	88	90	93	95	DHIS 2/HIS	Monthly	MOH
	% of community units submitting complete information (completeness of reports)	69	73	77	80	83	85	DHIS	Monthly	MOH
	% of health facilities submitting timely information (timeliness of reports)	77	78	83	87	90	92	DHIS 2/HIS	Monthly	MOH
	% of community units submitting timely information (timeliness of reports 515)	61	65	70	75	80	85	DHIS	Monthly	MOH
	Proportion of PHC facilities conducting quarterly data review meetings	-	50	60	70	75	80	PHC Survey/ County Reports	Annually	
Person Centeredness	C lients who felt they were adequately informed by the health workers about their health and care, including examinations	-	50	55	60	65	67	PHC Survey Exit Survey/ future KHHEUS		
	facilities where physical environment allows privacy	86	87	89	90	92	94	KHFA (For mothers at PNC)		
	Health worker absenteeism rate in dispensaries	44.5	40	30	25	20	15	SDI		
	% of facilities offering youth friendly services (for victims of youth violence)	17	20	25	30	35	40	Survey - KHFA		
	% of women 15-49 who reported problem in accessing health care due to issues getting money for treatment	37			22		18	KDHS 2014		
	Percentage of women 15-49 who reported problem in accessing health care due to due to distance to health facility	23			20		18	KDHS		

6.5. Data Analysis

Information on indicators will be analyzed as per the PHC M&E Framework in the following lines
1) Overall national achievement
2) Disaggregation of achievement by;
   - County
   - Strategic direction
   - Strategic objective
   - By KEPH level

An annual Primary healthcare performance report will be developed. The report will be validated by stakeholders to: -
   - Obtain stakeholder insight on the information generated;
   - Mitigate bias through discussion of the information generated with key M&E actors and beneficiaries;
   - Generate consensus on the findings and gaps
   - Strengthen ownership and commitment to M&E activities

6.6. Improving the performance monitoring and review processes

The performance review process will be one of the learning mechanisms in Primary healthcare. For proper follow up and learning:

- All performance reviews and evaluations will contain specific, targeted and actionable recommendations, the process is outlined in the M&E framework and guidelines.
- All target institutions will provide a response to the recommendation(s) within a stipulated timeframe, and outlining a) agreement or disagreement with said recommendation(s), b) proposed action(s) to address said recommendation(s), c) timeframe for implementation of said recommendation(s).
- All the planning units and institutions will be required to maintain a recommendation implementation tracking Plan which will keep track of review and evaluation recommendations, agreed follow-up actions, and status of these actions.
- The implementation of the agreed actions will be monitored by the M and E unit at all levels. The CHMTs will provide coordination and oversight of performance review at the sub national levels while the M&E unit at the national level will oversee the recommendations implementation tracking plan of the county units. During the quarterly performance review meetings, the sub national management teams together with all the non-state and external actors in their area will discuss the quarterly performance review report and review the recommendations implementation tracking plan for the quarter and identify performance gaps which will be mitigated and action points taken down and followed up.

Methods of assessments

- Joint assessments at community, sub county and County level
- Data review meeting from community to national level
- Support Supervision

Modes of data collection

- Routine data
- Surveys
- Operational research
- PHC Evaluations (Midterm and end term evaluation)

6.7. Enhancement of sharing of data and promoting information use

Data will be packaged and disseminated in formats that are determined by the needs of the stakeholders. This will be used for their decision-making processes and investment decisions Annual state of health in Kenya Report

The health sector shall publish annually a state of PHC report which will be a compilation of statistical information from different sources presenting a snap shot of performance covering the different strategic objectives articulated in this strategic plan.

Annual Performance Review Reports

At all levels a performance review reports will be produced outlining the performance against the strategic objectives outlined in this plan. The reports will be discussed by the health management teams including all the stakeholders at the quarterly performance review meetings.

The discussion will focus on a review of the findings and the agreed action points. The finalized report will be submitted to the next level of reporting.

Annual Work Plan Report

This is the annual report documenting progress against the implementation of the AWP for all planning units at the different levels. The county AWP review report will be presented at a County Annual Health Review Summit and be published on the MoH Website. The Sector AWP Performance Review Report will be presented and discussed at the National Annual Sector Review Meeting. This forum will draw attendance from MOH national level, the county health management teams, SAGAs and CSOs, DPs and county implementers and other health related sectors etc.

Quarterly PHC reviews

Quarterly national review meetings on PHC within the UHC review meetings. Performance sharing in different leadership and management for an Innovation and Research During implementation, data and research evidence will be generated through operational research which in-turn will be used in formulation of policy, strategies, programming and legislation making In the implementation of PHC, young scientists shall be encouraged to incubate ideas which will result to new knowledge in improving technology. Such ideas will be subjected to intellectual property rights.

7 References

Primary Health Care

References

1. World Health Organization: Primary Health Care. Available at https://www.who.int/news-room/fact-sheets/detail/primary-health-care.
2. Available at http://www.wessexghnetwork.org.uk/resources/global-health-policies/international/primary-health-care.aspx.
3. Primary Health Care. Available at https://www.who.int/gho/publications/world_health_statistics/2018/EN_WHS2018_TOC.pdf?ua=1
4. Rifkin SB Alma Ata after 40 years: Primary Health Care and Health for All—from consensus to complexity BMJ Global Health 2018; 3:e001188.
5. Available at http://www.aho.afro.who.int/en/ahm/issue/14/editorial/health-systems-and-primary-health-care-african-region
6. Global Burden of Disease, Institute of Health Metrics (IHME), 2017. https://vizhub.healthdata.org/gbd-compare/.
7. Kenya National Bureau of Statistics. Economic survey, 2018.
8. Kenya Demographic and Health Survey (KDHS, 2014).
9. Medium term review of Kenya Health Sector Strategic and Investment Plan, 2016. Ministry of Health
10. National AIDS Control Council (2015). Kenya HIV Estimates Report, 2015. Nairobi: National AIDS Control Council.
11. UNAIDS. (2019). KENYA | 2017. Retrieved from Country Factsheets: http://www.unaids.org/en/regionscountries/countries/kenya
12. National Tuberculosis, Leprosy and Lung Disease. (2018). Annual Tuberculosis Report. Nairobi: National Tuberculosis, Leprosy and Lung Disease.
13. National Malaria Control Programme (2019). Kenya Malaria Strategy 2019–2023. Nairobi: Ministry of Health.
14. Ministry of Health (2015). STEPwise Survey. Nairobi: Ministry of Health.
15. GLOBOCAN 2018: Kenya Factsheet. Available at https://gco.iarc.fr/today/data/factsheets/populations/404-kenya-fact-sheets.pdf.
16. District Health Information System (DHSI2), 2018.
17. Global Conference on Primary Health Care, Astana, Kazakhstan, and October 2018.
18. Kenya Community Health Sustainable Financing and Certification Guidelines, MOH, 2019.
19. Global Conference on Primary Health Care, Astana, Kazakhstan, and October 2018; WHO guideline on health policy and system support to optimize community health worker programmes 2018.
20. Kenya Health Policy 2014–2030).
21. A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2018.
22. Declaration of Astana. Geneva: World Health Organization/United Nations Children's Fund; 2018.
23. Lopez AD, MC Ezzati M. Washington, DC: World Bank; 2006. Global burden of disease and risk factors. [Google Scholar]
24. United Nations Report, 2000. Millennium Development Goals

25. Databank.worldbank.org. (2018). World Development Indicators | DataBank. [online] Available at: http://databank.worldbank.org/data/source/world-development-indicators# [Accessed 20 Nov. 2018].

26. Great Lakes University of Kisumu (GLUK), 2018. Annual scientific conference report of July 2018

27. Hauge, S., 2016. Primary care in Cuba. Einstein Journal of Biology and Medicine, 23(1), pp.37-42

28. International.commonwealthfund.org. (2018). India: International Health Care System Profiles. [online] Available at: https://international.commonwealthfund.org/countries/india/ [Accessed 19 Nov. 2018].

29. Macinko, J. and Harris, M.J., 2015. Brazil's family health strategy—delivering community-based primary care in a universal health system. New England Journal of Medicine, 372(23), pp.2177-2181.

