REPUBLIC OF KENYA

MINISTRY OF HEALTH

PRIMARY HEALTH CARE NETWORK GUIDELINES

MAY 2021

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Government of Kenya

Dr. Patrick.O. Amoth, EBS

FOREWORD

The Ministry of Health aims to scale up and improve delivery of primary health care services through the establishment of Primary Health Care Networks (PCNs). PCNs are a sound approach towards effective implementation of the Kenya Primary Health Care Strategic Framework 2019 - 2024. The strengthening of Primary health care (PHC) should start from the community, dispensaries and health centres, all linking to the hospital so as to form a network of practice. PCNs are a way of linking and strengthening health care services through building on a person-centred approach to health. This enables provision of proactive, personalized, coordinated and integrated social and health services.

For the Kenyan health system, this means a change from reactively managing illness in the facilities to proactively caring for people and communities. The delivery of PHC services has previously taken a vertical approach; however, it is clear that integration and teamwork can synergize our efforts towards achieving Universal Health Coverage (UHC). A successful PCN will result in communities accessing health services they require closer to them.

The Primary Health Care Networks Guidelines will support county governments and implementing partners to set up and operationalize PCNs. The Ministry appreciates all county governments and partners for the support and contribution towards the development of this manual. We look forward to the same spirit of cooperation and collaboration as we implement this guideline.

Ag. Director General for Health

MINISTRY OF HEALTH

Dr. Pacifica Onyancha

ACKNOWLEDGEMENT

The development of the Primary Health Care Networks Guidelines has been spearheaded by the National Primary Health Care Committee of Experts, whose members are drawn from the Ministry of Health, county governments as well as development and implementing partners. These members participated in many meetings and workshops, most of which were virtual, to share useful ideas towards finalization of this document.

We would like to acknowledge the Ministry of Health team, led by Dr. Salim Hussein and Dr. Agatha Olago, the county teams and all the partners who gave technical and financial assistance towards development of this guideline. Special mention is made of the Council of Governors (CoG), Clinton Health Access Initiative (CHAI), PATH, United Nations Children's Fund (UNICEF), World Health Organisation (WHO), Africa Resource Centre (ARC), SDG Partnership Platform, Duke University and E&K Consulting Firm.

The Primary Health Care Networks Guideline will definitely go a long way in guiding stakeholders in implementation as we strengthen Primary Health Care in all regions in the country.

Ag. Director, Medical Services/Preventive & Promotive Health

MINISTRY OF HEALTH

Dr. Salim Hussein

EXECUTIVE SUMMARY

Primary Health Care (PHC) is essential health care based on practical, scientifically sound and socially accepted methods and technology, made universally accessible to individuals and families in the community through their full participation. Additionally, in the spirit of self-reliance and self-determination, PHC is at a cost that the community and country can afford at every stage of their development. In order for Kenya to ensure quality PHC for all citizens, and in response to the call by the Astana Declaration 2018, the Ministry of Health developed the Kenya Primary Health Care Strategic Framework 2019-2024.

Effective implementation of PHC will happen through the establishment of Primary Health Care Networks (PCNs), which form a key building block for scaling up Universal Health Coverage (UHC). The PCNs will be in form of a 'hub and spoke model'. The hub is a Level 4 facility, as defined by the Kenya Essential Package for Health (KEPH) standards. The hub will support the spokes (Level 3, 2 and 1 facilities and the community health units). PCNs seek to improve efficiency and effectiveness of PHC services, particularly for those at risk of poor health outcomes, and to coordinate care through integrating primary health and public health care. It is in this respect that the PCN Operational Manual has been developed. It will guide the county governments and implementing partners to establish and operationalize the PCNs.

This PCN Operational Manual has nine chapters

Chapter 1: Introduction

Chapter 1 gives the background, highlighting government efforts to improve health status of people through reforms in PHC. The foundation set by the UHC implementation roadmap as well as the Kenya Primary Health Care Strategic Framework 2019 – 2024 is noted. The chapter defines the PCN, delignates its functions, and summarizes the stepwise approach to its establishment.

Chapter 2: **Leadership, Governance and Coordination**

Chapter 2 details governance structures required in establishing the PCN. It states the roles of played by the various stakeholders including the National Government, county, hub, spoke and the community.

Chapter 3: Establishment of the PCN

Chapter 3 goes through the stepwise approach to establishing the PCN, including mapping the hub, spokes, household registration and gazettement of the PCN.

Chapter 4: **Multi-disciplinary team for the PCN**

Chapter 4 introduces the multi-disciplinary teams that support service delivery for the PCN. It emphasises the team approach in the composition of the MDT. It also advocates for capacity building for health care workers at all PHC levels to ensure adequate skills for the delivery of quality primary care services.

Chapter 5: Service Delivery

Chapter 5 entails service delivery at the PHC referral facility and the PHC facility, highlighting the preventive and promotive approach to healthcare. It also takes note of critical aspects of service delivery such as the referral system, quality of care, commodity management, laboratory systems and logistics.

Chapter 6: Financing the PCN

This chapter focuses on financial mechanisms and resource mobilization for the PCN. It explores how the PCN can take advantage of pooling and efficiency to improve purchasing of services. It also gives the financial resource requirement for establishing the PCN.

Chapter 7: Role of the private sector

Chapter 7 discusses how the private sector can be engaged within the PCNs, to support establishment and activities.

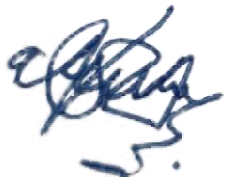
Chapter 8: Monitoring and evaluation, Accountability and Learning

The chapter outlines monitoring and evaluation of PCNs. Specific Indicators that can be used to assess functions of the PCN are reviewed.

Chapter 9: Research and innovation

Chapter 9 discusses the great role that research and innovation can strengthen PHC and PCNs.

This Operational Manual is a practical guide that can support Kenya's health sector in the establishment of PCNs as we seek to strengthen PHC.



Head, Department of Primary Health Care

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ABBREVIATIONS AND ACRONYMS

CHV	Community Health Volunteer
CHMB	County Health Management Board
CHMT	County Health Management Team
CMLT	County Medical Laboratory Technician
CDH	County Director of Health
CPHC	County PHC Coordinator
HRH	Human Resources for Health
M & E	Monitoring & Evaluation
MDT	Multi-Disciplinary Team
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
PCN	Primary Health Care Network
PHC	Primary Health Care
SDP	Service Delivery Points
SOP	Standard Operating Procedures

CHAPTER 1: INTRODUCTION

1.1. Development of the PCN Operational Manual

Primary Health Care (PHC) is the gateway to attaining Universal Health Coverage (UHC), and in Kenya, the PHC Strategic Framework (2019 – 2024) was developed to support this. However, learnings from the UHC pilot bring to light a set of factors that pose a risk towards the attainment of the Sustainable Development Goal (SDG) 3 global goal. The UHC pilot unearthed the following challenges:

1. People were still going to the higher-level health facilities to obtain primary health care services;
2. Health services for the community was not available at the point of need;
3. There were weak linkages between the PHC facilities and the community; and
4. Trust within primary health care service delivery was at a low level;

Discussions with technical experts

Following the challenges above, several discussions on setting up Primary health care networks (PCNs) were held by health teams from the County and National Government. The output of the series of discussions was to support the County Governments in setting up PCNs, which could improve coordination of primary health care services. This was then documented in an Inter-Governmental Participatory Agreement (IPA), which was to be signed by both the National and County government teams in planning for UHC.

Documentation of PCN Operational Manual

With the IPA in place, an initial draft of the PCN guideline was written by technical experts from the Department of Primary Health Care at the Ministry of Health. This draft was then shared for review and adoption by a technical working group (TWG) composed of members from the National Government, County Government, and partners. This resulted in the development of a second draft of the PCN Guideline.

In the month of March 2021, a workshop was held to refine and update the Guideline. This workshop brought together key stakeholders in the Kenyan health sector. Four thematic groups were formed at the workshop, each addressing various sections and themes of the PCN Guideline. Comprehensive and structured consultations then took place on the draft guideline

at various levels, including at the national level, county level and among key health-sector stakeholders.

Following review and approval by senior officials at the Ministry of Health, the guideline was validated by the County Governments through a virtual meeting.

1.2. Background

Significant achievements have been realized in healthcare service delivery since independence, resulting in improvement of various health indicators. However, Kenya is now faced with the burden of communicable, non-communicable diseases and injuries/road traffic accidents among other health needs. Despite these challenges, the Government of Kenya (GOK) is determined to provide quality, accessible, affordable and acceptable health services for its entire citizenry. Major strategies employed by GOK include improving access, realizing equity goals and providing quality services as well as strengthening the institutional framework for effective delivery of health services.

To address the challenges within its health landscape, Kenya has undertaken significant reforms in the health sector aimed at ensuring a healthy life for the entire population. These have included the adoption of the UHC strategy towards delivery of health services. These reforms are taking place within the context of both major commitments at the global level and governance reforms at the national level to achieve affordable health for all. At the global level, the PHC approach was first declared in 1978 at Alma-Ata. Due to unsuccessful implementation of preventive and promotive health care by the signatory countries, thus leading to unfavourable health outcomes and slow progress in implementation, the Astana declaration of 2018 renewed commitment to primary health care as key to attaining UHC. On the other hand, Kenya adopted a new constitution in 2010, with a devolved system of governance under which delivery of health services is assigned to county governments while the national government is assigned development of national policies, legislations, capacity building for counties and management of national referral health facilities.

In 2017, the GOK unveiled its developmental blueprint called the *Big 4 agenda* which recognized UHC as one of the key determinants of development. To realize this, the Ministry of Health has planned to roll out UHC by 2022 (1). Primary Health Care (PHC) has been identified as the driver of UHC. PHC is a first-contact personal health care services that employ a whole-of-society approach to health where the goal to ensure achievement of the highest

possible level of health, well-being and equitable distribution by focusing on individuals, families, and communities needs and preferences at the earliest opportunity along the continuum from health promotion and disease prevention, treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment. PHC is fundamental to addressing critical UHC aspects of: (i) reducing household expenditure on health by addressing the underlying determinants of health and by emphasizing population-level services that prevent illness and promote well-being; (ii) cost-effectiveness in service delivery where involvement of empowered people and communities as co-developers of services improves cultural sensitivity and increases patient satisfaction, ultimately increasing use and improving health outcomes; (iii) emphasis on handling the determinants of health, which underpin vulnerability optimally positions PHC to address the barriers and inequities for the majority of people who do not have access to care. Additionally, PHC focus on community-based services is the only way to reach remote and disadvantaged populations.

The initiative to invest in PHC services is in line with Kenya's four key health delivery documents/platforms: the Kenya National Health Sector Strategic Plan (KHSSP) (2) ; the UHC Policy; the Kenya Essential Package for Health (KEPH); and the Kenya Primary Health Care Strategic Framework 2019-2024 (3). By the end of 2024, the PHC Strategic Framework projects great benefits from the provision of preventive, promotive, curative, rehabilitative, and palliative services. The Community Health Policy 2020 – 2030 and the Kenya Community Health Strategy (KCHS) 2020 – 2025 will support the implementation of the PHC at the community levels. Previously, Kenya's health services delivery focus was mainly on curative with very little attention paid to preventive and promotive aspects of health care. With the introduction of UHC there is a paradigm shift to comprehensive primary healthcare.

1.3. The Primary Health Care Network

Primary Health Care Networks (PCNs) are an integral part of PHC and thus form a key building block for scaling up UHC. The PCNs will help achieve universal access to health care by availing person-centred services closer to communities in need and assure quality, continuity and sustainability of healthcare. Each PCN will have the responsibility of providing PHC services while utilizing resources available within its geographical region. These will include reorganization of human resource, infrastructure, health products and technologies, finance, and governance structures in order to be responsive to the healthcare needs of the community;

and to ensure efficient, rational and equitable allocation of supplies, while avoiding wastage and minimizing shortages/stock outs.

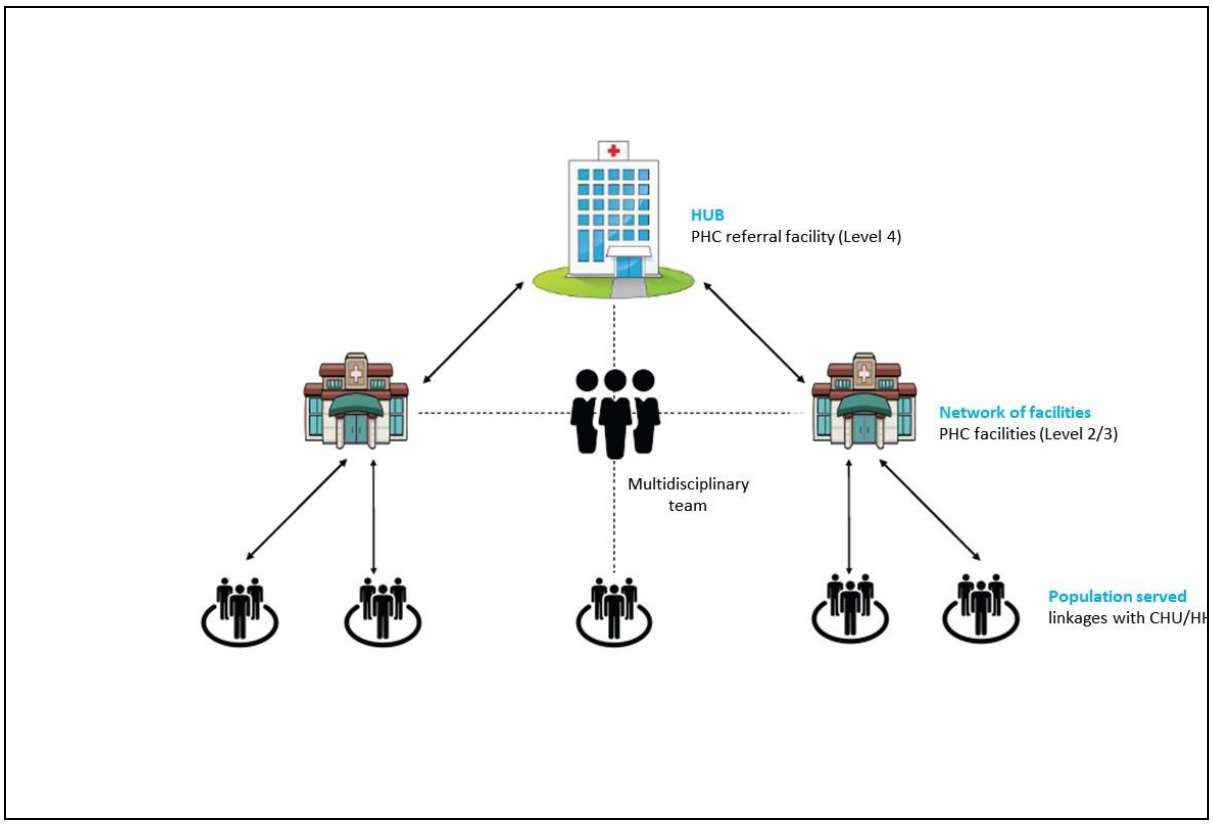
A PCN is defined as an administrative health region comprising of a primary health care referral facility (hub) and several other primary health care facilities (spokes) established to deliver access to primary health care services for patients, as well as coordinate with other hospitals in order to improve the overall operational efficiency of the network. The PCNs are designed to have a modified 'hub and spoke' model (Figure 1). The modified hub and spoke emphasizes the needs of the population with the community as the entry level to the health system. The hub is expected to be a level 4 facility (sub-county hospital, faith-based or private hospital) and will support the spokes which comprises of levels 2 and 3 facilities and level 1 community health units (CHUs). While in some regions a sub-county may constitute one PCN, some sub-counties in especially geographically vast counties may have more than one hub; hence more PCNs. In such situations a SCHMT shall have oversight over many PCNs.