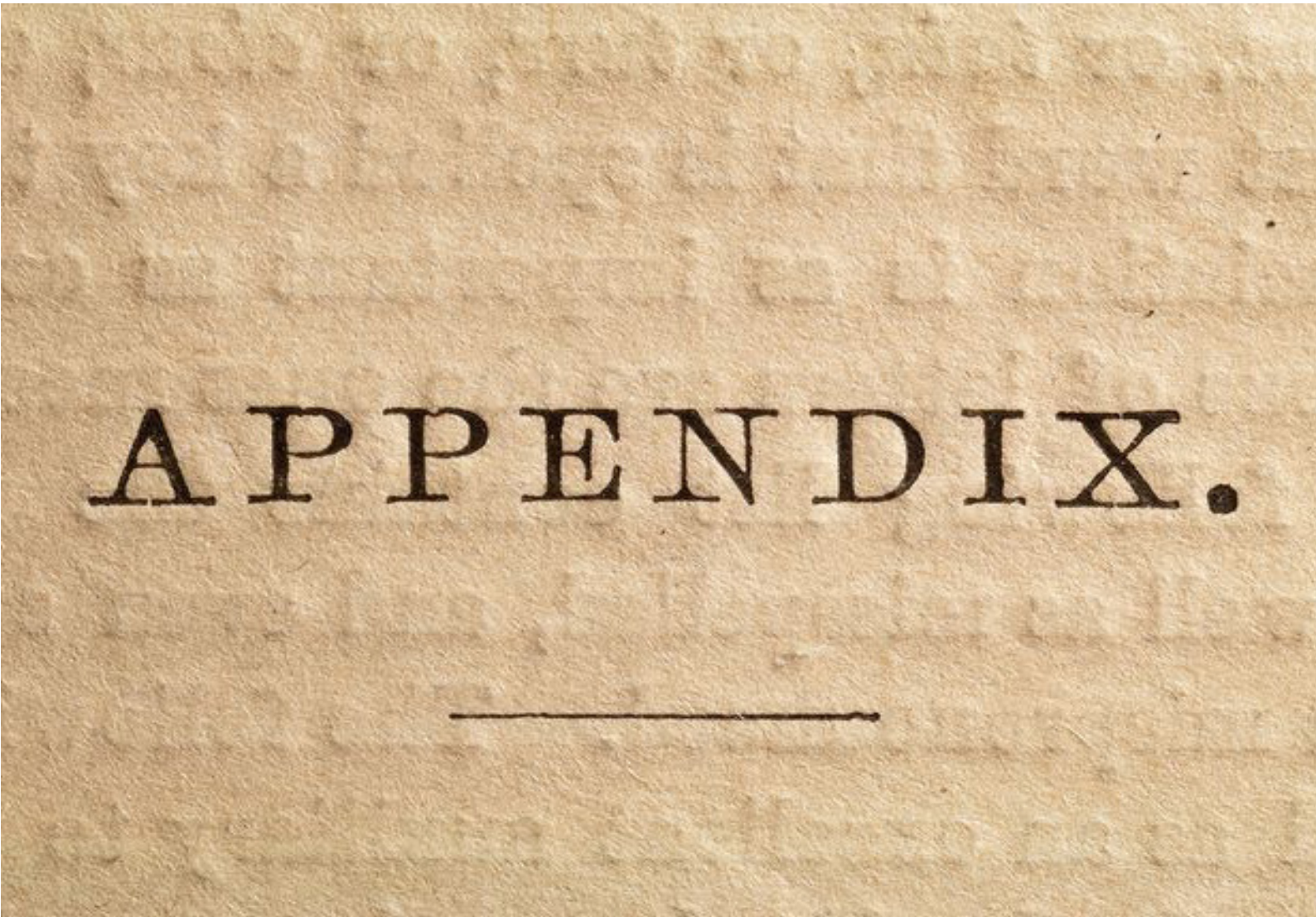
30. Primary health care systems (PRIMASYS): case study from South Africa, abridged version. Geneva: World Health Organization; 2017. License: CC BY-NC-SA 3.0 IGO.

31. WHO, 2015. World Health Statistics report. pg. 39-100

32. W. A. Haseltine, Affordable Excellence: The Singapore Healthcare Story (Brookings Institution Press, 2013).

8 Appendix

Primary Health Care



8.1. List of Contributors

Dr Mohamed Sheikh (MoH), Francis Ndwiga Benson (MoH), Dr. Salim Hussein (MoH), Dr. James Mwitari (MoH),Dr. Andrew Toro, Dr. Janette Karimi, Faith Githii (MoH), Nyokabi Njogu (MoH), Samuel Kiogora (MoH), Dr. Philip Muthoka (MoH), Alex Kisyanga (MoH), Dr. Kiio Ndolo (MoH) , Dr . Maxwell Lodenyo (MoH), Dr. Athanasius Ochieng (MoH), Leila Akinyi (MoH), Leonard Doyle (MoH), Dr. Eunice Gathitu (MoH), Beatrice Chelangat (MoH), Dr. Ibrahim Wako (MoH), Dr. Joseph Thigiti (Kenyatta University), Dr. Joy Mugambi (KAFP), Jackson Kimani (CHAI), Rosemary Kihoto (CHAI), Rajab Hamisi (CHAI), Dr. Frankline Keter (CHAI), Cecilia Maina (CHAI), Collins Cheruiyot (CHAI), Dr. Khadija Abdalla (UNICEF), Rose Njiraini (UNICEF), James Onsongo (KRCS), Dr. James Mukabi (PATH). George Oele (AMREF), Paul Ayalo (CCAK), Howard Akimala (Living Goods) Rosemary A Kombo (HENNET) Rachael Muthama, Nellius Nderitu, Robert Ngatia, Evans Omalla, Fredrick Oroko, Evans Obaga, Dr. Elijah Kinyangi, Dr Agatha Olago (MoH), John Wanyungu (MoH), Dr. Wangui Muthigani (MOH,), Dorcas Chelang'a (MOH), Dr. Emmanuel Tanui (MOH), Dickson Kioko (MOH), Caroline Gitonga (Philips), Dr. Athanasius Ochieng (MOH), Aisha Mohammed (MOH), Manasse Obwocha (MOH), Joh Gakenia (MOH), Moses Njatha (HealthIT), Dr. Valeria Makory (MOH)

The national coordination structures for PHC shall be guided by the Kenya Partnership and coordination framework. The Primary health care steering committee will be constituted within the Service Delivery, Quality Assurance & Human Resources Interagency coordinating committee.

8.2. The Kenya Primary health care advisory council

The purpose of the Primary Healthcare Advisory Council is to advise the Cabinet Secretary and Department of Primary Healthcare on implementation of the framework.

8.2.1. Mandates

1. Advise the Cabinet Secretary and Department of Primary Healthcare on primary healthcare matters
2. Advise the Cabinet Secretary and Department of Primary Healthcare on implementation of primary healthcare framework
3 Facilitate stakeholders review of the framework and implementation plan
4. Identify and make recommendations regarding framework implementation facilitators and barriers

8.2.2. Membership

1. Chairman - Shall be a person with strong understanding of Kenyan primary healthcare and shall be appointed by the cabinet secretary
2. Director General of Health – to be the alternate chairman
3. Head, Department of Primary Healthcare
4. CEO/ Head of secretariat
5. WHO Country representative
6. HENET Chief executive officer
7. One representative from the local Universities
8. Chair/Deputy of the Council of Governors
9. Representative from the leadership of religious organizations (2)
10. Representative from the civil society

8.3 The Primary Health Care Steering Committee/ Interagency Coordinating Committee

The purpose of the steering committee is to report to the PHC advisory council and various ICCs

in the health sector interagency steering committee for health on Primary health care

8.3 Mandate

- To strengthen coordination and harmonization among partners and stakeholders providing interventions at all levels. To monitor performance and ensure effective accountability of PHC services
- To mobilize resources and investment for PHC services
- To contribute to the development and review of policies, guidelines and strategies on PHC interventions.

8.3.2 Membership

1. Chair- DG Health, or designate
2. Head, PHC
3. Heads of Key designate departments and Divisions in MOH (10)

8.4. County primary healthcare advisory committee

The Committee shall be chaired by CEC with membership representation drawn from Religious Leaders, Women Rep, Youth Rep, PLWD Rep, Water Rep. Roads Rep, Agriculture Rep, Two reps from Implementing Partners. County Director of Health services (CHD) shall be the secretary. Coordination at the county will be done by the county secretary.

8.4.1. Mandates

Provide leadership and governance oversight in the implementation of PHC and related matters in the county.

1. Identify key PHC issues in the region that the committee will advocate and provide advice on.
2. Provide advice on other PHC issues from a regional perspective at the request health departments
3. Address consumers PHC issues, care coordination and innovative ideas for service delivery
4. To promote communications between health department, other stakeholders and the community.
5. Provide beneficiary input on departmental activities, policies, plans and projects at the individual, program, and organization and system levels in the county.
6. Propose further opportunities for consumer engagement that will promote PHC improvements in the county.
7. To work constructively to assist in addressing key PHC issues in the county.
8. To provide advice and/or input into PHC issues.
9. Advocacy on behalf of the diverse PHC users in the county, and are responsible for gathering the views of the residents/community they represent through their networks.
10. Fairly representing the views of the residents/community.
11. Provide feedback after meetings to members of the community
12. Provide leadership and advice in relation to the beneficiary and/or community views on PHC service delivery, planning and development in the relevant county.

8.5. Sub-county primary healthcare advisory committee

The Committee shall be chaired by a member elected from the team with membership representation drawn from Religious Community, Women Rep, Youth Rep, PLWD Rep, Water Rep. Roads Rep, Agriculture Rep, two reps from Implementing Partners. SCMOH shall be the secretary

8.5.1. Mandates

Provide leadership and governance oversight in the implementation of PHC and related matters in the sub county.