The PCN will have authority and resources to determine the range of services. They will respond to health needs as identified and prioritized by communities, while giving the necessary technical inputs for their implementation. They can scale up new and region-specific services, expand the range of services offered, monitor and evaluate them, identify problems, and solve them. The PCN will improve the efficiency and effectiveness of essential PHC services through coordination of care and integration of service delivery. The PCN will also ensure continuous and uninterrupted essential PHC services.

Shared resources within the PCN could include human resource capacity which will be achieved through mentorship, supportive supervision, referral of patients or regular outreaches to the PHC facilities by Multi-Disciplinary Teams (MDTs). Other services that can be shared include laboratory resources through networking, commodity support and reporting systems.

Primary Health Care structure

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



1.4. Goal and objectives of setting up Primary Health Care Networks

The goal of establishing PCN is to increase efficiency and effectiveness of healthcare services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.

The specific objective includes improving health outcomes through:

a) Lower costs of healthcare for individuals, families, and communities
b) Improved patient experience
c) Improved clinician experience

1.5. Functions of the Primary Health Care Network

These include:

a) Provision of leadership and governance;

b) Resource mobilization and financial management;
c) Coordination of integrated essential quality PHC services including referrals, outreaches, emergency response, and public health services;
d) Play the enablers role by building capability and capacity within service providers, funding system, service redesign, stimulating change.
e) Play the integrator role within and beyond the health sector
f) Advocate for improvement of physical infrastructure, and ensure availability appropriate medicines, products, and technologies, HR and other resources
g) Surveillance, monitoring and evaluating, accountability, and learning; and
h) Linkage with social services (e.g., child protection, vulnerable population, disability services and legal services).

1.6. Criteria for the establishment of a Primary Health Care Network

For successful establishment of PCN, the MOH has put into consideration the following factors;

a) Clear definition and specification of the public value outcomes which the PCNs will deliver. This requires clear and measurable objectives aligned to PHC needs and expectations; performance evaluation framework and clearly defined roles and responsibilities for every level of management.
b) Supporting policies that give mandate for PCNs in the health system.
c) Operational and administrative feasibility, with requisite resources for PCNs to deliver on their objectives.

The following criteria will be taken into account in determining what should constitute a PCN:

a) At least 1 level 4 health facility (public, private or faith based) subject to the private and faith-based facilities being assessed and categorized in terms of levels;
b) At least 3 level 2 or level 3 health facilities within the region (public, private and faith based) subject to the private and faith-based facilities being assessed and categorized in terms of levels;
c) At least 5 level 1 community health units;
d) Evidence of Public private partnerships established between county government and the private sector partners;
e) Geographic area and distance to determine the establishment of a hub and spokes;

f) The population size to determine the number of level 1 community units to be established guided by the Community Health Policy;
g) Availability of different cadres of human resources for health (HRH) guided by the provisions of the Norms and Standards of Human Resources for Health;
h) Availability of adequate financial resource envelop to support the establishment and operation of the PCNs;
i) The status of maintenance, equipment, supplies and functionality of the facility for essential health services measured in terms of Kenya Quality Model for health (KQMH).

1.7. Guiding principles for the establishment of a Primary Health Care Network

a) Results oriented: PCNs need to demonstrate achievement of meaningful and measurable outcomes to be successful. They must be held accountable to their local communities, working in collaboration with other regional stakeholders, to improve patient and community health outcomes.
b) Ensure availability of resources: The operating context of each PCN will differ depending on factors such as location, demography, socio-economic status, population health factors and predicted changes over time. PCNs require the right resources in the right amounts e.g., personnel, expertise, funding, government support to be able to deliver and achieve the intended goal.
c) Creating relationships and collaborations: The key to achieving and enhancing PHC outcomes through PCNs is anchored on work collaboratively with relevant stakeholders and developing strong partnerships.
d) Good public image: PCNs must proactively take ownership of community concerns, be accountable and clearly articulate the value proposition for patients, primary health care providers and the broader community.

CHAPTER 2: LEADERSHIP, GOVERNANCE AND COORDINATION

2.1. Role of national government

The national Ministry of Health will support counties to establish and monitor PCNs by leading the development of guidelines and assessment tools. The head of the department of PHC, supported by the Committee of Experts (COE) will lead the roll-out of PHC and operationalization of PCNs. The Department of Primary Health Care, will be involved in the following areas:

a) The development and dissemination of PHC policies and frameworks including PCN guideline, Advocacy, communication and community engagement strategy, job aids and assessment tools;
b) Resource mobilization - Advocating for increased funding from national and county governments as well as partners to enable setting up and operationalizing PCNs;
c) Setting national targets;
d) In consultation with the county governments, harmonization, guidance and coordination of partners supporting PCNs, to ensure equitable service delivery;
e) Consolidation of HMIS data from the counties, analysis and timely transmission to stakeholders, for use in decision making and planning;
f) Facilitate knowledge sharing and dissemination of promising practices;
g) Support building of the leadership and management capacity at the county level for PCNs;
h) Monitor implementation and operationalization of PCNs; and
i) Monitor standards and quality assurance.

2.2. Role of the Kenya PHC 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 Kenya Primary Healthcare Strategic Framework (4). The membership of the advisory council comprises of the: chairman - appointed by the cabinet secretary for health, director general of health who is the alternate chairman, head - department of primary healthcare, CEO/ head of secretariat, WHO country representative, HENET chief executive officer, one representative from the local universities, chair/deputy of the council of governors, representative from the leadership of religious

organizations, and a representative from the civil society. The main mandate of the council is to:

a) Advise the Cabinet Secretary and Department of Primary Healthcare on primary healthcare matters;
b) Advise the Cabinet Secretary and Department of Primary Healthcare on implementation of primary healthcare framework;
c) Facilitate stakeholders review of the framework and implementation plan; and
d) Identify and make recommendations regarding framework implementation facilitators and barriers.

2.3. Governance structures at the county level

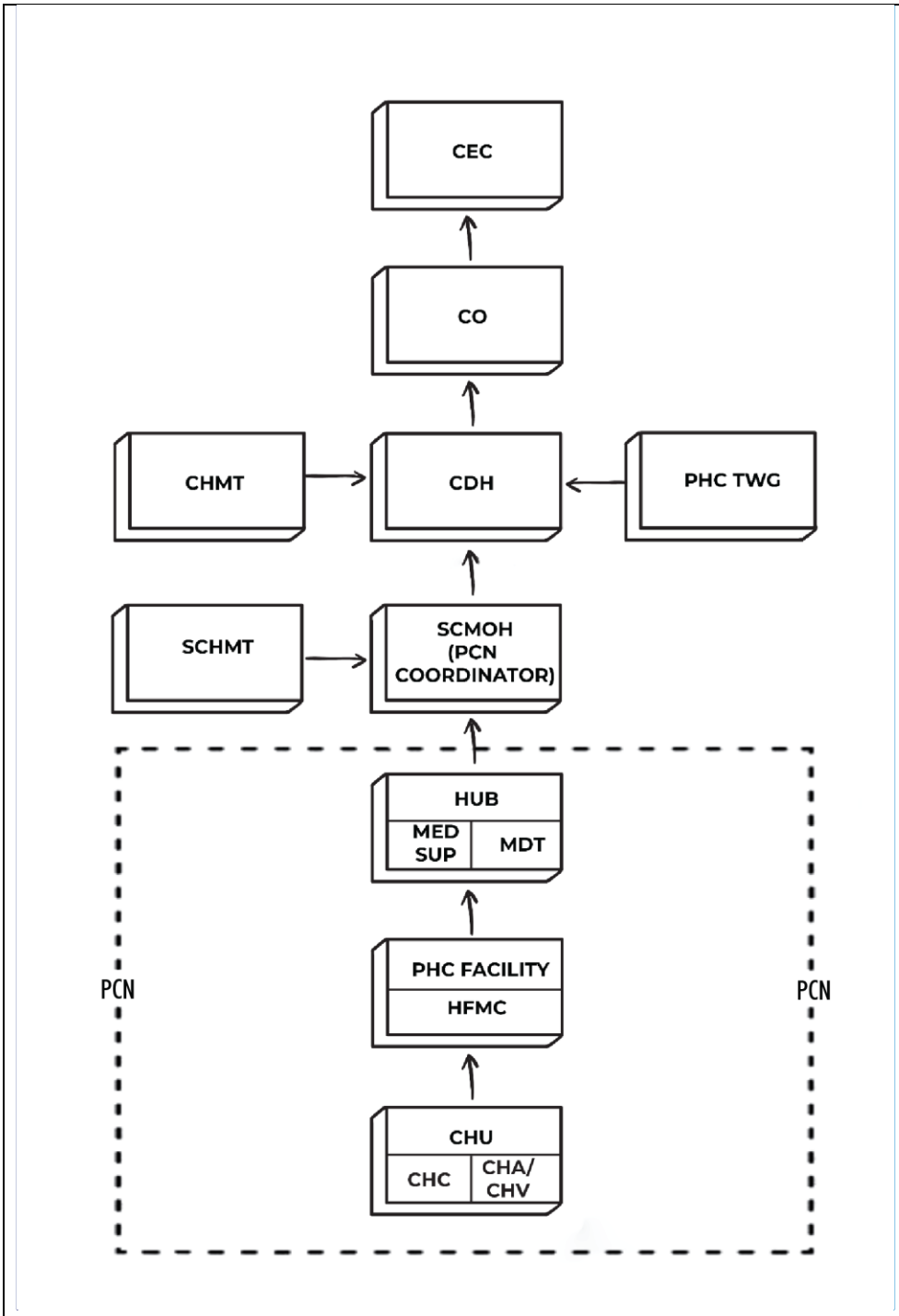
The county governance structure for PHC comprises County PHC Technical Working Group (PHC TWG) which comprises all CHMT members and representatives of non-state actors as well as other government agencies working in health; the Sub-County Management Team (SCHMT); Multi-Disciplinary Team (MDT), hospital boards or Health Facility Management Team (HFMT); and Community Health Committees (CHC). The PHC TWG, led by the County Director of Health (CDH), will coordinate the PHC activities at the county level through a PHC coordinator appointed by the CEC.

At the sub-county level, the Sub-County Medical Officer of Health (SCMOH) will coordinate the PCNs.

At the hub level, the Medical Superintendent (MedSup) will coordinate PCN activities at the hub, while the MDT will be in charge of daily activities of the hub, as well as linkages with the spokes and level 1 units within the PCN (Figure 2).

Figure 2: Coordination structure for a PCN

KEY	
CDH	County Director of Health
CEC	County Executive Committee
CO	Chief Officer
CHA	Community Health Assistant
CHMT	County Health Management Team
CHU	Community Health Unit
HFMC	Health Facility Management Committee
SCHMT	Sub-County Management Team
SCMOH (PCN COORDINATOR)	Sub-County Medical Officer of Health
MDT	Multi-Disciplinary Team
PHC TWG	Primary Health Care Technical working group



[DS1][AO2]

Coordination structure of a PCN

2.4. County PHC advisory committee

The Committee is chaired by CEC with membership representation drawn from religious leaders, women representative, youth representative, people living with disabilities

representative, water representative, roads representative, agriculture representative, and two representatives from implementing partners. The County Director of Health services (CDH) is the secretary to the committee. Coordination at the county is done by the county secretary. The main mandate of the council is to (4):

a) Provide leadership and governance oversight in the implementation of PHC and related matters in the county;
b) Identify key PHC issues in the region that the committee will advocate and provide advice on other PHC issues from a regional perspective at the request health departments;
c) Address consumers PHC issues, care coordination and innovative ideas for service delivery;
d) To promote communication between health department, other stakeholders and the community;
e) Provide beneficiary input on departmental activities, policies, plans and projects at the individual, program, and organization and system levels in the county;
f) Propose further opportunities for consumer engagement that will promote PHC improvements in the county;
g) To work constructively in addressing key PHC issues in the county;
h) To provide advice and/or input into PHC issues;
i) Carry out Advocacy and resource mobilization [DS3]on behalf of the county,
j) Fairly represent the views of the residents/community; Gathering the views of the residents/community they represent through their networks;
k) Provide feedback after meetings to members of the community; and
l) Provide leadership and advice in relation to the beneficiary and/or community views on PHC service delivery, planning and development in the relevant county.

2.5. Role of the PHC coordinator and TWG

A county PHC TWG, chaired by the CDH, and established in terms of the Partnership and Coordination Framework, supports the process of coordination and implementation of PHC activities by undertaking the following roles and responsibilities:

a) Plan for county needs and advocate for support and resources;
b) Set county targets for PCNs activities to be in line with the national targets;

c) Coordinate the formation, implementation, and optimal functioning of PCNs in the county;
d) Provide county-wide coordination and alignment of partners supporting PCNs;
e) Support PCNs to set targets for service delivery in line with agreed county targets and local health needs;
f) Support implementation of PHC related activities at county level in line with agreed county targets;
g) Ensure equitable distribution of resources and health services within the county;
h) Develop a county-wide human resource management plan to ensure health care worker availability at all facilities in the county at all times. (Their HR plan should include specific HR gaps, identification of training needs and plans to support HR capacity development in line with service requirements in the county);
i) Provide support supervision and coordination of county-wide mentorship and training activities through the MDTs;
j) Consolidate the HMIS data from the various PCNs and timely decision making at the county and national level;
k) Coordinate referral services within the county;
l) Support and enhance the integration of services;
m) Establish, support, maintain, and source funding for patient care networks e.g. referral, commodity distribution, reporting and laboratory networks;
n) Monitor standards, quality, impact and responsiveness of services to community needs using the standard tools/check lists developed by the national level; and
o) Monitor and ensure transparency and accountability of utilization of resources including funds.

2.6. Governance structures at the sub-county level

The SCHMT will be responsible for ensuring the PCN operates optimally. It will be responsible for the establishment and running of the PCN and should be involved in the planning and preparation stage.

The SCMOH is the coordinator of PCN at the sub-county level while the MedSup is in charge of the PCN at the hub level.

The duties of the PCN coordinator will be to:

a) Coordinate the formation, implementation, and optimal functioning of the PCN;
b) Provide coordination and alignment of partners;
c) Support the PCN to set targets in line with agreed county targets and local health needs;
d) Lead prioritization of service package/range of services to be offered through PCN;
e) Ensure equitable distribution of resources and health services within the PCN;
f) Reference and implement the human resource management plan to ensure availability and equitable distribution of health care workers as per level of care;
g) Support supervision and coordination of mentorship and training activities by the MDTs;
h) Consolidate and analyse the HMIS data from the various PCNs and for timely decision making at the sub-county and county levels;
i) Identify, setup, strengthen and coordinate activities of PHC referral sites in collaboration with the county level;
j) Work in collaboration with PHC referral facilities in identifying, setting up, strengthening and coordinating of PHC facilities;
k) Mainstream and facilitate integration of services thereby maximizing on available resources and avoiding duplications;
l) Coordinate community involvement in line with the Ministry of Health's Strategy for Community Health and with the local health needs;
m) Monitor and evaluate the delivery of local services to ensure quality, impact and responsiveness to local health needs and conditions, and the progress towards national targets for health;
n) Monitor and ensure transparency and accountability of utilization of resources including funds;
o) Institute an electronic commodities management system for all PHC facilities for real-time commodity management to avert commodities stock-outs.

2.7. Role of the PHC Referral Facility (Hub)

At the PHC referral facility/hub, the facility management board makes decisions that ensure overall smooth running of the facilities as well as engagement of the communities served. The community should be involved in decision-making regarding PHC services in the facility as well as in the community. The MedSup is in charge of PCN at the hub level while the MDT which he/she chairs, are the technical team to carry on the day-to-day implementation of PCN activities.

In the establishment and management of the PCNs, the following should be considered in the discharge of roles of the hub management team:

a) The facility management team should aim to strengthen the hub to ensure it complies with requirements with particular emphasis on quality issues, data management compliance and human resource capacity, to facilitate effective site support;
b) The hub needs to coordinate with the spokes to define the catchment population of each PHC facility. The catchment population need to be 100% covered by CHU linked to the PHC facility;
c) The facility must maintain links with the spokes (CHUs and the level 2 and 3 facilities) and have clear referral plan.

2.8. Role of the PHC Facility (Spoke)

The PHC facilities comprising of levels 2 and 3 are the first point of call for the citizens who cannot access certain PHC services at their community health units. They should provide a comprehensive range of services as defined by KEPH, to reduce upward referral.

The roles of the spokes will be to:

a) Lead the community in identifying health needs;
b) Administer patient care and support to the CHUs in collaboration with the Community Health Assistants/Officers;
c) Administer health promotion and prevention services;
d) Review services as per identified local health needs from community participation outcomes and ensure that they are continuous and supportive;
e) Analyse data from the community and facility and its utilization for patient care;
f) Report on commodities use and requirements as well as basic patient information data;
g) Ensure that continuous quality improvement is integrated in service delivery processes;
h) Support supervision, training and mentorship;
i) Provide and receive feedback to/ from the hub;
j) Define the specialties of the MDT teams needed for the outreaches –this should be evidenced by the data and other health needs of their catchment population; and
k) Design interventions to reverse trends of negatively performing health indicators in their catchment population

2.9. Role of the Community Health Unit

Engaging community in PHC services is a proven way to enhance program quality, in terms of clinical outcomes. The KCHS 2020-2025 (5) and the Community Health Policy (6) have outlined the standards and approaches to be taken to ensure that communities have the capacity and motivation to take up their essential role in health care delivery.

Thus, the first level of PHC service delivery is the Community Health Unit (CHU) which is a health service delivery structure within a defined geographical area covering a population of approximately 5,000. Each unit is assigned one community health assistant (CHA)/officer (CHO) and ten community health volunteers (CHVs) who offer promotive, preventive, basic curative services and referrals and is managed by a Community Health Committee (CHC).

Community members should be proactive in disease prevention and health promotion at the household levels, be active during the dialogue days and seek/demand care in a timely manner.

The community health workforce (i.e., the CHAs/CHOs and CHVs) will take lead in community engagement and linking the facilities and communities. They will also map households, while identifying their health needs and providing healthcare services as per the KCHS 2020-2025 (4).

2.10. Role of inter-sectoral and partnership coordination

Effective delivery of health services cannot be confined to the health sector alone but must be coordinated with several other sectors that have a direct impact on health such as water and sanitation and social services sector. Engagement and collaboration with partners in the health sector is key to the success of PCNs, through facilitating implementation and supporting active community participation. The development and implementation partners shall work in close partnership with the national and county governments, FBOs, CBOs, and other stakeholders to support policy formulation and implementation, coordination, capacity building, resource mobilization and monitoring and evaluation. For details, refer to chapter seven of private sector and partnerships. Inter-sectoral and partnership coordination forums should be established at the following levels:

a) County PCN inter-sectoral and partnership forum

This forum should bring together representatives of the CDH, other health related departments, non-state actors such as NGOs, CSOs, Faith-based organizations (FBOs), private health

facilities, and development partners. The roles and responsibilities of this forum should include joint planning and budgeting, resource mobilization, joint monitoring, evaluation and performance review, and joint oversight and accountability.

b) Sub-county PCN inter-sectoral representatives' forum

This forum should bring together representatives of the SCHMT, other health related departments, non-state actors such as NGOs, CSOs, FBOs, private health facilities, and development partners operating at the local level. The roles and responsibilities of this forum should include joint planning and budgeting, joint monitoring, evaluation and performance review, and joint oversight and accountability

c) PCN hub inter-sectoral and partnership coordination forum

This forum should include the hospital management board members, Med-Sup, representatives of the MDT, representatives of community-based organizations (CBOs), NGOs, FBOs, CSO, operating the catchment area covered by the PCN. The functions of this forum shall be joint planning and implementation of referrals and linkages in the PCN, joint resource mobilization, awareness creation, community involvement and participation in the PCN activities.

Conclusion

Success will be achieved through doing things differently which include inspiring change in communities, investing in the health workforce and leadership to reform PHC and ensuring resource flows and efficient systems that support service delivery. This will require:

a) Achieving a cohesive and integrated program that adheres to PHC policies and strategies;
b) Change management;
c) Integration into current coordination and governance structures;
d) Multidisciplinary and multi-sectoral approach; and
e) Performance management and accountability to monitor progress

CHAPTER 3: ESTABLISHMENT OF A PRIMARY HEALTH CARE NETWORK

The process to ensure successful establishment of a PCN should have the following components:

a) Establishment of the governance and coordination structures including MDTs;
b) Conducting a baseline assessment of community health needs, health facilities, resources, and partners;
c) Mapping of the hubs to serve a population in a defined geographical area;
d) Mapping of the spokes and CHUs, and linking them to the hubs;
e) Mapping and registration of households, taking into account the health profiles of each household member (health status profiling);
f) Identification of the financing requirements to establish and management of a PCN;
g) Gazettement of the PCNs; and
h) Setting up M&E systems for monitoring the PCNs.

a) Establishment of governance, coordination and financial structures

The first step in the process of establishment of a PCN is the establishment of the leadership, governance and coordination structures which are defined in chapter one.

b) Conducting baseline assessments

The next step in the establishment process is to conduct a baseline assessment of community health needs, health facilities, resources, and partners. The assessment should also map the population (to include the vulnerable, marginalized and hard to reach populations) and the resources in the county and sub-county.

In addition, the assessment should identify people who will benefit from targeted proactive support, in order to take a proactive approach to managing population health. Financial matters must be dealt with early in the process as this may delay the functioning of the PCNs' health care workers, in delivering services to their members. This should include: implementation costs e.g. support to be given to the CHUs, public health, coordination; and financial sustainability. Therefore, the assessment should also identify the financial requirements for the establishment of the PCNs.

This stock-taking process should be inclusive of all stakeholders, including community members, implementing partners, other sectors-e.g., agriculture, water, education. Through community engagement during baseline assessments and PCN management, the community members will give inputs in relation to their priority health needs, and their suggested preferred mode/method/avenue of addressing them within their PCN. This will guide the interventions that will be prioritized by the PCN.

c) Identification and establishment of the Hub

The CHMT, in collaboration with the SCHMT, should conduct a formal assessment of the PHC referral site (hub) to determine if it meets the conditions set out to being a hub.

The geographical or administrative area should first be considered in the overall plans for the PCN, taking into account accessibility to the PHC facilities (spokes). The hubs, together with the SCHMT, should determine the number of spokes they can efficiently manage to support adequate health care delivery based on their human resource and logistics capacity. Priority should be given to the need to increase the logistics, HRH, etc. for the hubs, to enable them to take care of spokes within their catchment population.

Areas for capacity building for the hubs should be determined. This should also take into account the need for regular supervision and mentorship of facilities in specific areas as per needs of the population. A key element here should be sensitization of all health care levels on PHC and importance of including communities and their inputs in their planning. The CHMT will advise the hub on the constitution and functions of the MDTs, who will be conducting outreaches to the PHC facilities and the community among other health care duties.

In summary, the steps to select a Hub should include:

a) Formal assessment by the CHMT and SCHMT;
b) Sharing of report derived from community engagement (health needs assessment);
c) Determining areas for capacity building;
d) The Hub and the CHMT to agree on the spokes; and
e) Selecting MDT which will conduct outreaches.

Outputs:

a) CHMT approved PHC referral sites to support the PCN;
b) Appropriate capacity building and logistics needed;
c) Identified and mapped PHC Facilities; and

d) Assigned core MDT.

d) Mapping the spokes and the CHU

The CHMT and PHC referral sites staff should conduct a formal assessment of the identified PHC facilities (spokes) and CHUs to identify existing capacity and services as well as capacity-building needs. This should encompass:

a) The ideal number of spokes and CHUs required:
   - Identify the existing number of spokes
   - Identify the existing number of CHUs
   - Identify the number of functional CHUs
   - Set up new CHUs to fill gaps
   - Identify staffing levels required
   - Identify the support required to operationalize all the CHUs

b) Detailed outline of systems, logistics and infrastructure necessary to support PCN process (e.g., lab networks, infrastructure, human resource needs, reporting, commodity management, communication, etc.);
c) A framework for linkages with the community (referral system);
d) Identification of the capacity-building areas required to strengthen the PHC facility.

Output:

a) Agreement reached on the services to be offered at the PHC facility, as well as support to be given by the PHC referral site - level of technical support/supervision and mentorship required to initiate services;
b) Clear SOPs on flow of services, commodities, reporting and communication, laboratory services available in the PCN;
c) PHC referral sites and PHC facility clearly define upward referral mechanism for patients who cannot be managed at the PHC facility (to include documentation);
d) PHC referral sites and PHC facility clearly defined downward referral mechanism for patients in PHC care for ongoing follow-up at the PCN.

e) Household registration

Registration of households within the PCN should be done, as per the KCHS 2020 – 2025 strategy (4). This will involve mapping of existing CHUs (active/not active) and updating

existing databases of registered household and CHVs. This registration should include health profiling of all household members, with periodic updates to capture births and deaths. Where possible, digitization should be done, to make it easier to access and utilize data within the PCN.

f) Inclusion of private partners and non-state actors

The leadership, governance and coordination structures establishing the PCNs should identify the existing Primary health care facilities in the sub-county owned and or operated by non-state actors and negotiate with them, on the basis of public private partnerships regarding how they will be incorporated in the PCN operations. The negotiations should culminate in agreements that define functions, roles and responsibilities of the privately owned hubs and PHC facilities. This is especially important when working with private and faith-based health institutions. Agreements will need to cover aspects such as shared resources, networking, referral systems and documentation on social corporate responsibilities.

Summary of a functional PCN

The length of time that PCN process moves between stages can vary, depending on the context.

A functioning PCN should have a:

a) Gazettement of the PCN in the respective county gazette
b) PCN coordinator;
c) Coordinated referral system;
d) Well defined linkages between the hub, spokes and CHUs;
e) Functioning system for logistics; and
f) Established monitoring and reporting systems.

CHAPTER 4: MULTI-DISCIPLINARY TEAMS FOR THE PRIMARY HEALTH CARE NETWORKS

As we plan to operationalize the PCNs, planning for human resources is required as per the Ministry of Health norms and standards (7), and should be tied to expected scale-up targets, MDT outreaches, and plans for downward referral of patients. The deployment, retention, motivation and training of health care workers will need to be well managed at all levels of health care delivery.

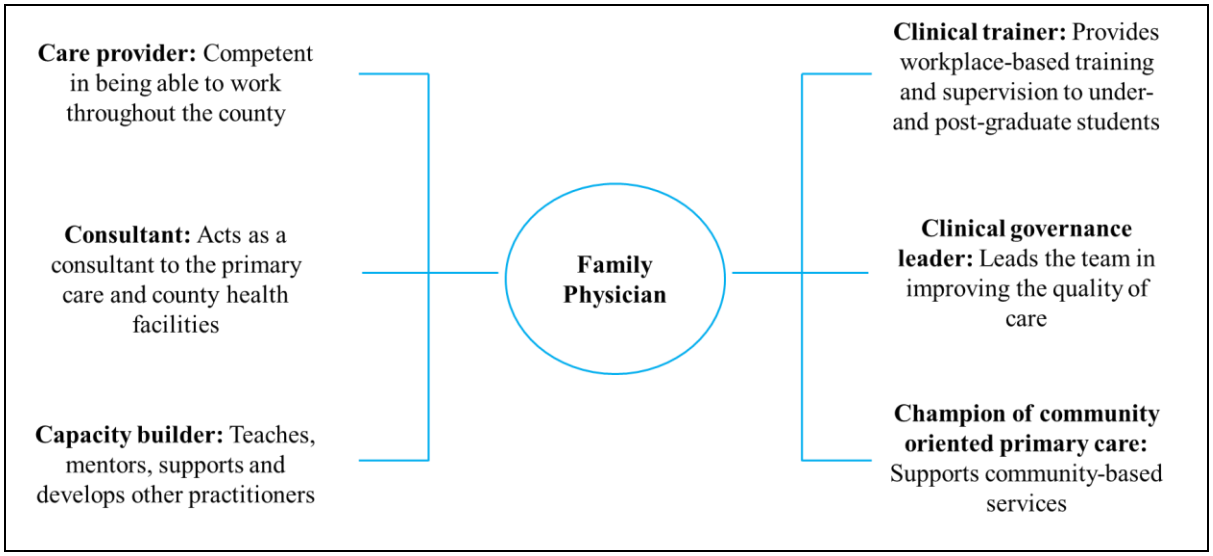
4.1. The MDTs

MDTs are the mechanism for organizing and coordinating health care services to meet the needs of the community (8). The team brings together the expertise and skills of different professionals to assess, plan, and manage health care jointly. The MDT is dynamic and should be composed of a care and support team that matches patient health needs and catchment population.