1. Identify key PHC issues in the region that the committee will advocate and provide advice on.
2. Provide advice on other PHC issues from a regional perspective at the request health departments
3. Address consumers PHC issues, care coordination and innovative ideas for service delivery
4. To promote communications between health department, other stakeholders and the community.
5. Provide beneficiary input on departmental activities, policies, plans and projects at the individual, program, and organization and system levels in the sub county.
6. Propose further opportunities for consumer engagement that will promote PHC improvements in the sub county.
7. To work constructively to assist in addressing key PHC issues in the sub county.
8. To provide advice and/or input into PHC issues.
9. Advocacy on behalf of the diverse PHC users in the sub county, and are responsible for gathering the views of the residents/community they represent through their networks.
10. Fairly representing the views of the residents/community.
11. Provide feedback after meetings to members of the community
12. Provide leadership and advice in relation to the beneficiary and/or community views on PHC service delivery, planning and development in the relevant sub county.

8.6. Health facility management committee

The Committee shall be chaired by an elected person from the members. Health Facility in-charge shall be the secretary with one female member elected as treasurer. The HFMC are responsible for the management and operations of levels 2 and 3 facilities3 services. Every HFMC shall have seven to nine members, four of whom are selected from the community and comprises of at least three women. It shall also contain representation by the MCA.

8.6.1. Mandates

HFMCs have the responsibility for overseeing the preparation and implementation of the facility work plans. This involves supervision and control of all resources related, received, and managed by the health facility.

8.7. Community health committee

The committee shall be chaired by elected person from the members. CHA/CHEW shall be the secretary with one nominated CHV as treasurer

8.7.1. Mandates

Provide leadership and governance oversight in the implementation of health and related matters in community health services at level 1.

The following shall be the key responsibilities:

1. Prepare and present to the Link Health Facility Committee (and to others as may be needed) the community Annual Operational Plan (AOP) on health related issues at level 1

2. Network with other sectors and developmental stakeholders towards improving the health status of people in the Community Unit, e.g. Ministries of Water, Agriculture, Education, etc.
3. Facilitate resource mobilization for implementing the community work plan and ensure Accountability and transparency
4. Carry out basic human resources and financial management in the community
5. Plan, coordinate and mobilize the community to participate, along with themselves, in community dialogue and health action days through social mobilization
6. Work closely with the link facility health committee to improve the access of the CU to health services
7. Facilitate negotiations and conflict resolution among stakeholders at level 1
8. Lead in advocacy, communication and social mobilization
9. Call for monitoring and evaluation of the CHU plan including the work of the CHWs through monthly review meetings
10. Prepare quarterly reports on events in the CU
11. Hold quarterly consultative meetings with Link Facility Health Committees

8.8. Community Health Volunteers/Officers

These will be recruited from the community through a community participatory approach and maintained as per the MOH community health strategy guide. They will be initially trained and given periodic updates and shall undertake the following activities in each household (HH);

8.8.1. Mandates

1. Ensure all eligible persons (children, mothers, Girls, etc.) in that Household are vaccinated, if not refer to the nearest vaccinating center

2. Ensure all persons with chronic health conditions have the required medications, are properly using them, and are attending their clinic days as per schedule . In case of default, take immediate corrective action, which may include sending them to the nearest health facilities –under supervision- for care, calling for an ambulance to ferry incapacitated persons to health facilities and liaising with the local administration
3. Ensure all mothers attend ANC care and educate them on the benefits of doing this and follow up on them to ensure they deliver under the care of qualified medical personnel.
4. Ensure each household has a functioning and well utilized toilet/latrine and educate them on the benefits of using them
5. Ensure each household has access clean, safe and portable water and educate them on the diseases which could be contracted through the use of contaminated water, etc.
6. Ensure each HH understands the benefit of using a balanced diet, etc.
7. Check whether there is any infectious problem in any member of each household and if there is take necessary remedial actions including-and not limited to- referring them to the nearest health facility, educating them on the basics of that disease transmission, causative organisms, treatment, prevention and control options applicable. This information should be relayed to the nearest health facility and the supervising community health extension worker/officer (CHEW/O) to form the basis of community surveillance which will be aggregated at every community health unit (CHU) and transmitted daily to the nearest health facility for compilation and transmission to the next level-community PHC center, the MDT, to the level 4 PHC facility, and then to the county level etc.
8. Put in place environmentally friendly measures to control vectors like mosquitoes, breeding of snails in schistosomiasis prone areas, etc.
9. Other duties as stipulated in their TORs and training manual

8.9. PHC Services package for Kenya

8.9.1. Primary health care services shall include:

1. **Promotive**
   This will include counselling and health education
2. **Preventive**
   This will comprises primary, secondary and tertiary screening, immunization, chemoprophylaxis and adherence monitoring
3. **Ambulance and emergency response**
4. **Acute ambulatory care**
   This is the health care given to 'walk in" stable patients
5. **Chronic diseases care**
6. **Palliative care**
   Palliative care will be given to patients with terminal illnesses
7. **Rehabilitative care**
   Rehabilitative care will be given to persons with disabilities from any cause to improve the quality of their lives

The coverage of these primary health care services is organised as in the Kenya Essential Package for Health (KEPH) format and borrows heavily from the ICPC-2(WHO) as presented below.

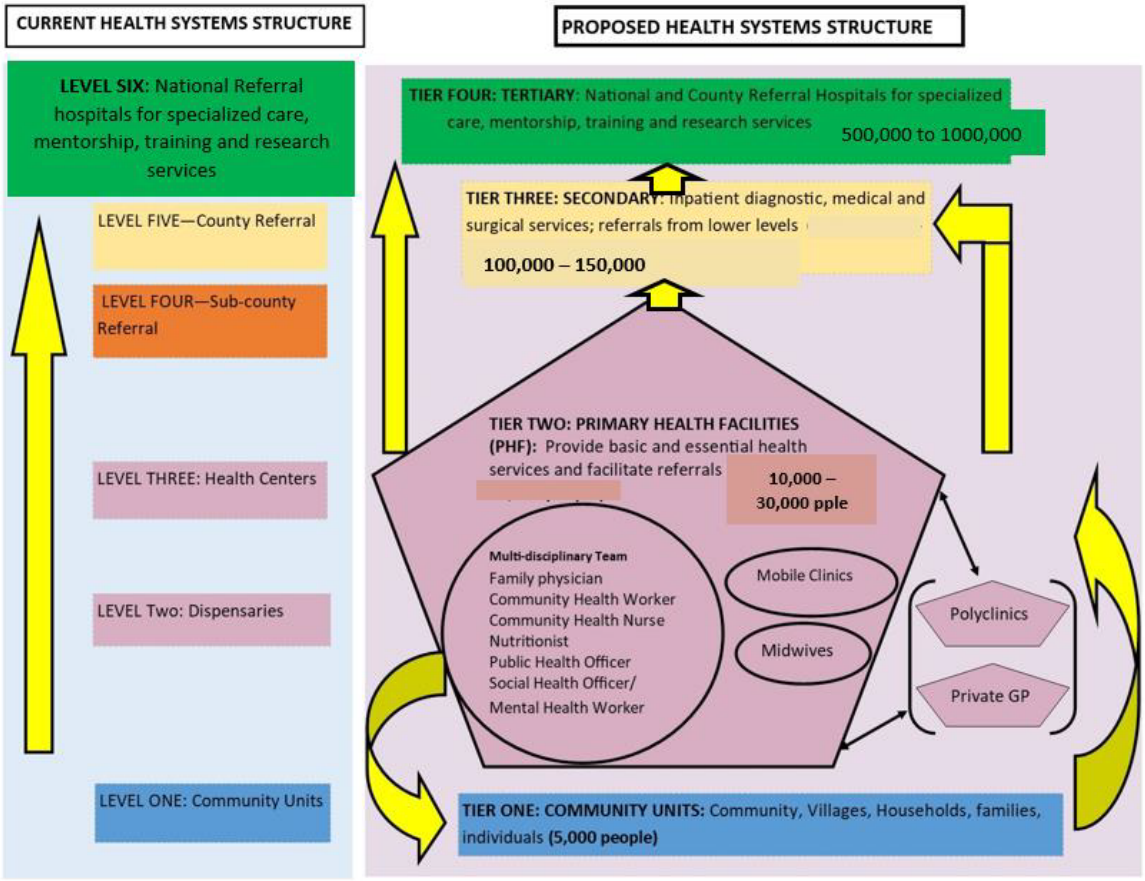


Figure 16: : Illustration of Former and Current Primary Health Care service delivery structure.