4.2. MDT Team Lead

The team lead for the MDT should be the Family Physician (FP) who is a licensed medical practitioner. The FP 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 (9). He/ She is concerned with providing comprehensive care to individuals and families by integrating biomedical, behavioural and social sciences.

Figure 3: Roles of the Family Physician *(10)*



Administrative roles

a) Lead the MDT;
b) Coordinate baseline assessment of the PCN in forming the hub and spoke;
c) Oversee appropriate documentation and interpretation of data to ensure continuous quality improvement of PHC and report monthly/ oversee and report monthly on PHC data/ oversee monitoring and evaluation of PHC data;
d) Design/ propose mentorship models between the hubs and spokes to achieve holistic person-centered care i.e., referral pathway, patient flow, and emergency response, pre-hospital care;
e) Inform budget and resource needs for the PCN as well as resource mobilization and partnership; and
f) Engage in advocacy and policy making for PHC at the county level.

Clinical roles

a) Advance holistic and patient centered healthcare delivery according to Ministry of Health guidance (11) including preventive, promotive, rehabilitative, curative and palliative services;
b) Facilitate training and capacity building for health workers under PCN;
c) Establish community-based research and quality improvement projects.

4.3. Composition and roles of the MDT

The core MDT team at the PHC referral sites should be composed of the following cadres of staff:

1) Family physician – Lead
2) Medical Officer
3) Clinical Officer
4) Nursing Officer
5) Nutritionist
6) Lab personnel
7) Public health Officer
8) Pharmacy personnel
9) Community health Assistants
10) Health Record and Information managers
11) Health Promotion Officers
12) Mental health officer
13) Medical Social worker

In addition to routine clinical roles, the MDT should be proactive in supporting preventive and promotive health services in the community. capabilities which may become necessary for the smooth running for the PCN and technical expertise is not covered by the team enlisted here can be sourced from the county or sub-county level if need be e.g., finance team etc.

The MDT Roles will include:

a) Oversee the Maintenance and managing (analyze etc.) population data for the PCN;
b) Ensure effective Upward and downward referrals of patients and services;
c) Support Outreaches to the community (strengthen beyond zero services with the right health products and technologies and personnel)
d) Regular/periodic and planned screening for health problems at the community e.g. diabetes, cancers, cardiovascular ailments etc.
e) Strengthen behavior change communication and communication of development
f) Manage medical supplies in the PCN/ community;
g) Continuity of care within the PCN; Health education, including and not limited to, drug adherence, healthy eating habits, home care, mental health, physical exercise etc.;
h) Nutritional assessment & counselling;
i) Coordinate public health activities within the PCN;
j) Support the Networking of shared service delivery resources including lab and radiological services;
k) Support referral services within the PCN
l) Supervise, train and mentor health-workers in the spokes, and CHUs; and

m) Monitor and evaluate services.

n) Institute fully equipped knowledge resource center at level one for community education

CHAPTER 5: SERVICE DELIVERY

Reforms in PHC will require changes in delivery of services. This will include a focus on preventive and promotive health services to improve health of the population. Different models of service delivery, such as the polyclinics, community midwifery and mobile clinics can be adopted and tailored to the county context.

The following components of KEPH package will be provide at the PCN:

a) Promotive: This will include advocacy, communication and Social Mobilization;
b) Preventive: This will comprise primary, secondary and tertiary preventive measures including screening, immunization, chemoprophylaxis and adherence monitoring;
c) Ambulance and emergency response;
d) Acute ambulatory care: This is the health care given to 'walk-in" patients;
e) Chronic disease care;
f) Palliative care: This will include care that improves the quality of life;
g) Rehabilitative care**:** This will be given to all eligible persons to improve their quality of life, and to prevent disabilities where possible.

5.1. PHC Facilities (Spokes)

The spokes offer preventive, promotive, rehabilitative and curative care services and have the potential for expanding and improving services with support by and under the supervision of a PHC referral sites. PHC facilities will provide different services as per the KEPH. PHC services provided will depend on access to resources for human resources for health (HRH), infrastructure, healthcare financing, health and support from the PHC referral sites. The range of services provided by a spoke may expand/improve over time. Gradually, the services offered at the spoke should become as comprehensive as possible in order to minimize upward referrals.

5.2. PHC Referral Facility (Hubs)

These facilities provide comprehensive services to a large population. Other than healthcare workers with experience in PHC, these facilities should have adequate laboratory capacity as well as the human resource, logistics, and systems capacity to supervise, support and provide mentorship for healthcare workers and to a county and sub-county network of PCNs and PHC facilities.

5.3. Outreaches

The MDT may provide some health services at a PHC facility or community. In this model a PHC referral site sends MDTs/ health care workers with necessary skills/ supplies on a regular basis (e.g. once a month) to a PHC facility to directly provide PHC care and treatment services. This model may result in the transfer of capacity/ services to the HCWs at the PHC facility over time. It has immediate benefits to the community served, with high quality of care.

5.4. Quality of care

The hub plays a crucial role in supporting the PHC facilities to provide a wider range of services. The Hub supports in:

a) Quality of care on medical management;
b) Commodity availability and supply;
c) Laboratory and radiological services;
d) Nutrition counseling;
e) NCD management;
f) ANC, immunization, and reproductive health services; and
g) Health promotion and prevention

5.5. Referral systems

A referral is a process in which healthcare personnel at one level of the healthcare system, having insufficient resources (drugs, equipment, skills) to manage a clinical condition, seeks the assistance of a different provider at the same or another facility to assist in, or take over the management of, the client's case**.** A referral system is a mechanism to enable clients' healthcare needs be comprehensively managed using resources beyond those available where they access care. The full scope of referral services expected of health services include: movement of clients, expertise movements, specimen movement and client parameter movement (e-health). Effective referral and communication systems and tools for use between the hub and the spokes should be reviewed (12).

Upward referral

Clinical conditions which cannot be handled at the community or PHC facility will need to be

referred to the PHC referral facility. There should be clear standard operating procedures to ensure that patients are seen at the appropriate level of expertise expeditiously- preferably guided by a health care worker / MDT member covering the PCN/spoke the patient has originated from. This will ensure patient follow-up is taken-up and arranged by the MDT member to improve continuity of care. Tracking of referral should be carried out within the PCN.

A clear system for preparedness and swift response to emergencies should be anchored within each PCN. Components of the PCN referral plan should include:

a) System of referral from community to spoke to hub and vice versa;
b) Contacts/ Persons in charge of referral;
c) Feedback to referral site; and
d) Emergency response.

Downward referral

Stable patients may be referred from the PHC referral facility to PHC facilities or community for care to ensure that patient care is as close to their home as possible; there should however be no coercion of patients to move, but rather the patient's informed decision for transfer of their care to this level with the option of reverting back to the referral facility as need arises. based on lessons learnt from home-based care e.g., for Covid-19, HIV etc., it is recommended that the PHC delivery process entrenches home based care for all eligible clients.

Horizontal referral

Within the PCN, shared resources may allow for a patient to be referred to a health facility of the same level offering a service not available in a similar level e.g., Radiology, Laboratory or nutrition services.

5.6. Health Products and Technologies (HPT)

Efficient commodity management in the PCN supports optimal service delivery. The SCHMT should prioritize scaling up supply and management of PHC level commodities. Health products and technologies (HPT) include medicines, vaccines, medical supplies, diagnostic supplies (laboratory and radiology), rehabilitation commodities and nutrition commodities. Selection of the these should be guided by the essential commodity lists such as the Kenya Essential Medicines List (13), Kenya Essential Medical Supplies List (14) and the Kenya Essential Diagnostics List. Appropriate management of HPTs through inventory management, distribution

should be carried out as per the Health Products & Technologies Supply Chain Strategy 2020-2025 and guidelines (15).

Commodity management at the community level should be overseen by the MDT. The PHC referral facilities have the role for supporting the PHC facilities in forecasting, quantifying, and ordering commodities. There is need to institute a robust electronic commodities management information system at the hub, linked to the PHC facilities and the county level, for real time information on critical stock levels and the urgency of re-stocking of all HPTs.

Commodity security technical working groups

Commodity security Technical Working Groups (TWG) should be formed at the county level with the goal of improving supply chain performance and product availability. The TWG should comprise of the Director of Health, County Pharmacist, County Laboratory Technologist, County Nursing Officer, and County Nutritionist. It is recommended that the sub-county pharmacist, Laboratory Technologist, Nursing Officer and Nutritionist of the PCN should be also be part of the TWG, so as to allow support for the PCN.

The TWG should ensure that all levels of care, levels1 to 4, have access to commodities that are recommended and required. TWG meetings, that connect staff from different levels in the supply chain, should be held regularly. Emergency TWG meetings may be held in the event that a hub's commodities electronic monitoring system raises an alarm for emergency re-stocking.

Roles and responsibilities of commodity security technical working groups

a) Ensure the installation and operationalization of an electronic HPTs management/monitoring system in every hub, with an inbuilt alert, critical and emergency stock levels for each commodity, linked to the county level;
b) Ensure product availability for the whole PCN, including the community level by undertaking rationalization of orders from facilities at county level, redistribution where there is overstocking or under-stocking;
c) Promote the use of data to assess performance against desired targets, and to guide timely problem solving, decision making and action taking at all levels to solve supply chain issues;
d) Improve communication and collaboration among team members bound by the common goal of improving product availability;
e) Build capacity and ownership in staff with supply chain responsibilities to take action

that helps to ensure good inventory management practices, reduce stock outs and improve reporting and quality of data;

f) Ensure availability of community health volunteers product availability (Kits);

g) Information management systems that provide real-time supply chain data for performance monitoring including documentation in the Health Products and Technologies (HPTs) Tracer Register (MOH 647); and

h) Ensure appropriate use of commodities through good prescribing and dispensing practices.

5.7. Laboratory services

The PHC referral facilities should have the capacity to perform basic diagnostic, screening and monitoring lab tests, including hematological, biochemical and possibly tests for screening for emerging pathogens. They should have the capacity to provide the services and form viable networks with spokes which may not have access to these tests. They should form appropriate networks to allow for sample referral so as to avail tests that may not be available on-site. Mentorship should be provided to the PHC facility by the PHC referral sites on standard operating procedures, testing, referral, reporting, QA systems and inventory management.

5.8. Human Resources for Health

For the effective implementation of PHC through the PCNs, it is the aspiration of this document that the Ministry of Health norms and standards relating to human resources for health are met as stipulated in the norms and standards for health service delivery - 2014-2018 (16)**.** It is envisaged that all counties will maintain data base for all human resources for health for ease of visualizing where capabilities/deficiencies are with the intention of utilizing /ameliorating them.

In summary:

a) The Hub should support PHC facilities that are located within the PCN. The hub and spoke should have an existing administrative relationship, although this does not preclude any PCN models across the sub-county or organizational type e.g., GOK – FBO, FBO – private, GOK – private. The model of care should, as much as possible, build on existing systems or ultimately aim at strengthening sustainable systems. A PCN outside the public sector administrative structures should nonetheless be channeled through the CHMT, which should remain overall in-charge of the process in the county.

b) PHC facilities should be supported to provide wider range of services. This may be dependent on availability of appropriately skilled human resource, commodities and equipment.

c) The PCN may mature over time. The management (CHMT, SCHMT, PCN coordinator), capacity of the PHC facility including human resource availability, capacity, training and mentorship as well as access to networking services and logistics systems will determine the range and quality of services offered at the PHC facility.

d) The community MUST be involved in the PCN, to ensure that it is responsive to the people's needs. The community health structures should be functional to ensure that patient care at the community complements and supports the care at the health facility level.

CHAPTER 6: FINANCING FOR PRIMARY HEALTHCARE NETWORKS

Health financing refers to the "function of a health system that relates to the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system" (17). Its purpose is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care". The adequacy of resources and efficiency in which such resources are allocated and used is critical to the provision of quality health service and elimination of inequalities in the operationalization of the PCNs. This will guarantee that all Kenyans have access to essential health services they need as provided in the Constitution of Kenya (18), without suffering financial hardship as envisaged under the UHC. For successful implementation of PCNs, the hubs will need to be cognizant of the health financing principles of resource mobilization and, pooling, strategic purchasing and efficiency gains as detailed below.

6.1. Resource mobilization

The PCNs will obtain funding from the following sources: -

a) **National Treasury:** The operation of the PCNs will rely on equalization funds and/or health conditional grants from the Government (National Treasury) to be disbursed through the county revenue fund (CRF)/County Special Purpose Account (CSPA). The development partners as "off" or on "budget" support also provides a source of funding, especially for the vertical programs such as HIV, FP/RMNCH, Malaria, and TB, provided within the PCN. As donor support to the health sector is set to decline, both levels of government are set to take on increased responsibility for funding the sector. In this respect, there will be need for both levels of government to collaboratively develop the health sector wide transition road map to ensure sustainable financing on the path to UHC. Counties will continue to have drawing rights to purchase for PCN drugs and other non-pharmaceutical items from KEMSA as per the essential medical list and, based on their respective Ministry of Health budgetary allocations for drugs.

b) **County Government Own Source Revenue (OSR).** The County Governments will need to adopt the following strategies to provide financing for the PCNs: -

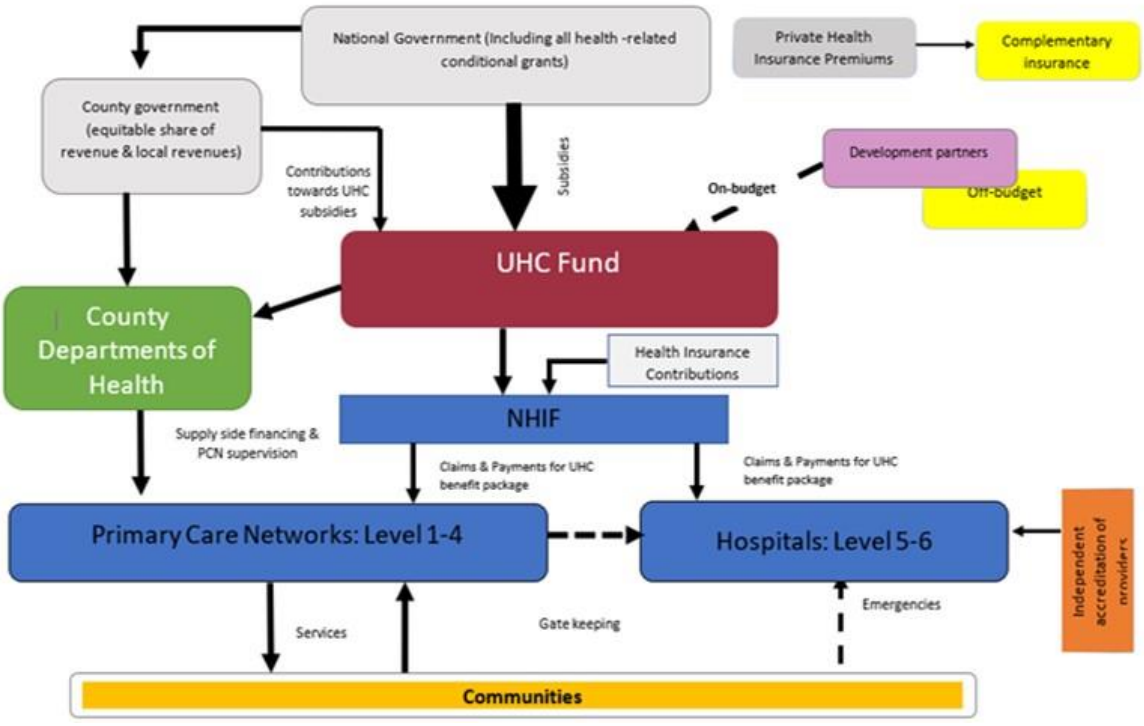
- Maintain and progressively increase county revenue allocations to health at a minimum of 30%, with increased allocation towards primary health care, community, sanitation, preventive, and promotive health services;
- Enact county legislations as per the PFM Act of 2012 (Section 109) (19) to allow for the retention of funds by the facilities within the PCNs to improve quality of services. This is particularly critical to obtain dedicated use of allocated PCN funds;
- Improve the financial flow of health funds from the Treasury through to the CRF/CSPA, hub and, primary health facilities. The PCNs should embrace approaches that facilitate smooth flow of health funds to service delivery points in a manner that supports timely delivery of health services, this would include adopting the FIF guidelines to allow for funds flow to service delivery points and the health facilities retaining their AIA to cover operations and maintenance;
- Undertake advocacy with the county assemblies to increase or, at worst, maintain heath budgetary allocations and, prioritize PHC within the available fiscal space;
- Develop mechanisms to identify and subsidize the poor and vulnerable populations who are unable to pay for services or for the national health insurance.

Private Sector: The Counties will need to harness private sector funding to support the PCNs/Hubs. This is notably through the various PPP approaches as detailed in Section 7.

6.2. Pooling

As part of on-going Ministry of Health reforms, there are plans to pool health resources at the national level by consolidating the different insurance schemes (e.g., EduAfya, Linda Mama, Civil Servants) within the NHIF as shown in Figure 4. The PCNs will need to be well acquainted with these reforms so as to expand pooling arrangements for the various pre-payment schemes within their areas of jurisdiction. As an illustrative example, community-based health insurance and other prepayment schemes within the PCN could be strengthened and, gradually integrated to the UHC Fund including NHIF. The aim is to reduce direct OOP spending to at most 15% as recommended by WHO (2020) as well as to improve financial protection for all through the proposed UHC Fund that will comprise funding from the donors, national and county contributions.

Figure 4: Pooling mechanism



Source: Ministry of Health, Kenya 2019

6.3. Purchasing

Purchasing refers to the transfer of pooled resources to healthcare providers for the provision of healthcare services. It provides a critical link between healthcare financing and healthcare service delivery, and facilitates efficiency, equity and quality in health systems performance. In line with other UHC-inspired reform efforts by the Ministry of Health (e.g. restructuring of NHIF), the PCNs will need to make deliberate efforts to shift from 'input based budgeting' to 'strategic purchasing', to increase efficiency of health spending with a focus on public goods and public health governance. This calls for determining which services the PCNs should buy, from who and at what cost with the aim of maximizing health system performance. The PCNs will need to take advantage of the NHIF provider payment methods—e.g. capitation for outpatient services and, case-based and fee-for- service payments-- and the new rates for the new outpatient and specialized benefit packages to maximize on the respective claims. This will be in addition to maintaining accurate and timely health data as well as streamlining NHIF claims reimbursement systems through establishment and operationalization of NHIF Offices

at the PHC facilities. PCN may contract, where feasible, clerks to follow-up with NHIF clients to enhance revenue collections at the facilities.

6.4. Efficiency

Even with additional resources for health, the PCNs would have to ensure utmost prudence in resource use in order to achieve the UHC objective and must pay attention to volatility of the county's fiscal space and in health system reform endeavours. To enhance both allocative and technical efficiency, this Manual proposes the following: -

a) Public spending on health be allocated to high impact interventions with the greatest impact on health outcomes. Resource allocation criteria to the PCNs should consider (i) population health needs as reflected by epidemiological patterns; (ii) cost-effectiveness paying attention to shifts towards health orientation (as opposed to disease orientation) and, (iii) use of medical procedures, technologies, and medicines that have proven efficacy, among others. To increase financing for health, the County Governments will need to implement the following strategies; (i) maintain and progressively increase current county revenue allocations to health with increasing allocation to primary health care, community, sanitation, preventive and promotive health services in line with where the majority of health services are administered. Advocacy efforts for increased funding to health will also be required at both levels of government. (ii) ring fencing of health sector funds to ensure dedicated use of allocated funds to the health sector. (iii) retention of facility generated funds in the facility and health sector as described in the FIF user fees guidelines (year). On wage and non-wage, Counties should not spend more than 30% of total county health budget on wages.

b) In line with the Health Partners Coordination Framework, Adapt and implement the principle of 'One Policy, One Strategy and One M&E Plan' through Joint Annual Work Planning, Budgeting and Priority Setting. *This would ensure* close collaboration in the implementation of PCN activities, ensuring greater reach, avoiding duplication of effort, and making the most of available resources.

c) Capacity building of those with fiduciary responsibilities in PFM, Costing and program-based budgeting (PBB) to enhance transparency and accountability of the available resources and, for the partners including development partners to work under SWAP approach.

d) Gate keeping: Counties should ensure there are proper gatekeeping mechanisms for referral of clients to avoid congesting the level 4 and above hospitals for conditions that can be treated at the lower levels successfully.

These proposals separately and together have the potential to increase funding for the PCNs.

6.5. The Cost of setting up PCNs

As part of developing the PCN guidelines, a costing exercise was conducted to give budgetary indications of setting up a PCN. This section will seek to highlight the key assumptions made and summarize the outputs of the costing exercise. *(Detailed information is provided in Appendix 5)*

Assumptions to the cost of setting up a PCN

The costing exercise took on an activity-based costing approach. The activities were grouped under thematic areas identified as key resources needed in the setting up of a PCN. The thematic areas, and hence resources, are:

a) Capacity building for HRH
b) Service delivery
c) Operations and management
d) Planning
e) Coordination
f) Advocacy and communication
g) Monitoring and Evaluation

Under each thematic area, activities were identified and subsequently costed. Costing data was sourced from the standard costing data used by the Ministry of Health. The detailed assumption is provided in Appendix 5.

Key outputs

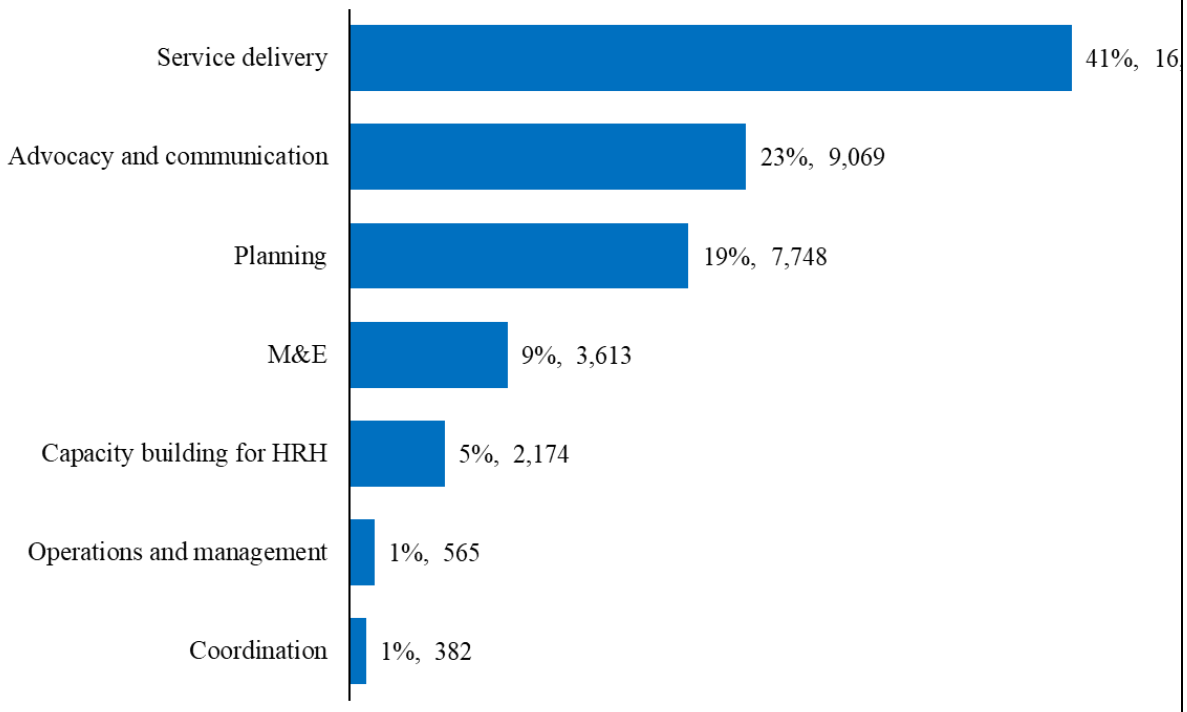
It will cost KES 40 million to set up and run a PCN for one year. This cost is expected to decrease in subsequent years, given that the majority of the capital expenditures are going to be incurred only in the first year. See Figure 5 below which shows the constituents of the KES 40 million budget.

Additionally, and as expressed in the Appendix 5, this is the cost of setting up one PCN. It is noted however, that each county will have numerous PCNs and may not need to cost every resource/ thematic area. For this reason, the costing framework allows for users (i.e. at the county level) to:

a) Input the number of hubs and/or spokes to be costed for each activity within each thematic area; and
b) Input whether or not to cost a particular activity within the thematic areas.

This therefore means, that the KES 40 million estimate assumes all the activities need to be costed for each PCN. The guidelines however acknowledge this may not be the reality for many of the counties as some of the mentioned activities are already in progress and/or accounted for in other budgets. See Appendix 5 for a detailed breakdown of the activities under the thematic areas.

Figure 5: Breakdown of costs needed to set up and run a PCN for a year (KES, thousands)



Notes:

a) The percent shows the proportion of the cost to the total budget. Thus, as an example: service delivery accounts for 41% of the total cost whereas coordination accounts for 1%.

b) The whole numbers represent costs, and they are in KES, thousands. Thus, as an example: service delivery costs KES 16.5 million whereas coordination costs KES 382,000

CHAPTER 7: PRIVATE SECTOR ENGAGEMENT

The private sector plays a critical role in healthcare delivery in Kenya (20) yet, its potential for the delivery of health services is not adequately maximized to improve health outcomes. This situation provides an opportunity for the hubs and affiliated PCN facilities to tap on to the private sector potential to meet the funding, expertise and service delivery gaps. The private sector comprises four key groups.

I. Private for profit (PFP) entities that carry out healthcare businesses such as manufacturing, laboratory services, supply chain of medicines, equipment and medical supplies with the aim of providing sustainable services through generation of profits.
II. Private not for profit (PNFP) entities, non-governmental organizations (NGOs) and faith based organizations (FBOs) - that have a significant role in strengthening emergency response systems, and provide health services in remote and, hard-to-reach areas.
III. Private corporates whose core business is not necessarily in health but provide health services to their employees through workplace programs, health insurance, health financing and, corporate social responsibility (CSR).
IV. Informal private health sector such as informal drug peddlers, Traditional birth attendants (TBAs) and, Traditional healers.

Through a public-private partnerships (PPPs) approach[1] guided by the Kenya Health Public Private Collaboration Strategy (21) and accompanying tool (22), and the Kenyan PPP Act of 2013, PPP Act's Regulations of 2014 and the PPP Project Facilitation Funds of 2017, among others, the hubs should establish partnerships with both PFP and PNFP actors to work together on areas of common interest. This is after undertaking a mapping of the PFP and PNFP entities within the hub to know what the players are doing, and where, as well as identifying potential opportunities for engagement.

Kenya Health Public Private Collaboration Strategy identifies priority areas for collaboration and investment, emphasizing the principles that must guide such engagements, and goes further to define the institutional ecosystem under which collaborations must operate to achieve

[1] This can be defined as a contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility, and remuneration is linked to performance

sustainability and high impact. The Strategy points to several objectives the hubs can work towards in fostering effective engagements with the private sector. These include: -

a) Supporting the creation of a policy and regulatory environment that allows effective private sector participation in meeting public health goals;
b) Leveraging private sector efficiency strengths, and innovation and technological capacity to improve public health service delivery;
c) Harnessing private sector resources and channelling them towards equitable financing of public health services;
d) Guiding contracting authorities on identifying and prioritizing projects that can deliver better value through collaboration with private partners;
e) Developing mechanisms for effective information sharing to promote transparency and accountability between the public and private health sectors; and
f) Building the capacity of stakeholders to initiate and engage in public private dialogue and establish mutually beneficial collaborations for maximum impact.

Illustrative models for hub-led PPP engagements include: -

a) Leasing contract (e.g., Managed Equipment Services (MES): Partnership with the private sector to upgrade facilities within the hub by providing modern equipment and technology and, specialized medical equipment such as theatre equipment, sterilization equipment, renal dialysis equipment, ICU equipment and radiology equipment;
b) Management contract: contracting the private sector to: (i) manage specialty hospitals within the hub, with specific provisions free care to the vulnerable or, (ii) act as voucher management agents to pay providers especially for partner or, NHIF supported programs;
c) Direct contracting: engaging private sector doctors to provide health services especially maternal health (e.g., deliveries and caesarean sections) in public health facilities at a negotiated fee;
d) Service contracts: contracting the private sector to provide clinical services including primary care and, clinical support services (e.g. diagnostics); and
e) Direct provision of services (e.g. Tele-Medicine): The private sector would provide, among others, consultations, lab tests and treatment of outpatient services and, referrals and, emergency services under a Build-Finance-Operate model.