8.9.1. The Kenyan PHC Package

Table 1: PHC Services *

Tally 1	Tally 2	Service Area	Intervention
	1	Package for eliminating communicable conditions Immunization	BCG vaccination
1			Oral Polio Vaccination
2			Pentavalent vaccination
3			Rotavirus vaccination
4			PCV – 10 vaccination
5			Measles vaccination
6			Typhoid vaccination
7			Yellow fever vaccination
8			HPV vaccination
9	2	Child Health	Deworming
10			Management of pneumonia
11			Management of malaria
12			Management of diarrhea
13	3	Screening for communicable conditions	HIV Testing and Counseling (HTC)
14			Active case search for TB
15			Diagnostic Testing for Malaria
16			Screening for drug resistant TB
17			Screening for Animal Transmitted Conditions
18	4	Antenatal care	Physical examination of pregnant mother
19			Tetanus Vaccination
20			Supplementation (*Folic acid, multivitamins, calcium, ferrous sulphate)*
21			Intermittent Presumptive Treatment for

			Malaria in endemic areas
22			Antenatal profiling
23			Delivery planning
24			Hypertensive disease case management
25			Syphilis detection and management
26	5	Prevention of Mother to Child HIV Transmission	HIV Testing and Counseling
27			ARV prophylaxis for children born of HIV+ mothers
28			Highly Active Anti retroviral Therapy
29			Cotrimoxazole prophylaxis
30			Counseling on best breastfeeding and complementary feeding practices in HIV
31	6	Integrated Vector Management	Indoor Residual Spraying of malaria
32			ITN distribution
33			Destruction of malaria breeding sites
34			Household vector control (cockroaches, fleas, rodents)
35	7	Good hygiene practices	Appropriate Hand washing with soap
36			Appropriate latrine use
37			Food outlet inspections
38			Meat inspections (abbartoirs, butcheries)
39			Household water treatment
40	8	HIV and STI prevention	Male Circumcision
41			Management of Sexually transmitted Infections
42			Pelvic Inflammatory Disease management
43			Post Exposure Prophylaxis
44			Condom distribution/ provision
45			HIV Testing and Counselling (HTC)
46	9	Port health	Monitoring of imported and exported commodities affecting public health
47			Monitoring of people movement in

			relation to International Health Regulations
48			Cholera vaccination
49			Meningococcal vaccination
50			Yellow fever vaccination
51	10	Control and prevention neglected tropical diseases	Mass education on prevention of NTDs (*Kalar Azar, Schistosomiasis, Drucunculosis, Leishmaniasis)*
52			Mass deworming for schistosomiasis control
53			Mass screening of NTDS (*Kalar Azar, Schistosomiasis, Drucunculosis, Leishmaniasis)*
54	11	**Reversing rising burden of Non communicable conditions** Health Promotion and education for NCD's	Public information on NCD's prevention, screening and early treatment
55			Community detection and diagnosis for NCD's
56			Education on Referral/evacuation of persons with NCD's
57	12	Institutional Screening for NCD's	Routine Blood Sugar testing
58			Routine Blood Pressure measurement at OPD
59			Routine Body Mass Index (weight and height) measurement for all outpatients
60			Cervical cancer screening
61			Fecal Occult Blood testing for bowel cancers
62			Breast cancer screening
63			Lung Function Testing
64			Lipid profiling
65			Annual prostate examination for all men over 50 years
66	13	Community screening for NCD's	Routine Blood Pressure measurement in the community
67			Adult Mid Upper Arm Circumference measurement
68	14	Rehabilitation	Home based care clients with NCD's
69			Physio therapy for persons with physical disabilities
70			Occupational therapy for persons with disabilities
71			Psychosocial therapy for persons with disabilities
72			Provision of rehabilitative appliances
73	15	Workplace health and safety	Workplace wellness programs

74			Inspection and certification
75			Safety education
76	16	Food Quality and safety	Food demonstrations (at community and facilities)
77			Food quality testing
78			Consumer Education on food quality and safety
79	17	**Package for managing the rising burden of violence and injuries** Health Promotion and education	Awareness creation on violence and injuries (including Sexual and Gender Based Violence)
80	18	Pre hospital Care	Public education on prevention of violence and injuries
81			Basic First Aid
82	19	OPD/Accident and Emergency	Evacuation Services for Injuries
83			Basic Emergency Trauma care
85			Referral of advanced Emergency Trauma care
86	20	Management for injuries	Basic imaging for violence and injuries
87			Referral of advanced imaging for Violence and Injuries (*CT Scan, MRI)*
88			Basic Lab services for violence and Injuries (*Blood transfusions, vaginal swabs, HIV serology)*
89			Referral of advanced Lab services for violence and Injuries (*DNA testing)*
90	21	Rehabilitation	Physiotherapy following recovery from violence and Injuries
91			Occupational Therapy following recovery from violence and Injuries
92			Psychosocial therapy for violence and Injuries
93			Rehabilitative appliances following violence and injuries
94	22	**Package for providing essential health services** General Outpatient	Management of ENT conditions (*Pharyngitis, Tonsillitis, sinusitis)*
95			Management of Eye conditions (*Allergies, Bacterial Keratitis, Conjunctivitis (Pink Eye), Dry Eye, Low Vision, Myopia (Nearsightedness), Stye)*
96			Management of Oral conditions (dental carried, *dental extraction, halitosis,)*

97			Management of Respiratory conditions (*Croup, Asthma, bronchitis, bronchiolitis)*
98			Management of Cardiovascular conditions (e.g. *Ischaemic heart disease, stroke, peripheral vascular diseases, RHD, congential heart* *disease)- Referral as appropriate*
99			Management of Gastrointestinal conditions (*Hepatitis)*
100			Management of Genito -urinary conditions (e.g. *Lower UTI's, genital tract infections)*
101			Management of Muscular skeletal conditions (*Juvenile rheumatoid arthritis, fructures)*
102			Management of Skin conditions (*Impetigo, dermatitis / eczema, scabies, fungal skin infections)*
103			Management of Neurological conditions
104			Management of mental disorders
105			Management of Sexual and Gender Based Violence
106			Identification and management of disabilities
107			Management of Endocrine and metabolic conditions (*Diabetes Mellitus, Hypothyroidism, hyperthyroidism)*
108			Management of Haematological conditions (*Anaemia, Leukaemia, Lymphoma)*
109			Management of birth defects (*Downs syndrome, Edwards syndrome)*
110			Management of nutritional disorders (micronutrient deficincies, *Kwashiorkor, Marasmus, Obesity, Iodine and Vitamin A deficiency)*
111			Management of other infectious conditions *(Malaria, typhoid, amoebiasis, HIV,)*
112			Vaccination services *(Yellow fever, rabies, Tetanus toxoid)*

113			Management of minor injuries
114			Management of cancers
115			Client registration and management
116			Evacuation / transfer to other service areas / facilities
117	23	Integrated MCH / Family Planning services	Vitamin A supplementation
118			Micronutrient supplementation
119			Iron and folic Acid supplementation
120			Weight monitoring
121			Height measurement
122			Mid Upper Arm Circumference measurement
123			Counseling: On infant feeding: Exclusive Breastfeeding, and complementary feeding
124			
125			Screening: for malnutrition, skin diseases, anemia
126			FP Barrier methods (*Condoms, diaphragm, caps, vaginal ring and sponge)*
127			FP Hormonal methods (*Oral, injectable, sub dermal implants)*
128			FP Surgical methods (*Tubal ligation, vasectomy)*
129			FP Natural methods
130			FP Intra Uterine Contraceptive Devices
131	24	Accident and Emergency	Management of ENT conditions (*Pharyngitis, Tonsillitis, sinusitis)*
132			Management of Eye conditions (*Allergies, Bacterial Keratitis, Cataracts, Detached and Torn Retina, Glaucoma)*
133			Management of Oral conditions (*Oral Infections, maxillofacial trauma, oral cancers)*
134			Management of Respiratory conditions (*Croup, Asthma, bronchitis, bronchiolitis)*

135			Management of Cardiovascular conditions (*Infective endocarditis, Rheumatic heart disease, Congestive heart failure, Shock,* *hypertension)*
136			Management of Gastrointestinal conditions (*Hepatitis, Liver failure, Ascitis, Malabsorption, GI bleeding, Acute abdomen)*
137			Management of Genito -urinary conditions (*Nephritis, nephrotic syndrome, renal failure, lower UTI's, pyelonephritis)*
138			Muscular skeletal conditions (*Pyomyoscitis, septic arthritis, osteoarthritis, Juvenile rheumatoid arthritis, fructures)*
139			Management of Skin conditions (*Dermatitis, fungal skin infections)*
140			Management of neurological conditions (*Meningitis, encephalitis, seizure disorders, cerebral palsy, tumours, raised intracranial pressure,* *coma)*
141			Management of Endocrine and metabolic conditions (*Diabetes Mellitus, Hypothyroidism, hyperthyroidism)*
142			Management of Haematology conditions (*Anaemia, Septicemia, Hemophilia, Idiopathic Thrombocytopenic Purpura, Leukaemia,* *Lymphoma)*
143			Management of other infectious conditions *(complicated Malaria, severe diarrhoea, typhoid, amoebiasis, HIV,)*
144			Management of injuries
145			Management of birth defects
146			Client registration and management
147			Evacuation / transfer to other service areas / facilities
148	25	Emergency life support	Triage for emergency cases