Ideally, a well-structured PPP collaboration can harness private sector efficiencies learned through years of operating in competitive environments, and direct them towards delivering public services and achieving intended health goals. The collaborations can harness private capital and encourage private firms to invest in projects they would otherwise have deemed unfavourable. This in effect allows county governments to free up resources for more urgent uses. Collaborations may also enable public entities to engage in projects that carry benefits over long periods of time and can promote trust and accountability through objective performance assessment. Collaborations with the private sector can unlock innovative solutions and encourage 'out-of-the-box' thinking. Private entities may also have access to newer technologies, including those under patent, which could be quickly availed for public benefit. By focusing on life cycle costs (costs over a long period), long-term collaborations encourage better use of resources. For instance, when a private firm is contracted to construct and operate a facility, they are likely to do it in such a way that operations will be optimized in the future, allowing them to run the facility at low-cost post-construction. At the end of the contract, the public entity will inherit an efficient facility, thereby enjoying residual benefits beyond the life of the contract. This kind of benefit would not be possible for a short-term procurement project, where both the government and private firm's focus is on delivering the facility. Furthermore, collaborations can allow public benefit from private skill and expertise without the need to invest in training and capacity building. This is particularly helpful in health and other social sectors, where prohibitive costs of developing capacity for low demand services remain a major barrier.

Success in actively engaging the private sector will require strong leadership and political will from the County Governments; strong, formal, and regular public-private dialogue and joint planning and review through the new health partnership coordination framework and, improved regulatory and monitoring capacity by the national and county governments.

CHAPTER 8: MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING

An efficient monitoring and evaluation system is key in successful implementation of PHC. Monitoring ensures interventions are implemented as planned, identifies problems and allows for continuous corrections along the course of implementation (23).

Systematic collection, collation, analysis and reporting of data in a PCN will ensure verification for compliance with policy goals, outcome analysis, and will act as a guide to decision-making. There should be periodical review of the PHC targets based on the disease trends, prevalence, national targets and local health needs to ensure population needs are prioritized for intervention.

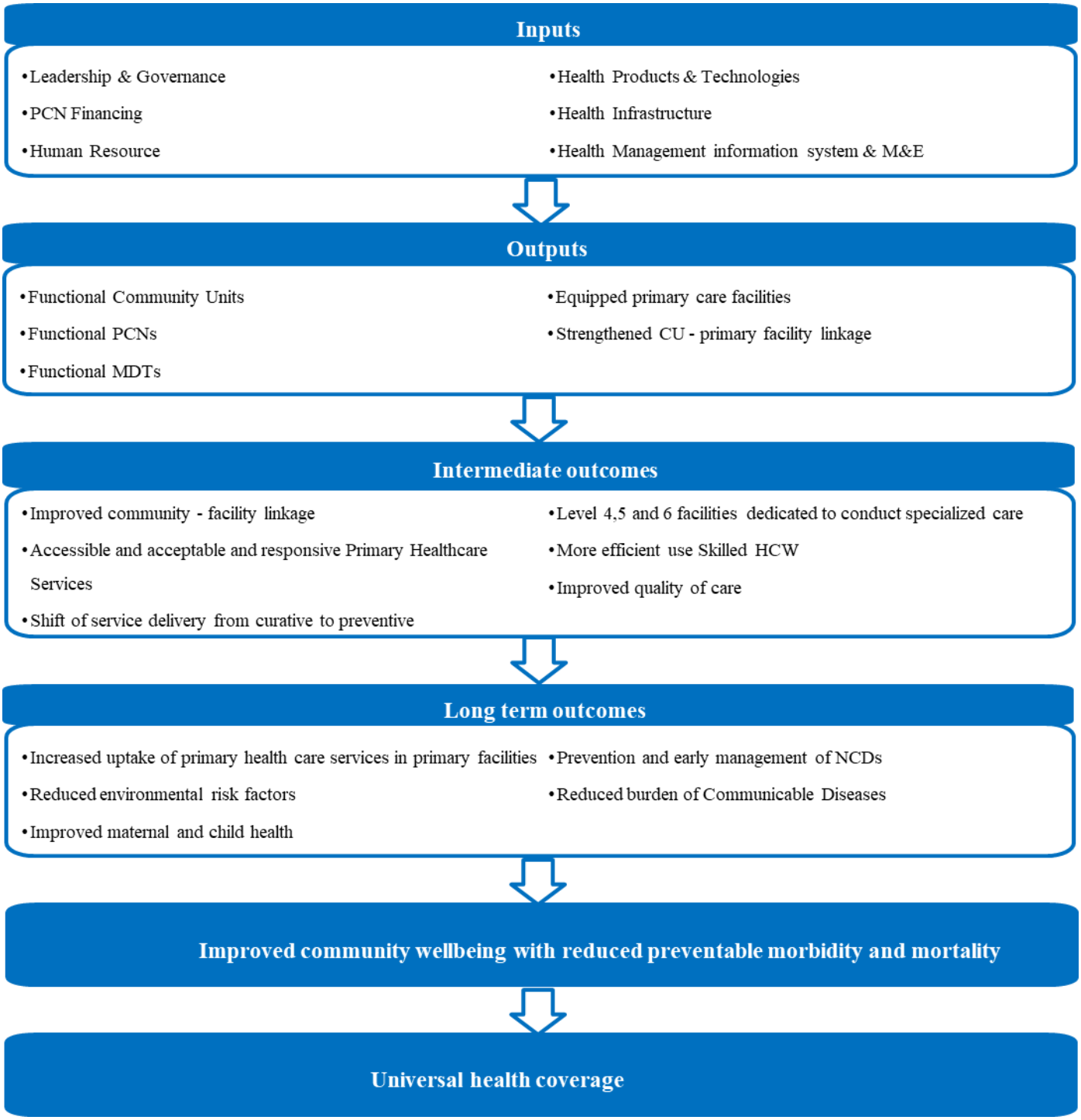
This section will provide guidance on the process of PCN monitoring, evaluation and learning, to systematically track the progress of PCNs as an intervention, and assesses its effectiveness, efficiency, relevance, and sustainability. The evaluation process will episodically assess achievement against standard criteria that complements the knowledge base of routine monitoring data. Involvement of key stakeholders including the private sector will contribute to better outcomes and better data quality because it reinforces their understanding of indicators and achievements.

PCN Logic Model

The logic model looks at what it takes to achieve intended results, thus linking results expected, with the strategies, output and input, for shared understanding of the relationships between the results expected, activities conducted, and resources required. This is represented in Figure 6 which shows the PCN Monitoring and Evaluation Logic Model. The indicators to measure performance are outlined in detail at the end of the chapter and are dependent on the assumptions outlined.

PCN goal: Improve the quality of services provided to the general population through a coordinated community-primary facility focused system

Figure 6: PCN Monitoring and Evaluation Logic Model



Logic Frame Assumptions

Critical-Assumptions

i. Adequate resources and organizational systems will be available
ii. Trainings offered during implementation will result in knowledge gain and behaviour change among those trained
iii. Data and information used for monitoring and evaluation is credible, accurate, reliable, and timely
iv. Information passed to members of the community and various stakeholders will result in actual change in behaviour and practices
v. Enhanced coordination with various stakeholders, will impact positively on the outcomes
vi. There will be a favourable prevailing evidence-based policy and political environment
vii. Investments as input, will result in desired outputs and outcomes, and eventually, achievement of overall results as outlined in the strategy

8.1. MONITORING

8.1.1. Routine PCN Data Collection and Management

Collection of PCN data will follow the routine data collection mechanisms in place. Data will be collected routinely using existing MOH data tools and digital platforms where available. Health care workers will collect health facility service data from the community, primary health referral facilities (Spokes) and the Primary Care Facility (The Hub).

This data will be fed into existing systems for aggregation and analysis at higher levels as below:

i. Kenya Health Information System (KHIS) will be used to collect PHC data;
ii. Logistics Management Information System (LMIS) is used to collect commodities ordering, supply and utilization information from health facilities;
iii. Community-based Health Information System (CBHIS) is used to collect routine health interventions data at community level.

a) The community unit

i. Registration

- Registration of household members shall be done by CHVs on a bi –annual basis, using MOH 513 tool. The county shall effectively budget for this process to enable mapping out of all community members per CU. The Community members shall also be mapped to their nearest primary care facility (spoke) which shall be their first contact facility.

ii. Service delivery- The CHVs shall documents services given to community members using exiting reporting tools.

- Household Register (MOH 513) which gives the denominators for measuring the service delivery of the CHVs;
- CHVs Service Delivery Log Book (MOH 514), which is a diary that CHVs use to collect information from the household during their visitation as they give messages and services;
- Community treatment and tracking register, which is a treatment register used by CHVs when offering integrated community case management;
- CHEW Summary (MOH 515), which is filled monthly by CHVs using the information from the Community Service Log at the end of month;
- CHIS Chalk Board (MOH 516), which displays the general health status of the community unit.

✓ The CHVs shall submit the reports to the CU CHA/CHEW who will summarize the data into the MOH 515 and submit to the link facility in-charge.

✓ The Facility in-charge shall submit this report to the SCHRIO by 5th of the next month. The SCHRIO will enter the data in to the KHIS by the 15th of the next month.

iii. Referrals services

- The Community health personnel shall refer all cases that require procedures outside of their approved scope of work to the nearest link health facility using MOH 100;
- The referral tool (MOH 100) is filled in triplicate.;
- The first and second copies are carried by the patient to the receiving facility. Upon providing health services required by the patient, the receiving facility will then retain a copy and let the patient carry a copy reflecting services the patient

has received and the referral needs for the condition that prompted referral and any other medical advice as may be necessary.

b) Primary Health Facility (Spokes):

i. Routine reporting - At level 2 and 3, the facility in charge will be responsible for compiling the monthly reports and will submit to sub-county HRIO who will validate and thereafter key into KHIS. However, where the digital systems are in place the reports will be submitted directly into KHIS by the respective facility and CHAs.

ii. Community integrated outreach services - The Primary health facility organizing the outreach shall be responsible for reporting the number of clients served in the outreach. This shall be done by ensuring entry of data about services offered in the several outreaches in a month are captured in the routine data reporting tools for the month.

iii. The outreach data collected by a partner offering integrated outreach services shall ensure that they are submitted to the link facility to be included in the final routine reporting tool.

c) Primary Health Referral Facilities (Hub):

The primary referral facility will report routinely to KHIS by 5th of every month

Additionally, the Level 4 hub shall provide;

i. Monthly report to the SCHMT on number of outreach facilities conducted in the PCN

ii. Any reverse referral visits conducted in lower-level facilities i.e. (specialists in level 4 moving to provide integrated services including special clinics in level 3 or 2 (spoke facilities)

iii. Document financial expenditure for the outreach activities conducted

iv. A report on referrals on monthly basis from lower-level facilities to level 4 facility and referrals back to spokes. The report will also capture referrals beyond the hub and will give a snap shot of the specialized needs, typical of a level 4 explained by the regions known dynamics

d) The SCHMT will give a quarterly report to the CHMT on the following;

1. Percentage of households registered into a CU and linked to a primary facility
2. Functionality of a Community Health Unit

   The functionality of the CU shall be based on these set criteria;

i. Existence of trained community health committee (CHC) that meets at least quarterly
ii. Trained CHVs and CHAs that meet prescribed guidelines
iii. Coordination by county community health leadership
iv. Supportive supervision for all community health personnel done at least quarterly
v. Availability of reporting and referral tools for all trained CHVs and CHAs have
vi. Household visits by all trained CHVs and CHAs as per their targets and at least to each household, once a quarter.
vii. Availability and use of mechanisms for feedback, local tracking and dialogue
viii. Presence of functional Health Information System (HIS) structure in accordance with prescribed guidelines
ix. Availability of community health supplies and commodities as defined by prescribed guidelines
x. CHU registered in Master Community Health Unit List (MCHUL) and linked to health facility
xi. CHU conduct meetings at least quarterly for dialogue days and monthly for health action days as well as household registration exercises at least once every six months

e) **The CHMT** through the community health focal person/primary health care focal person shall discuss and submit a soft copy of the summary report from all the SCHMT on PCN quarterly to the head of department of PHC (National office).

A standard reporting template to be used by the SCHMT in reporting PCN progress as well as full establishment shall be determined periodically. This shall be based on needs as well as UHC demands towards achieving the vision 2030 agenda on Kenyan population health care.

8.1.2. PCN Data Analysis

The demand for data both from the supplier and demand side is essential to its quality. This involves data synthesis, comparisons and analysis, and summarizing into a consistent assessment of the health situation and trends, using the core indicators and targets. This is complemented by more complex analyses that provide estimates, for example, of the burden of disease, patterns of risk behaviour, health service coverage, trends in indicators, and PCN

performance. The analysis will focus on both quantitative and qualitative aspects to deduce progress in short and long term.

Matrix on data needs of stakeholders

Who?	Why?
National and County level managers	• To understand the contribution of PCNs to the overall quality of the health and care system • To consider future priorities for policy and spending • To understand whether the quality of primary care is improving • To inform strategic quality improvement planning and resource allocation • To understand the impact of primary care redesign, including in relation to inequalities and informing approaches to address these
Health providers, MDTS and relevant programs and IPs	• To understand the quality-of-care provision in the context of the agreed primary care outcomes • To inform where future improvement activity might be needed • To consider changing workforce requirements and alignment • To allow benchmarking with other similar organizations and over time • To help support PCNs and
Researchers, academics, evaluators and other analysts	• To understand the quality of primary care, with reference to the agreed primary care outcomes • To inform the evaluation of primary care redesign activity
The public/service users	• To widen and improve understanding of services and policies through greater data accessibility and transparency about service activities and quality • To support public accountability and engagement

Health technology will be utilized to synthesize data. Existing digital platforms will be strengthened to create dashboards for real time data visualization. PCN indicators will be analysed as per the PHC M&E framework in the following lines:

- Overall national/county achievement and disaggregation of achievement by National County /Sub County.