149			Basic life support
150	26	Maternity	Pre-term labour management (*Corticosteroids, antibiotics for pPROM, tocolytics)*
151			Complications during pregnancy (*Pre eclampsia, fever (due to infections)*
152			Abnormal pregnancy management (*Ectopic pregnancy, molar pregnancy, spontaneous abortion)*
153			Labour induction
154			Labour monitoring
155			Normal Vaginal Delivery
156			Assisted Vaginal Delivery (vacuum extraction)
157			Caesarian section
158			Obstetric emergencies (*Eclampsia, Shock, Post Partum Hemorrhage, Premature Rupture of Membranes)*
159			Active management of 3rd stage of labour
160			Feeding of mothers post labour
161			Post partum care
162			Post operative care for mother and child
163			Client registration and management
164			Referral of clients
165	27	Neonatal services	Neonatal resuscitation
166			Treatment of newborns with sepsis
167			Early initiation of breastfeeding
168			Kangaroo mother care
169			Management of newborn conditions *(Asphyxia, jaundice, birth trauma)*
170			Client registration and management
171			Care for premature babies (*Warmth, feeding)*
172	28	Reproductive health	Breast examination by palpation

173			Management of abnormal uterine bleeding
174			Management of other gynaecological conditions
175			High Vaginal Swab
176			Management of Infertility
177	29	In patients	Management of Cardiovascular conditions (*Infective endocarditis, Rheumatic heart disease, Congestive heart* *failure, hypertension)*
178			Management of Respiratory conditions (Croup, Asthma, bronchitis, bronchiolitis)
179			Management of Gastrointestinal conditions (*Hepatitis, Ascitis, Malabsorption, GI bleeding)*
180			Management of Genito-urinary conditions (*nephritis, nephrotic syndrome, lower UTI's, bilharzia,)*
181			Management of gynaecological conditions *(abnormal uterine bleeding, ovarian cysts, 1pelvic floor disorders)*
182			Management of Muscular skeletal conditions (*Pyomyoscitis, septic arthritis, osteoarthritis, Juvenile rheumatoid arthritis, uncomplicated fractures)*
183			Management of Skin conditions (*Impetigo, dermatitis / eczema, fungal skin infections)*
185			Management of neurological conditions (*Seizure disorders, cerebral palsy)*
186			Management of Endocrine and metabolic conditions (*Diabetes Mellitus, Hypothyroidism, hyperthyroidism)*
187			Management of Haematology conditions (*Anaemia)*
188			Management of nutritional disorders (*Kwashiorkor, Marasmus, vitamin and mineral deficiencies)*
189			Management of various infections conditions *(complicated malaria,*

			diarrhoea)
190			Management of mental disorders
191			Client registration and management
192	30	Clinical laboratory	Haematology *(Hb, RBC/WBC counts, hematocrit, peripheral film)*
193			Pregnancy test
194			Bleeding and coagulation time
195			Blood grouping with Rh factors
196			Parasitology *(RDT)*
197			Hepatitis B and C tests
198			Bacteriology *(ZN staining, Alberts staining, Gram Staining)* microscopy
199			ELISA tests
200			Widal tests
201			Agglutination tests
202			Urinalysis
203			Liver Function Tests
204			Renal Function Tests
205			Blood sugar
206			Fecal Occult Blood testing
207			Tumour markers *(Bence Jones protein, cytology)*
208			Histopathology (FNA, Tru cut, Incision or excision) and cytology
209			Cerebro Spinal Fluid analysis *(culture, biochemistry, cytology)*
210			Client registration and management
211	31	Specialized laboratory	Food analysis
212			Water analysis
213			Blood analysis *(alcohol, drug)*
214			Stool testing
215	32	Imaging	Ultra sound scan

216			X – ray
217	33	Pharmaceuticals	Medical Therapy Management
218			Medicines dispensing
219	34	Blood safety	Blood donation and storage
220			Blood screening (*Hepatitis B and C, Syphilis, Malaria, blood grouping)*
221			Blood transfusion
222	35	Rehabilitation	Physiotherapy
223			Speech and hearing therapy
224			Orthopedic technology (appliances)
225			Occupational therapy
226			Client registration and management
227	36	Palliative care	Pain management
228			Counseling services
228			Psychosocial support
229			Client registration and management
230	37	Specialised clinics	HIV clinic (*ART provision (1st and 2nd line), AT's for TB patients, Opportunistic infection management, nutrition care and support,* *Cotrimoxazole prophylaxis for children and TB patients, TB screening)*
231			TB clinic (*TB treatment (1 st and 2nd line), MDR and XDR TB management, Treatment follow up)*
232			Pediatric clinic (*Nutrition, neurological conditions, birth defects, chronic pediatric conditions, post admission foll ow up)*
233			ENT clinic (*Sinusitis)*
234			Eye clinic (*Bacterial Keratitis, Cataracts, Detached and Torn Retina, Diabetic Retinopathy, Glaucoma)*
235			Dental clinic (*Oral Infections)*
236			Chest clinic (*Croup, Asthma, bronchitis, bronchiolitis, uncomplicated TB)*

237			Cardiac clinic (*Infective endocarditis, Rheumatic heart disease, Congestive heart failure , Shock, hypertension)*
238			Gastro Intestinal clinic (*Hepatitis, Ascitis, GI bleeding, Acute abdomen)*
239			Genito-urinary clinic (*nephritis, nephrotic syndrome, pyelonephritis)*
240			Mental health clinic (*Substance abuse, Neurotic conditions, psychosis)*
241			Surgical clinic (*Pyomyoscitis, septic arthritis, osteoarthritis, Juvenile rheumatoid arthritis, Uncomplicated fractures)*
242			Skin clinic (*Impetigo, dermatitis)*
243			Neurological clinic (*Meningitis, seizure disorders, coma)*
244			Endocrine and metabolic clinic (*Diabetes Mellitus, Hypothyroidism, hyperthyroidism)*
245	38	Comprehensive youth friendly services	Haematology clinic (*Anaemia, Septicaemia)*
246			Information on healthy lifestyle
247	39	Operative surgical services	Outpatient operations
248			Emergency operations
249			General operations
250			Client registration and management
251	40	**package for addressing health risk factors** Health Promotion including health Education	Health promotion on violence and injury prevention (*Road Traffic, Burns/Fires, Occupational , Poisoning, Falls , Sports , Drowning ,Conflict/war, Female Genital mutilation, Self -inflicted , Interpersonal injuries ,Gender Based violence, Child maltreatment* .)
252			Health promotion on prevention of communicable conditions (Environmental sanitation and hygiene, in fection prevention pr actices, safe dwellings and habitant, safe sex practices, safe food handling, safe water, blood safe ty practices, immunization*)*
253			Health promotion on prevention of Non

			Communicable conditions (tobacco control, control of harmful u se of alcohol, prevention of drug and substance abuse, health diets and physical activities, control of indoor polu tion, control of environmental polution and contamination, radiation protection, safe sex practices, work place safety, personal hygiene)
254			Sensitization of the community on safe sex practices
255	41	Sexual education	Incorporation of sex education in education curricular
256			Targeted education methods for high risk groups (MARPS) (*commercialsex workers, uncircumcised men, Men Having Sex with men, intravenous drug users,Adolescents)* and negative cultural practices
257	42	Substance abuse	Communication on harmful effects of Tobacco use
258			Communication on harmful effects of Alcohol abuse
259			Communication on harmful effects of Substance abuse (*Cocaine, Heroine, glue, khat, and others)*
260			Communication on harmful effects of Prescription drug abuse
261			Counseling
262	43	Micronutrient deficiency control	Advocate for food fortification
263			Advocacy for consumption of fortified foods
264			promotion of dietary diversification
265			Food supplementation
266	44	**package for collaboration with health related sectors** Safe water	Provision of safe water sources
267			Health Impact Assessment
268			Community sensitization on safe water
269			Water quality testing
270			Water purification / treatment at point of use
271			Water source protection
272	45	Sanitation and hygiene	Monitoring human excreta disposal practices
273			Hand washing facilities
274			Hygiene promotion
275	46	**package for collaboration with health related sectors**	Home inspections for sanitation

			adequacy
276			Health Impact Assessment
277			Promotion of safe food handling
278			Sanitation surveillance and audits
279	47	Nutrition services	Nutrition education and counseling
280			Community based growth monitoring and promotion
281			Micronutrient supplementation (e.g vitamin A, IFA)
282			Management of acute malnutrition
283			Health Impact Assessment
284			Health education on appropriate infant and young child feeding
285	48	Pollution control	Indoor pollution management
286			Liquid, solid and gaseous waste 287management
288			Health Impact Assessment
289			Control of Water body, soil and air pollution
290	49	Housing	Approval of building plans
291			Health and environmental impact assessment
292			Advocacy for enforcement of standards on housing
292			Physical planning and housing environment to promote healthy living including prevention of rickets
293	50	School health	School feeding and nutrition
294			School Health promotion
295			School based disease prevention programme
296			School water sanitation and hygiene
297			Health Impact Assessment
298			Children with special needs

299	51	Food fortification	Salt fortification with Iodine
300			Toothpaste fortification with fluoride
301			Health Impact Assessment
302			Micronutrient fortification of food products (*flour, cooking oil, sugar, etc)*
303	52	Population management	Information on child spacing benefits
304			Awareness creation on the impact of population growth
305			Health Impact Assessment
306			Management of population movement particularly to informal settlements
307	53	Road infrastructure and transport	Improve road infrastructure to health facilities
308			Road safety/Injury prevention
309			Health Impact Assessment

*The management of these conditions will be guided by the ICPC-2 as in table 2 below

The international classification of primary care conditions (ICPC) includes, but not limited to the conditions provided below.

8.9.2. International Classification of Primary Care – 2nd Edition

[Wonca International Classification Committee, (WICC)]

Table 2; ICPC-2

Process codes **-30 Medical Exam/Eval-Complete** **-31 Medical Examination/Health EvaluationPartial/Pre-op check** **-32 Sensitivity Test** **-33 Microbiological/Immunological Test** **-34 Blood Test** **-35 Urine Test** **-36 Faeces Test** **-37 Histological/Exfoliative Cytology** **-38 Other Laboratory Test NEC** **-39 Physical Function Test** **-40 Diagnostic Endoscopy** **-41 Diagnostic Radiology/Imaging** **-42 Electrical Tracings** **-43 Other Diagnostic Procedures** **-44 Preventive Imunisations/Medications** **-45 Observe/Educate/Advice/Diet** **-46 Consult with Primary Care Provider** **-47 Consultation with Specialist** **-48 Clarification/Discuss Patient's RFE** **-49 Other Preventive Procedures**	**Blood, Blood Forming Organs and Immune Mechanism B** **B02 Lymph gland(s) enlarged/painful** **B04 Blood symptom/complaint** **B25 Fear of aids/HIV** **B26 Fear cancer blood/lymph** **B27 Fear blood/lymph disease other** **B28 Limited function/disability** **B29 Sympt/complt lymph/immune other** **B70 Lymphadenitis acute** **B71 Lymphadenitis non-specific** **B72 Hodgkin's disease/lymphoma** **B73 Leukaemia** **B74 Malignant neoplasm blood other** **B75 Benign/unspecified neoplasm blood** **B76 Ruptured spleen traumatic** **B77 Injury blood/lymph/spleen other**	**Eye F** **F01 Eye pain** **F02 Red eye** **F03 Eye discharge** **F04 Visual floaters/spots** **F05 Visual disturbance other** **F13 Eye sensation abnormal** **F14 Eye movements abnormal** **F15 Eye appearance abnormal** **F16 Eyelid symptom/complaint** **F17 Glasses symptom/complaint** **F18 Contact lens symptom/complaint** **F27 Fear of eye disease** **F28 Limited function/disability (f)** **F29 Eye symptom/complaint other** **F70 Conjunctivitis infectious** **F71 Conjunctivitis allergic** **F72 Blepharitis/stye/chalazion**	**Musculoskeletal L** **L01 Neck symptom/complain** **L02 Back symptom/complaint** **L03 Low back symptom/complaint** **L04 Chest symptom/complaint** **L05 Flank/axilla symptom/complaint** **L07 Jaw symptom/complaint** **L08 Shoulder symptom/complaint** **L09 Arm symptom/complaint** **L10 Elbow symptom/complaint** **L11 Wrist symptom/complaint** **L12 Hand/finger symptom/complaint** **L13 Hip symptom/complaint** **L14 Leg/thigh symptom/complaint** **L15 Knee symptom/complaint**	

-50 Medicat-Script/Reqst/Renew/Inject
-51 Incise/Drain/Flush/Aspirate
-52 Excise/Remove/Biopsy/Destruction/ Debride
-53 Instrument/Catheter/Intubate/Dilate
-54 Repair/Fixate-Suture/Cast/Prosthetic
-55 Local Injection/Infiltration
-56 Dress/Press/Compress/Tamponade
-57 Physical Medicine/Rehabilitation
-58 Therapeutic Counselling/Listening
-59 Other Therapeutic Procedure NEC
-60 Results Tests/Procedures
-61 Results Exam/Test/Record
-62 Administrative Procedure
-63 Follow-up Encounter Unspecified
-64 Encounter Initiated by Provider
-65 Encounter Initiated third person
-66 Refer to Other Provider (EXCL. M.D.)
-67 Referral to Physician/Specialist/ Clinic/Hospital
-68 Other Referrals NEC
-69 Other Reason for Encounter NEC

General and Unspecified
A
A01 Pain general/multiple sites
A02 Chills
A03 Fever
A04 Weakness/tiredness general
A05 Feeling ill
A06 Fainting/syncope
A07 Coma
A08 Swelling
A09 Sweating problem
A10 Bleeding/haemorrhage NOS
A11 Chest pain NOS
A13 Concern/fear medical treatment
A16 Irritable infant
A18 Concern about appearance
A20 Euthanasia request/discussion
A21 Risk factor for malignancy
A23 Risk factor NOS
A25 Fear of death/dying
A26 Fear of cancer NOS
A27 Fear of other disease NOS
A28 Limited function/disability NOS
A29 General symptom/complaint other
A70 Tuberculosis
A71 Measles
A72 Chickenpox
A73 Malaria
A74 Rubella
A75 Infectious mononucleosis
A76 Viral exanthem other
A77 Viral disease other/NOS
A78 Infectious disease other/NOS
A79 Malignancy NOS
A80 Trauma/injury NOS
A81 Multiple trauma/injuries
A82 Secondary effectof trauma
A84 Poisoning by medical agent
A85 Adverse effect medical agent
B78 Hereditary haemolytic anaemia
B79 Congen.anom. blood/lymph other
B80 Iron deficiency anaemia
B81 Anaemia, Vitamin B12/folate def.
B82 Anaemia other/unspecified
B83 Purpura/coagulation defect
B84 Unexplained abnormal white cells
B87 Splenomegaly
B90 HIV-infection/aids
B99 Blood/lymph/spleen disease other

PROCESS CODES
SYMPTOMS/COMPLAINTS
INFECTIONS
NEOPLASMS
INJURIES
CONGENITAL ANOMALIES

OTHER DIAGNOSES
Digestive D
D01 Abdominal pain/cramps general
D02 Abdominal pain epigastric
D03 Heartburn
D04 Rectal/anal pain
D05 Perianal itching
D06 Abdominal pain localized other
D07 Dyspepsia/indigestion
D08 Flatulence/gas/belching
D09 Nausea
D10 Vomiting
D11 Diarrhoea
D12 Constipation
D13 Jaundice
D14 Haematemesis/vomiting blood
D15 Melaena
D16 Rectal bleeding
D17 Incontinence of bowel
D18 Change faeces/bowel movements
D19 Teeth/gum symptom/complaint
D20 Mouth/tongue/lip symptom/complt.
D21 Swallowing problem
D23 Hepatomegaly
D24 Abdominal mass NOS
D25 Abdominal distension
D26 Fear of cancer of digestive system
D27 Fear of digestive disease other
D28 Limited function/disability (d)
D29 Digestive symptom/complaint other
D70 Gastrointestinal infection
D71 Mumps
D72 Viral hepatitis
D73 Gastroenteritis presumed infection
D74 Malignant neoplasm stomach
D75 Malignant neoplasm colon/rectum
D76 Malignant neoplasm pancreas
D77 Malig. neoplasm digest other/NOS
D78 Neoplasm digest benign/uncertain
D79 Foreign body digestive system
F73 Eye infection/inflammation other
F74 Neoplasm of eye/adnexa
F75 Contusion/haemorrhage eye
F76 Foreign body in eye
F79 Injury eye other
F80 Blocked lacrimal duct of infant
F81 Congenital anomaly eye other
F82 Detached retina
F83 Retinopathy
F84 Macular degeneration
F85 Corneal ulcer
F86 Trachoma
F91 Refractive error
F92 Cataract
F93 Glaucoma
F94 Blindness
F95 Strabismus
F99 Eye/adnexa disease, other
Ear H
H01 Ear pain/earache
H02 Hearing complaint
H03 Tinnitus, ringing/buzzing ear
H04 Ear discharge
H05 Bleeding ear
H13 Plugged feeling ear
H15 Concern with appearance of ears
H27 Fear of ear disease
H28 Limited function/disability ear
H29 Ear symptom/complaint other
H70 Otitis externa
H71 Acute otitis media/myringitis
H72 Serous otitis media
H73 Eustachian salpingitisCardiovascular K
K01 Heart pain
K02 Pressure/tightness of heart
K03 Cardiovascular pain NOS
K04 Palpitations/awareness of heart
K05 Irregular heartbeat other
K06 Prominent veins
K07 Swollen ankles/oedema
K22 Risk factor cardiovascular disease
K24 Fear of heart disease
K25 Fear of hypertension
K27 Fear cardiovascular disease other
K28 Limited function/disability (k)
K29 Cardiovascular sympt./complt. other
K70 Infection of circulatory system
K71 Rheumatic fever/heart disease
K72 Neoplasm cardiovascular
K73 Congenital anomaly cardiovascular
K74 Ischaemic heart disease w. angina
K75 Acute myocardial infarction
K76 Ischaemic heart disease w/o angina
L16 Ankle symptom/complaint
L17 Foot/toe symptom/complaint
L18 Muscle pain
L19 Muscle symptom/complaint NOS
L20 Joint symptom/complaint NOS
L26 Fear of cancer musculoskeletal
L27 Fear musculoskeletal disease other
L28 Limited function/disability (l)
L29 Sympt/complt. Musculoskeletal other
L70 Infections musculoskeletal system
L71 Malignant neoplasm musculoskeletal
L72 Fracture: radius/ulna
L73 Fracture: tibia/fibula
L74 Fracture: hand/foot bone
L75 Fracture: femur
L76 Fracture: other
L77 Sprain/strain of ankle
L78 Sprain/strain of knee
L79 Sprain/strain of joint NOS
L80 Dislocation/subluxation
L81 Injury musculoskeletal NOS
L82 Congenital anomaly musculoskeletal
L83 Neck syndrome
L84 Back syndrome w/o radiating pain
L85 Acquired deformity of spine
L86 Back syndrome with radiating pain
L87 Bursitis/tendinitis/synovitis NOS
L88 Rheumatoid/seropositive arthritis
L89 Osteoarthrosis of hip
L90 Osteoarthrosis of knee
L91 Osteoarthrosis other
L92 Shoulder syndrome
L93 Tennis elbow
L94 Osteochondrosis
L95 Osteoporosis
L96 Acute internal damage knee
L97 Neoplasm benign/unspec musculo.
L98 Acquired deformity of limb
L99 Musculoskeletal disease, other
Neurological N
N01 Headache
N