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

- Periodically, qualitative data collection will be undertaken to evaluate the impact of the PCN and identify challenges while documenting best practices. Patient/community satisfaction surveys will also be conducted to assess implementation success. HCW/ Health facility level assessments will also support review of the implementation strategy

- Efficiency will be assessed through analysis of inputs, outputs, outcome and impact. Process evaluation will also be conducted to assess implementation of the activities set to achieve PCN

8.1.3. Quality of data/reports

In order to provide reliable information generated from a functioning PCN, the sub- county team shall;

- Conduct data quality audits of PCN at all levels within the network as per national M&E protocols
- Conduct quarterly PCN data review meetings at the sub-county hosting the PCN(s)
- Conduct during and after establishment of the PCN an assessment of the magnitude of service availability and readiness of health facilities to provide the essential health services which will ensure that quality of data will reflect the documented reality

- Conduct an assessment of the extent to which access of health services provides a direct or correlated reflection of the quality of data used in decision making.
- The facility team and CHUs shall conduct monthly meetings to review the quality of data at the CHU link facility

Data quality will provide at a glance increase and or improvement of quality health services as per the indicators for outputs, outcome and impact.

8.1.4. Data/reports sharing mechanisms

PCN data and reports will be packaged and disseminated in formats that are determined by the national government M&E division. These shall ensure uniformity in the sharing formats which leaves no required parameters.

In particular, the reports shall be;

a) Quarterly PCN review report at the sub- County and County level.
b) Bi-annual bulletins
c) Annual performance review report

The county shall publish annually a state of PCN report which will be a compilation of statistical information from different sources (e.g., public health facilities, private health facilities, implementing partners and FBO-based health facilities) presenting a snapshot of performance covering service delivery in all the levels (Hub & Spokes) of care encompassed in the PCN(s).

These reports will generate a pool of lessons as well as best practices to be used for decision making after credible evaluation and validation in replicating to other counties. The sharing of reports will also form a strong base for informed decision making in future PCN(s) investments.

8.2. Evaluation

There shall be an evaluation of performance of the PCN networks across all counties. Evaluations will be done periodically, one at baseline, and midterm review coinciding with the midterm review of the KHSSP. The end term review will also take place every 5 years in line with the end term review of the KHSSP and the Primary Health Care Strategy. The aim of the evaluations will be to assess the functionality and impact of the PCNs on health outcomes. The evaluation will aim to assess:

1. Establishment of PCNs
2. Functionality of PCNs based on the following criteria:
    a. Hub identification and the primary link facilities mapping to it
    b. Functional community units under the primary link facilities
    c. Household registration done in the community units and population awareness of their primary level link facility
    d. Functional MDT team members' identification
    e. MDT lead identification
    f. Gazettement of the PCN in the respective county
    g. PCN coordinator; -SCMOH
    h. Coordinated referral system with back-and-forth referral documentation
    i. MDT organizing and leading monthly community outreach activities
    j. Organization of specialist/MO visits from the level 4 facility to the lower-level facilities *(Details are in the **PCN assessment checklist in appendix 2**)*
3. Contextual factors affecting formation and functionality of PCNs, and the greater context of PHC implementation
4. Client surveys to evaluate the user perception of community health services and primary care services at the Primary Care Facility (level 2-3) and the Primary Referral Facility

The evaluations will serve the purpose of:

1. Taking stock of the progress in implementation of Primary Care Networks
2. Assessing challenges in implementation
3. Assessing best practices/lessons learnt in implementation of PCNs
4. Collecting data to feed into global commitments on Primary Health Care which includes populating the Vital Signs Profiles report. The Vital Signs Profile will be used to assess and strengthen PHC systems at county and national level (24). Development of the Vital Signs Profile is an initiative of the Primary Health Care Performance Initiative (PHCPI) (25). The VSP provides a snapshot of primary health care systems in individual countries/counties by shinning a light on where systems are strong and where they have challenges

8.3. Social Accountability

Social accountability refers to the broad range of actions and mechanisms beyond voting that citizens can use to hold the state to account and make it responsive to their needs, as well as actions on the part of government, civil society, media and other societal actors that promote or facilitate these factors (26).

MOH and county government will empower communities including vulnerable and marginalized groups to hold primary health care providers to account for the quality of the services provided. Elements of quality of services include: safety, access, effectiveness, appropriateness and equity, among others. The catchment population need to be informed of their catchment facility and have dialogues in the community dialogue days to address issues.

Accountability mechanisms to the community shall be institutionalized through various mechanisms:

1. Community score card – a tool which visually represents performance of identified interventions against set targets to gauge good or poor performance at a glimpse and can be simply understood by all community members and leaders across different levels. It empowers community members to take action to improve health outcomes when assessments reveal issues that need to be addressed.
   (see Appendix 3)
2. Monthly community dialogue days - the community scorecard can be used as part of the discussions during community dialogue days to ensure community needs and concerns are heard and recommendations actioned for the improvement of the community health and services provided in the primary facilities. The community dialogues shall be guided by the following principles:

   a) **Participation:** Involves the community and health service providers in a joint decision-making and processes;
   b) **Transparency:** Openly share and receive feedback on how health services are being experienced by the community members;
   c) **Accountability:** On quality of services to key decision makers at all levels of the health systems; community, ward, sub-county, county, national and international;

d) **Informed decision making**: The stakeholders to make decisions based on data and evidence generated;
e) **Responsibility:** The stakeholders with the community shall be responsible for following through the action plans to ensure improved quality of services;
f) **Tracking Progress**: Monitoring health services and timely mitigation of the gaps

3. Quarterly community action days – where there is follow up on agreed upon action plans agreed upon during the community dialogue days.
4. Quarterly Facility visits and feedback – done by the community health committee.
5. Community feedback mechanisms which enable communities give feedback of their perception of quality of services offered at the primary care facilities and the referral facility. These include:
    - Annual customer satisfaction surveys
    - Suggestion box at an accessible place at the facility, opened regularly by the HMT /MDT with documented discussions of the complaints, suggestions and action points

8.4. Monitoring, Evaluation, Accountability and Learning Team and Capacity

The monitoring and evaluation team

The national M&E unit is responsible for overall oversight of M&E activities. There will be an M&E team at PCN level, as part of the MDT, that will be responsible for the day-to-day implementation and coordination of the M&E activities at PCN level. The M&E team will develop (together with relevant stakeholders) and share their quarterly progress reports with the SCHMTs who will forward to the CHMT and PHC TWG, who will take lead in the joint performance reviews. The PHC TWG secretariat will then share this information with the national level PHC M&E focal persons by the 30th of every quarter. The consolidated reports from all county PCNs will be shared during the national health forum, which brings together all stakeholders in health to jointly review the performance of the health sector for the year under review.

Monitoring and Evaluation team capacity

The sub-county management team shall conduct an in-depth M&E specific assessment to establish the capacity needs by ensuring the following set of requirements are and or can be met by the target staff. They should have clear understanding of;

i. M&E terminology and have a sound understanding of the differences between monitoring and evaluation
ii. How M&E data can be used for PCN planning, management, and improvement.
iii. PCN indicators and describe reporting requirements
iv. Needs of PCN specific M&E plans, including PCN planning, goals and objectives
v. PCN M&E results framework, indicators, and data use
vi. The need to identify the five threats to data quality and methods to minimize and manage such threats
vii. The need to identify how M&E is used to manage and improve PCN, beyond reporting and accountability
viii. How to generate a plan for information sharing mechanism?

Capacity in M&E shall focus on the different levels i.e.;

a) **At county level:** The focus of the county M&E unit is to strengthen the PCN by building the capacity of the sub-counties to collect, analyse and use data at the local level before it is forwarded to the higher levels.
b) **PCN-Hub and Spoke facilities:** M&E capacity building will be done through supportive supervision by the SCHMT and MDTs who will focus on:
c) **Validation of monthly reports**
   i. Address challenges and constraints
   ii. Mentorship
   iii. Assessment and troubleshooting of data records and systems
   iv. Collection of reports
d) **At community level:** Emphasis will be on accurate data collection, digitization of health records and use of data at the community level to improve accessibility and demand for health services.

8.5. PCN Specific Monitoring and evaluation Indicators

Domain	Indicator	Data Source	Frequency

PCN Input Indicators			
Finance	County budgetary allocation to PCN activities (%)	County	Annually
Leadership, governance and coordination	Number of quarterly meeting held by the PHC TWG	SCMOH	Quarterly
	PCN annual work plan per sub county	SCMOH	Annually
	County PCN Advisory Council meetings	CDH	Quarterly
	County PCN inter-sectoral and partnership forum meeting	CDH	Quarterly
	Sub-county PCN inter-sectoral representatives' forum meeting	SCMOH/MDT - lead	Quarterly
Infrastructure and Equipment	Availability of standard lab equipment per level of care (Select tracer indicators)	KHFA	3 yearly
HRH	Number of CHMT members sensitized on PCNs	County PCN Report	Annually
	Number of Health facility in charges sensitized on PCNs	County PCN Report	Annually
	MDT team members identified	County PCN Report	One off
	MDT lead identified	County PCN Report	One off
	Annual report on training conducted for the Community Unit Workforce	County PCN Report	Annually
HPTs	Proportion of CHVs with Kits (Denominator- total number of CHVs serving in a PCN)	SCCHFP	Monthly

	# of Commodity security Technical working group meetings held quarterly	SCPHARM	Quarterly
HIS& M&E	Availability of reporting tools per tool (MOH 100, MOH 513, MOH 514, MOH 515)	National/County	Annually
	CU Reporting rates	KHIS	Monthly
	Percentage of community health units submitting timely reports	KHIS	Monthly
Service delivery	**Output Indicators**		
	Number of community units established in sub county	KHIS	Bi annually
	% of functional community units in sub county	PHC survey	3 yearly
	Proportion of households in the CU visited by CHVs (Denominator – total number of households in a CU)	KHIS	Monthly
	Number of PCN networks established per County	County PCN Report	Bi-annually
	Proportion of households mapped and registered per PCN	County PCN Report	Bi-annually
	Number of PCNs gazetted per county	County PCN Report	One off
	Number of outreaches/in reaches conducted within the spoke per month	County PCN Report	Monthly
	Number of PCNs conducting at least 1 community health and promotion outreach monthly	County PCN Report	Monthly
	Number of clients reached during the in reaches by the MDT	County PCN Report	Monthly

Service delivery	PCN outcome Indicators		
Population coverage outcomes	1st ANC visits within 1st trimester	KHIS	Monthly
	4th ANC Coverage	KHIS	Monthly
	Skilled Birth Attendance Coverage	KHIS	Monthly
	DPT3 Coverage	KHIS	Monthly
	Full Immunization Coverage	KHIS	Monthly
	# of new HTN cases per 100,000 OPD cases	KHIS	Monthly
	# of new DM cases per 100,000 OPD cases	KHIS	Monthly
	# of Cervical cancer screening cases in women 25-49 years	KHIS	Monthly
Referral outcomes	% of 1st ANC visits in L2-3 primary care facilities	KHIS	Monthly
	% of Skilled Birth Attendance in L2-3 primary care facilities	KHIS	Monthly
	% of DPT3 Coverage in L2-3 primary care facilities	KHIS	Monthly
	% of new HTN cases per 100,000 OPD cases in L2-3 primary care facilities	KHIS	Monthly
	% of new DM cases per 100,000 OPD cases in L2-3 primary care facilities	KHIS	Monthly
	% of Cervical cancer screening cases in women 25-49 years in L2-3 primary care facilities	KHIS	Monthly

8.6. Learning

The purpose of monitoring and evaluating learning practices is to apply knowledge gained from documented evidence from routine support supervision and data analysed to deduce

meaningful outcomes. In addition, learning will be achieved by use of PCN performance review reports, M&E symposia, exchange visits among counties, and annual learning PCN conference. The conference will bring together counties and other stakeholders to share their experiences in implementing PCN.

The PCN team therefore shall;

i. Routinely provide support supervision to ensure accurate steps are gathered and documented for subsequent learning
ii. Document health service delivery demand and supply change from the model based on the resources utilized to achieve them
iii. Ensure each county implementing PCN establishes a PCN model/centre of excellence to promote Intra and Inter county learning.
iv. Ensure the county health management team in liaison with the CEC and the CDH for health replicates the establishment of PCN(s) in other sub- counties gradually based on required resources and existing capacity and ensure reporting for further learning.

CHAPTER 9: RESEARCH AND INNOVATION

With the shifting burden of disease, it is essential that a primary healthcare system integrates innovation and learning, in order to adequately meet the changing needs of the population it serves. Evidence shows that primary healthcare is crucial to improving population health outcomes and with the renewed focus on PHC, teams managing PCNs will need to understand how to maximize these benefits in their context. It will therefore be essential to incorporate research, innovation and learning as PCNs are rolled out. This can be done through developing systems that capture new ideas and insights to allow for testing and advancement of innovative models that increase the impact of PCNs.

Aside from integrating new ideas generated by the implementing team, the health system needs a means to systematically evaluate promising evidence-based innovations implemented in other contexts in order to determine which innovations to adapt and integrate. Primary Care Networks are a novel approach in Kenya and will therefore require standardized ways of capturing learning as the model is implemented. Additionally, as PCNs are rolled out there will be an increased demand for evidence both to answer questions that arise during implementation and to provide data on the impact of this new service delivery model. This chapter therefore seeks to illustrate how teams can support a culture of continuous learning that supports innovation and research. As teams integrate research and innovation, this will enable shared learning across different contexts to strengthen primary health care delivery in Kenya.

9.1. Research for PHC

Evidence derived from research is key in informing impactful changes in the form of solutions to certain PHC challenges. Despite the significance of PHC and the huge role it plays towards population health, evidence shows that PHC research has been sub-optimal, globally, but more so in low- and middle-income countries (LMICs) where Kenya also lies. This could then be translated to innovations in PHC.

Research also plays a key role in informed decision making at the community to the facility and the policy makers' level. This means that there needs to be a nexus between the community, researchers and policy makers when it comes to identifying PHC research priorities as well as dissemination and translation of research into policy; in the form of embedded research.

It is therefore important to have priority-driven research which would be guided by a research priority framework that would ensure that the entire research is embedded in an evidence-based process that would yield high impact and sustainable solutions in PHC.

9.2. Developing a research agenda for PHC

Borrowing from the PHC Performance Initiative (PHCPI) PHC Conceptual Framework below (Appendix 4) we could see how a research agenda could be derived within a PCN, going by the key indicators within the process of delivering PHC. Taking service delivery as an illustrative example, some research questions teams could address include:

- Does the population within the PCN have geographic access to the health facility?
- Are there healthcare workers available at the health facilities within the PCN?

At the outcomes level, some illustrative research questions include:

- Are the services offered within the PCN responsive to the target populations health needs?
- Is the PCN efficient?

To enhance the PHC research process, some key recommendations would include:

- Creation of a PHC research coordinating body within the PCN which could then link with the other coordinating bodies within other PCNs for knowledge sharing;
- PHC research training for healthcare workers, both clinical and non-clinical;
- Continuous collection and broad dissemination of PHC related knowledge and sharing of best practices between the community, healthcare workers and policy makers for an integrated research approach.