Neurological N
N01 Headache
N03 Pain face
N04 Restless legs

A86 Toxic effect non-medicinal substance
A87 Complication of medical treatment
A88 Adverse effect physical factor
A89 Effect prosthetic device
A90 Congenital anomaly OS/multiple
A91 Abnormal result investigation NOS
A92 Allergy/allergic reaction NOS
A93 Premature newborn
A94 Perinatal morbidity other
A95 Perinatal mortality
A96 Death
A97 No disease
A98 Health maintenance/prevention
A99 General disease NOS

Psychological P
P01 Feeling anxious/nervous/tense
P02 Acute stress reaction
P03 Feeling depressed
P04 Feeling/behaving irritable/angry
P05 Senility, feeling/behaving old
P06 Sleep disturbance
P07 Sexual desire reduced
P08 Sexual fulfilment reduced
P09 Sexual preference concern
P10 Stammering/stuttering/tic
P11 Eating problem in child
P12 Bedwetting/enuresis
P13 Encopresis/bowel training problem
P15 Chronic alcohol abuse
P16 Acute alcohol abuse
P17 Tobacco abuse
P18 Medication abuse
P19 Drug abuse
P20 Memory disturbance
P22 Child behaviour symptom/complaint
P23 Adolescent behav. Symptom/complt.
P24 Specific learning problem
P25 Phase of life problem adult
P27 Fear of mental disorder
P28 Limited function/disability (p)
P29 Psychological symptom/complt other
P70 Dementia
P71 Organic psychosis other
P72 Schizophrenia
P73 Affective psychosis
P74 Anxiety disorder/anxiety state
P75 Somatization disorder
P76 Depressive disorder
P77 Suicide/suicide attempt
P78 Neuraesthenia/surmenage
P79 Phobia/compulsive disorder
P80 Personality disorder
P81 Hyperkinetic disorder
P82 Post-traumatic stress disorder
P85 Mental retardation
P86 Anorexia nervosa/bulimia
P98 Psychosis NOS/other
P99 Psychological disorders, other

Respiratory R
R01 Pain respiratory system
R02 Shortness of breath/dyspnoea
R03 Wheezing
R04 Breathing problem, other
R05 Cough
R06 Nose bleed/epistaxis

D80 Injury digestive system other
D81 Congen. anomaly digestive system
D82 Teeth/gum disease
D83 Mouth/tongue/lip disease
D84 Oesophagus disease
D85 Duodenal ulcer
D86 Peptic ulcer other
D87 Stomach function disorder
D88 Appendicitis
D89 Inguinal hernia
D90 Hiatus hernia
D91 Abdominal hernia other
D92 Diverticular disease
D93 Irritable bowel syndrome
D94 Chronic enteritis/ulcerative colitis
D95 Anal fissure/perianal abscess
D96 Worms/other parasites
D97 Liver disease NOS
D98 Cholecystitis/cholelithiasis
D99 Disease digestive system, other

Skin S
S01 Pain/tenderness of skin
S02 Pruritus
S03 Warts
S04 Lump/swelling localized
S05 Lumps/swellings generalized
S06 Rash localized
S07 Rash generalized
S08 Skin colour change
S09 Infected finger/toe
S10 Boil/carbuncle
S11 Skin infection post-traumatic
S12 Insect bite/sting
S13 Animal/human bite
S14 Burn/scald
S15 Foreign body in skin
S16 Bruise/contusion
S17 Abrasion/scratch/blister
S18 Laceration/cut
S19 Skin injury other
S20 Corn/callosity
S21 Skin texture symptom/complaint
S22 Nail symptom/complaint
S23 Hair loss/baldness
S24 Hair/scalp symptom/complaint
S26 Fear of cancer of skin
S27 Fear of skin disease other
S28 Limited function/disability (s)
S29 Skin symptom/complaint other
S70 Herpes zoster
S71 Herpes simplex
S72 Scabies/other acariasis
S73 Pediculosis/skin infestation other
S74 Dermatophytosis
S75 Moniliasis/candidiasis skin
S76 Skin infection other
S77 Malignant neoplasm of skin
S78 Lipoma
S79 Neoplasm skin benign/unspecified
S80 Solar keratosis/sunburn
S81Haemangioma/lymphangioma
S82 Naevus/mole
S83 Congenital skin anomaly other
S84 Impetigo
S85 Pilonidal cyst/fistula

K77 Heart failure
K78 Atrial fibrillation/flutter
K79 Paroxysmal tachycardia
K80 Cardiac arrhythmia NOS
K81 Heart/arterial murmur NOS
K82 Pulmonary heart disease
K83 Heart valve disease NOS
K84 Heart disease other
K85 Elevated blood pressure
K86 Hypertension uncomplicated
K87 Hypertension complicated
K88 Postural hypotension
K89 Transient cerebral ischaemia
K90 Stroke/cerebrovascular accident
K91 Cerebrovascular disease
K92 Atherosclerosis/PVD
K93 Pulmonary embolism
K94 Phlebitis/thrombophlebitis
K95 Varicose veins of leg
K96 Haemorrhoids
K99 Cardiovascular disease other

H74 Chronic otitis media
H75 Neoplasm of ear
H76 Foreign body in ea Perforation ear drum
H78 Superficial injury of ear
H79 Ear injury other
H80 Congenital anomaly of ear
H81 Excessive ear wax
H82 Vertiginous syndrome
H83 Otosclerosis
H84 Presbyacusis
H85 Acoustic trauma
H86 Deafness
H99 Ear/mastoid disease, other
Cardiovascular K

Urological U
U01 Dysuria/painful urination
U02 Urinary frequency/urgency
U04 Incontinence urine
U05 Urination problems other
U06 Haematuria
U07 Urine symptom/complaint other
U08 Urinary retention
U13 Bladder symptom/complaint other
U14 Kidney symptom/complaint
U26 Fear of cancer of urinary system
U27 Fear of urinary disease other
U28 Limited function/disability urinary
U29 Urinary symptom/complaint other
U70 Pyelonephritis/pyelitis

N05 Tingling fingers/feet/toes
N06 Sensation disturbance other
N07 Convulsion/seizure
N08 Abnormal involuntary movements
N16 Disturbance of smell/taste
N17 Vertigo/dizziness
N18 Paralysis/weakness
N19 Speech disorder
N26 Fear cancer neurological system
N27 Fear of neurological disease other
N28 Limited function/disability (n)
N29 Neurological symptom/complt. other
N70 Poliomyelitis
N71 Meningitis/encephalitis
N72 Tetanus
N73 Neurological infection other
N74 Malignant neoplasm nervous system
N75 Benign neoplasm nervous system
N76 Neoplasm nervous system unspec.
N79 Concussion
N80 Head injury other
N81 Injury nervous system other
N85 Congenital anomaly neurological
N86 Multiple sclerosis
N87 Parkinsonism
N88 Epilepsy
N89 Migraine
N90 Cluster headache
N91 Facial paralysis/bell's palsy
N92 Trigeminal neuralgia
N93 Carpal tunnel syndrome
N94 Peripheral neuritis/neuropathy
N95 Tension headache
N99 Neurological disease, other
X75 Malignant neoplasm cervix
X76 Malignant neoplasm breast female
X77 Malignant neoplasm genital other (f)
X78 Fibromyoma uterus
X79 Benign neoplasm breast female
X80 Benign neoplasm female genital
X81 Genital neoplasm oth/unspecied (f)
X82 Injury genital female
X83 Congenital anomaly genital female
X84 Vaginitis/vulvitis NOS
X85 Cervical disease NOS
X86 Abnormal cervix smear
X87 Uterovaginal prolapse
X88 Fibrocystic disease breast