9.3. Innovation

WHO defines health innovation as, '… the development of new or improved health products and technologies, and services and delivery methods that improve people's health, with a special focus on the needs of vulnerable populations.' (27)

In order to support the establishment and sustainability of PCN, it is crucial to identify health care innovations that improve access to affordable quality health care at the community and health facility level.

The sub-county health management team shall adopt a multi-step process that involve;

i. Identifying innovations- This process shall be driven by the demand of the population and teams implementing the PCNs. The demands of the population include but not limited to:

    a. Quality of maternal and child health,
    b. Developing models for chronic disease management
    c. Increasing access to essential health services for vulnerable populations.

ii. Adaptation of most relevant innovations- The innovations selected at this step would need to be implemented at a small scale in order to generate learning and understand if there are any adaptations required in the new context.

iii. Integrating proven innovation as a model by evaluating the suitability of the innovation by assessing against a set of objective criteria as follows:
    a) Evidence of impact
    b) Contribution to financial protection
    c) Access and quality
    d) Sustainability

iv. Innovations on technology to improve access of services from specialists for various needs are encouraged. However, it is mandatory that e-health policy and guidelines on accepted versions of soft-wares are referenced. This is meant to ensure patient data about their health are safe and confidentially shared ONLY to the intended recipients.

Key takeaways

- Systematic processes are required in order to increase the chances of success for health innovations implemented within the PCN model
- There are linkages between research, learning and innovation that support evidence-based primary healthcare interventions
- Clear decision-making criteria are required to drive health systems towards investing in proven innovations that generate impact

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APPENDICES

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APPENDIX 2: PCN ASSESSMENT CHECKLIST

Appendix 2 details the assessment checklist for PCN that can be used for the evaluation of performance of the PCN networks. The checklist acts as a reference to organization of specialist/MO visits from the level 4 facility to the lower-level facilities.

	County	Subcounty	PHC Facilities	Community	Total Score
Organizational structure of PHC	Availability of PHC Coordinator ***(0-No, 1-Yes)***	SCHMT in place ***(0-No, 1-Yes-does not meet regularly, 2-Yes- meets regularly (confirm with minutes))***	Do all HF have Health Facility Management Committee in place? ***(Scoring- 0-None, 1- Yes, not gazetted, 2- Yes, gazetted)***	Are there areas in the county that do not have CHVs/ CHUs? ***(1-No, 0- Yes)*** Are all established CHUs linked to health facilities? ***(0-No, 1- Yes)***	Max. Score-7
Planning	Available AWP ***(0-No, 1-Yes)*** If yes, Approach used in Development of county AWP	Do Sub-counties have their AWPs? ***(0-No, 1-Yes)***	Do facilities develop their own AWPs? ***(0-No, 1- Yes)***	Are Communities consulted in development of facilities AWPs? ***(0-No, 1- Yes)***	Max. Score-7

	(1- County level 2-Top-down, 3-Bottom-up)				
Financing	Does the county Allocate funds to PHC activities? ***(0-No, 1-Yes)***	Does the subcounty have funds for management and supervision of PHC services? ***(0-No, 1-Yes)***	Does the facility receive funds for Operation and Maintenance? ***(0-No, 1- Yes)*** Does the facility receive funds for Outreach services? ***(0-No, 1- Yes)***	Do CHVs receiving stipend? ***(0-No, 1-Inconsistent, 2-Regular/monthly)***	Max Score-6
Stockouts and replenishment of essential HPTs	Do the health facilities experience stock-outs of tracer HPTs? ***(0-No, 1-Yes)***	Are the Sub-county teams involved in the F&Q of essential HPTs? ***(0-No, 1-Yes)***	Do the facilities carry out Forecasting and Quantification of essential HPTs? ***(0-No, 1- Yes)***		Max Score-3

Referral and emergency services	Does the county have a plan for referral services? ***(0-No, 1- Yes)***	Are the SCHMTs involved in planning for referral services? ***(0-No, 1- Yes)***	Are all PHC facilities linked to a PHC referral facility? ***(0-No, 1- Yes)***	Do your facilities conduct outreaches to the communities? ***(0-No, 1- Yes)***	Max Score-4

APPENDIX 3: COMMUNITY SCORE CARD

Appendix 3 details the Community score card which is a tool which visually represents performance of identified interventions against set targets to gauge good or poor performance at a glimpse and can be simply understood by all community members and leaders across different levels.

FORM A

COMMUNITY SCORECARD ASSESSMENT SUMMARY

NAME OF FACILITY……. NAME OF CHU(s)…….…….
COUNTY……SUBCOUNTY……
WARD……QUARTER ……
YEAR…… DATE…….

PERFORMANCE CRITERIA		SCORE	REASONS FOR THE SCORE/COMMENTS
1.	**Respectful and compassionate care.**		
	Provide person-centred care with respect and empathy		
	Effective communication with clients or accompanying family members		
	Observation of the patients' privacy		
2.	**Waiting time for provision of health care services**		

	Time patient takes to receive services		
3.	**Availability of medicines and diagnostic services**		
	Medicines and diagnostics services		
4.	**Responsiveness to community health needs**		
	Participation in community dialogue meetings on a quarterly basis		
	Response to community grievances		
	Response to community scorecard action points		
5.	**Cleanliness of the facility**		
	Availability of running water		
	Clean toilets		
	Handwashing facilities with soap and water		
	General cleanliness of the facility		
6.	**Safety and security of the facility**		

	Appropriate waste disposal		
	Separate toilets for both gender with lockable doors		
	Regular power supply		
	Presence of security personnel		
	No overgrown grass/bushes at the facility		
7.	**Home visits by Health Workers/Community Health Volunteers**		
	Health workers conduct home visits on a quarterly basis		
8.	**Assessment of NHIF services**		
	How well health facilities are providing NHIF accredited services		
9.	**Emergency and referral services**		
	Availability and access of emergency (ambulance) services		
	Presence of bi-directional referral services (Community to facility and facility to community)		

Guide for scoring	**Assessment Guide (Point %)**
Good - 3	20-27 points (70-100%)
Average - 2	13-19 points (50-69%)
Bad – 1	9-12 points (<49%)

Compiled By: ……Designation: …… Signature: …….

Endorsed By: ……. Designation: ……. Signature: …….

FORM B

KENYA COMMUNITY SCORECARD ACTION PLAN

County: _____Sub County: _____Ward _____

Name of facility: _____Date created: _____

Committee Members Present:

1: …… 2: ……3: ……..

4: …… 5: ……

Chairperson: _____ Phone No: _____ Secretary: _____ Phone no: _____

Problem description	Action description	Stakeholder/ Collaborators	Person responsible (Owner)	Deadline (Date)

APPENDIX 4: INNOVATION CONCEPTUAL FRAMEWORK

Appendix 4 details how a research agenda could be derived within a PCN, going by the key indicators within the process of delivering PHC. Taking service delivery as an illustrative example, some research questions teams could address include:

- Does the population within the PCN have geographic access to the health facility?
- Are there healthcare workers available at the health facilities within the PCN?

System	Inputs	Service delivery			Outputs	Outcomes
➢ **Governance and Leadership** • PHC Policies • Quality Management Infrastructure • Social Accountability ➢ **Health Financing** • Payment Systems	➢ **Drugs and Supplies** ➢ **Facility Infrastructure** ➢ **Information Systems** ➢ **Workforce** ➢ **Funds**	➢ **Population Health Management** • Local Priority setting • Community engagement • Empanelment ➢ **Proactive population outreach** • Facility Organization	➢ **Access:** • Financial • Geographic • Timelines ➢ **Availability of Effective PHC Services** • Provider availability • Provider competence • Provider	➢ **High Quality PHC**: • First contact accessibility • Continuity • Comprehensiveness • Coordination • Person-centered	➢ **Effective Service Coverage**: • Health Promotion • Disease Prevention • RMNCH • Childhood illnesses • Infectious Disease • NCDs and mental	➢ **Health Status** ➢ **Responsive to people** ➢ **Equity** ➢ **Efficiency** **Resilience of Health systems**

• Spending on PHC Financial Coverage ➢ **Adjustments to Population Health Needs** • Surveillance • Priority Setting • Innovation and learning		and Management • Team-based care organization • Facility management capability and leadership • Information systems use ➢ **Performance measurement and management**	motivation • Patient-provider respect and trust • safety		health • Palliative care	

APPENDIX 5: COSTING FRAMEWORK

The costing framework has three parts:

a) The Summary tab – it shows the outputs of the costing work, relative to the assumptions fed into the calculations
b) The Inputs tab – it is where the users (at county level) are expected to input the variables unique to their county. This sheet requires two sets of information from the user, namely:
    - Whether or not to cost the named activity;
    - Number of spokes/ hubs/ community health units present in each PCN;
c) The Master sheet – it presents the standard costs as prescribed by the Ministry of Health. Users are advised not to change the data in this sheet.

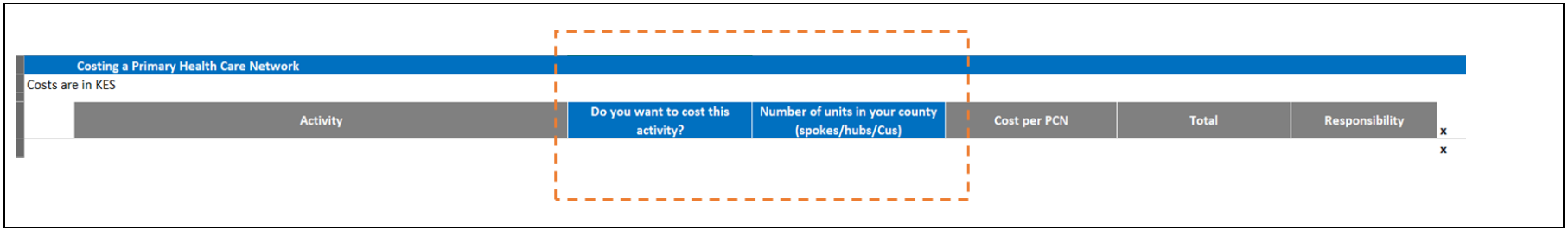
Assumptions

The costing framework made assumptions which are outlined below.

a) The costing framework assumes all the activities under each thematic area will need to be costed. This may not be reflective of reality as some of the activities are already ongoing or are accounted for in other budgets. Should this be the case, the user is advised to turn "off" the option to cost that particular activity. The default setting reads "yes"; however, this can be changed to "no" by selecting so on the drop down list of the relevant cells (Figure 7).

b) The costing framework is costing one PCN. This means one hub and several spokes and community health units. Therefore, it is advised that the users input the number of hubs/ spokes/ community units as will be applicable for their county. This can only be adjusted for in the Inputs tab (Figure 7).

Figure 7: PCN costing framework – Inputs tab



c) The costing exercise took on an activity based costing (ABC) approach. The activities were grouped under thematic areas identified as key resources needed in the setting up of a PCN. The thematic areas, and hence resources, are:

i. Capacity building for HRH
ii. Service delivery
iii. Operations and management
iv. Planning
v. Coordination
vi. Advocacy and Communication
vii. Monitoring and Evaluation

Under each thematic area, the corresponding activities were identified and subsequently costed, and responsibilities were assigned (i.e. to either County or National Governments). The summary of costed activities is provided in the table below. After identification of activities and sub-activities, cost line items were identified and then costed as prescribed by the standard costing guidelines provided by the Ministry of Health. The individual line items and costs per units are provided for in the Master sheet. Figure 8 below illustrates the ABC costing of one thematic area.

Table 1: Summary of PCN activities costed

		Responsibility
Capacity building for HRH		
1.1.	Train County TOT on PCNs	National
1.2.	Train sub-county TOT on PCNs	County
1.3.	Train MDTs at the hub	County
Service delivery		
2.1.	Conduct outreach programs	National
2.2.	Strengthen referral systems	County
2.3.	Movements of MDTs/ Expertise	County
2.4.	Purchase standard ambulance vehicles	County
Operations and management		
3.1.	Strengthen governance, coordination and financial structures for the PCN	National
3.2.	Engage community in the baseline assessment	County
3.3.	Confirm household registration and mapping to the PCN	County
3.4.	Conduct meetings with health facilities managers to orient selves on PCN	County
Planning		
4.1.	County planning	County
4.2.	Sub - county planning	County
4.3.	County review meeting	County
4.4.	Sub-county review meeting	County
4.5.	County stakeholder health forum	County
Coordination		
5.1.	Improve IT and Communication within the hub	County
Advocacy and communication		

6.1.	Enhance capacities of high level leadership to advocate for PCNs	National
6.2.	Develop advocacy communication package for PCN	National
6.3.	Promote PCNs through media engagements	County
6.4.	Sensitize different actors on the PCN model	County
M&E		
7.1.	Develop tools and checklists for a PCN	National
7.2.	Conduct baseline assessment	National
7.3.	Quarterly support supervision at the sub county level	County
7.4.	Conduct data quality checks and review	County
7.5.	Develop reports on performance of PCNs	County

Figure 8: Example of ABC costing as in the PCN costing framework

Costing a Primary Health Care Network

Costs are in KES

	Activities	Sub -activity	Budget Assumptions	Line cost items	Number (Pax/Litres/Copies)	Unit Cost	Number of units/meetings/ workshops	Days	Months/Quarter (Frequency per year)	Total Cost (KES)
3	Operations and management									
3.1.	Strengthen governance, coordination and financial structures for the PCN	Meeting at county	Virtual meeting for 12 pax, for one day, to establish the governance, coordination and financial structures for PCNs	Airtime for internet bundles	12	2,000	1	1	1	24,000
				Total						**24,000**
		Meeting at sub-county	Virtual meeting for 15 pax, for one day, to establish the governance, coordination and financial structures	Airtime for internet bundles	12	2,000	1	1	1	24,000
				Total						**24,000**
				TOTAL						**48,000**
3.2.	Engage community in the baseline assessment	Stakeholder meeting	Non residential stakeholder meeting for 3 days; 30 pax to include MoH officials, CSOs and partners (5)	Breakfast package	25	1,500	1	3	2	225,000
				Coordination - Airtime	1	2,000	1	1	2	4,000
				Participants per diem	-	-	1	-	-	-
				Total						229,000
				TOTAL						**229,000**
3.3.	Confirm household registration and mapping to	Household registration	Costed in the KCHS 2020-2025 budget (Reference SD 5.2.5. Costed at KES 2.9M)							
3.4.	Conduct meetings with health facilities managers to orient selves on PCN	Management meeting	Virtual meeting expenses for 35 pax including partners. 20 require reimbursements	Airtime for internet bundles	35	2,000	1	1	4	280,000
				Coordination - Airtime	1	2,000	1	1	4	8,000
				Total						**288,000**
	Total									**565,000**

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