R07 Sneezing/nasal congestion
R08 Nose symptom/complaint other
R09 Sinus symptom/complaint
R21 Throat symptom/complaint
R23 Voice symptom/complaint
R24 Haemoptysis
R25 Sputum/phlegm abnormal
R26 Fear of cancer respiratory system
R27 Fear of respiratory disease, other
R28 Limited function/disability (r)
R29 Respiratory symptom/complaint oth.
R71 Whooping cough
R72 Strep throat
R73 Boil/abscess nose
R74 Upper respiratory infection acute
R75 Sinusitis acute/chronic
R76 Tonsillitis acute
R77 Laryngitis/tracheitis acute
R78 Acute bronchitis/bronchiolitis
R79 Chronic bronchitis
R80 Influenza
R81 Pneumonia
R82 Pleurisy/pleural effusion
R83 Respiratory infection other
R84 Malignant neoplasm bronchus/lung
R85 Malinant neoplasm respiratory, other
R86 Benign neoplasm respiratory
R87 Foreign body nose/larynx/bronch
R88 Injury respiratory other
R89 Congenital anomaly respiratory
R90 Hypertrophy tonsils/adenoids
R92 Neoplasm respiratory unspecified
R95 Chronic obstructive pulmonary dis
R96 Asthma
R97 Allergic rhinitis
R98 Hyperventilation syndrome
R99 Respiratory disease other

PROCESS CODES
SYMPTOMS/COMPLAINTS
INFECTIONS
NEOPLASMS
INJURIES
CONGENITAL
OTHER DIAGNOSES

S86 Dermatitis seborrhoeic
S87 Dermatitis/atopic eczema
S88 Dermatitis contact/allergic
S89 Diaper rash
S90 Pityriasis rosea
S91 Psoriasis
S92 Sweat gland disease
S93 Sebaceous cyst
S94 Ingrowing nail
S95 Molluscum contagiosum
S96 Acne
S97 Chronic ulcer skin
S98 Urticaria
S99 Skin disease, other
Endocrine/Metabolic and Nutritional T
T01 Excessive thirst
T02 Excessive appetite
T03 Loss of appetite
T04 Feeding problem of infant/child
T05 Feeding problem of adult
T07 Weight gain
T08 Weight loss
T10 Growth delay
T11 Dehydration
T26 Fear of cancer of endocrine system
T27 Fear endocrine/metabolic dis other
T28 Limited function/disability (t)
T29 Endocrine/met./sympt/complt other
T70 Endocrine infection
T71 Malignant neoplasm thyroid
T72 Benign neoplasm thyroid
T73 Neoplasm endocrine oth/unspecified
T78 Thyroglossal duct/cyst
T80 Congenital anom endocrine/metab.
T81 Goitre
T82 Obesity
T83 Overweight
T85 Hyperthyroidism/thyrotoxicosis
T86 Hypothyroidism/myxoedema
T87 Hypoglycaemia
T89 Diabetes insulin dependent
T90 Diabetes non-insulin dependent
T91 Vitamin/nutritional deficiency
T92 Gout
T93 Lipid disorder
T99 Endocrine/metab/nutrit. dis. other

U71 Cystitis/urinary infection other
U72 Urethritis
U75 Malignant neoplasm of kidney
U76 Malignant neoplasm of bladder
U77 Malignant neoplasm urinary other
U78 Benign neoplasm urinary tract
U79 Neoplasm urinary tract NOS
U80 Injury urinary tract
U85 Congenital anomaly urinary tract
U88 Glomerulonephritis/nephrosis
U90 Orthostatic albumin./proteinuria
U95 Urinary calculus
U98 Abnormal urine test NOS
U99 Urinary disease, other

Pregnancy, Childbearing, Family Planning W
W01 Question of pregnancy
W02 Fear of pregnancy
W03 Antepartum bleeding
W05 Pregnancy vomiting/nausea
W10 Contraception postcoital
W11 Contraception oral
W12 Contraception intrauterine
W13 Sterilization
W14 Contraception other
W15 Infertility/subfertility
W17 Post-partum bleeding
W18 Post-partum symptom/complaint oth.
W19 Breast/lactation symptom/complaint
W21 Concern body image in pregnancy
W27 Fear complications of pregnancy
W28 Limited function/disability (w)
W29 Pregnancy symptom/complaint other
W70 Puerperal infection/sepsis
W71 Infection complicating pregnancy
W72 Malignant neoplasm relate to preg.
W73 Benign/unspec. neoplasm/pregnancy
W75 Injury complicating pregnancy
W76 Congenital anomaly complicate preg.
W78 Pregnancy
W79 Unwanted pregnancy
W80 Ectopic pregnancy
W81 Toxaemia of pregnancy
W82 Abortion spontaneous
W83 Abortion induced
W84 Pregnancy high risk
W85 Gestational diabetes
W90 Uncomplicate labour/delivery live
W91 Uncomplicate labour/delivery still
W92 Complicate labour/delivery livebirth

X89 Premenstrual tension syndrome
X90 Genital herpes female
X91 Condylomata acuminata female
X92 Chlamydia infection genital (f)
X99 Genital disease female, other

Male Genital Y
Y01 Pain in penis
Y02 Pain in testis/scrotum
Y03 Urethral discharge
Y04 Penis symptom/complaint other
Y05 Scrotum/testis sympt/complt. other
Y06 Prostate symptom/complaint
Y07 Impotence NOS
Y08 Sexual function sympt./complt.(m)
Y10 Infertility/subfertility male
Y13 Sterilization male
Y14 Family planning male other
Y16 Breast symptom/complaint male
Y24 Fear of sexual dysfunction male
Y25 Fear sexually transmitted dis. male
Y26 Fear of genital cancer male
Y27 Fear of genital disease male other
Y28 Limited function/disability (y)
Y29 Genital sympt./complt.male other
Y70 Syphilis male
Y71 Gonorrhoea male
Y72 Genital herpes male
Y73 Prostatitis/seminal vesiculitis
Y74 Orchitis/epididymitis
Y75 Balanitis
Y76 Condylomata acuminata male
Y77 Malignant neoplasm prostate
Y78 Malign neoplasm male genital other
Y79 Benign/unspec. neoplasm gen. (m)
Y80 Injury male genital
Y81 Phimosis/redundant prepuce
Y82 Hypospadias
Y83 Undescended testicle
Y84 Congenital genl anomaly (m) other
Y85 Benign prostatic hypertrophy
Y86 Hydrocoele
Y99 Genital disease male, other

Social Problems Z
Z01 Poverty/financial problem
Z02 Food/water problem

		W93 Complicate labour/delivery stillbirth W94 Puerperal mastitis W95 Breast disorder in pregnancy other W96 Complications of puerperium other W99 Disorder pregnancy/delivery, other Female Genital X X01 Genital pain female X02 Menstrual pain X03 Intermenstrual pain X04 Painful intercourse female X05 Menstruation absent/scanty X06 Menstruation excessive X07 Menstruation irregular/frequent X08 Intermenstrual bleeding X09 Premenstrual symptom/complaint X10 Postponement of menstruation X11 Menopausal symptom/complaint X12 Postmenopausal bleeding X13 Postcoital bleeding X14 Vaginal discharge X15 Vaginal symptom/complaint other X16 Vulval symptom/complaint X17 Pelvis symptom/complaint female X18 Breast pain female X19 Breast lump/mass female X20 Nipple symptom/complaint female X21 Breast symptom/complt. female other X22 Concern breast appearance female X23 Fear sexually transmitted disease (f) X24 Fear of sexual dysfunction female X25 Fear of genital cancer female X26 Fear of breast cancer female X27 Fear genital/breast disease other (f) X28 Limited function/disability (x) X29 Genital symptom/complt female oth. X70 Syphilis female X71 Gonorrhoea female X72 Genital candidiasis female X73 Genital trichomoniasis female X74 Pelvic inflammatory disease	Z03 Housing/neighbourhood problem Z04 Social cultural problem Z05 Work problem Z06 Unemployment problem Z07 Education problem Z08 Social welfare problem Z09 Legal problem Z10 Health care system problem Z11 Compliance/being ill problem Z12 Relationship problem with partner Z13 Partner's behaviour problem Z14 Partner illness problem Z15 Loss/death of partner problem Z16 Relationship problem with child Z18 Illness problem with child Z19 Loss/death of child problem Z20 Relationship prob. parent/family Z21 Behaviour problem parent/family Z22 Illness problem parent/family Z23 Loss/death parent/family member Z24 Relationship problem friend Z25 Assault/harmful event problem Z27 Fear of a social problem Z28 Limited function/disability (z) Z29 Social problem NOS Abbreviations Anom anomaly behav. behaviour bronch. bronchus complicat. complication congen. congenital dis. disease eval. evaluation exam. examination gen. genital malig. malignant metab. metabolic musculo. musculoskeletal NEC not elsewhere classified NOS not otherwise specified nutrit. nutrition oth other preg. pregnancy prob. problem RFE reason for encounter sympt. symptom unspec. unspecified w with w/o without	

REPUBLIC OF KENYA

MINISTRY OF HEALTH

Nairobi, Kenya:
Government of Kenya;

PUBLISHED BY:
Ministry of Health
Afya House, Cathedral Road
PO Box 30016 Nairobi 00100
http://www.health.go.ke

Ministry of Health Kenya. Primary Health Care strategy framework, aims to provide the right services, at the right time, at the right place, at right cost and by the right provider.

KENYA PRIMARY HEALTH CARE STRATEGIC FRAMEWORK

2019-2024

This policy is intended as a guide for the health sector for management of medical devices in Kenya towards the provision of quality health care