**PRIMARY HEALTH CARE**

**History of PHC**

In the 1977, World Health Assembly, the government of Kenya along with other member states of WHO, endorsed the worldwide social objective of 'The attainment by all people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life' (WHO, 1977).

However, many countries in the developing world recognized the fact that it was not possible in the near future for them to achieve this worldwide social objective. This was because many lacked the resources needed to develop and run health services. They needed to adopt a strategy that allowed them to use the available resources to give some benefit to everyone and provide special attention to those at high risk. The member governments endorsed the PHC strategy for the provision of health services for all.

The strategy for the implementation of PHC was adopted by the Kenya government to provide health services to its population, the majority (80%) of who live in the rural areas.

**Definition of PHC**

In 1978, the Alma Ata international conference on PHC defined primary health care as:

'Essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

In addition, it forms an integral part both of the country’s health system.

From the definition, you need to note the following key statements which identify PHC as essential health care. These are:

PHC is universally accessible to individuals and families in the community.

PHC is socially acceptable to all, meaning that the health care is appropriate and adequate in quality to satisfy the health needs of people, and is provided by methods acceptable to them within their social cultural norms.

PHC is affordable, that is, whatever methods of payment used, the services should be at a price the community can afford.

PHC promotes full participation of individual, families and communities.

PHC is appropriate technology that is, the use of methods and technology which use locally available supplies and equipments.

**The Concept of PHC**

It is easily identified using the five 'A's as follows:

**Accessible**

That is, the services are geographically, financially and culturally within easy reach to the whole community.

**Acceptable**

The quality of health services offered are appropriate, adequate, and able to satisfy the health needs of people; and are provided by methods which are within their social cultural norms.

**Affordable**

That the services are provided at a cost that the community can afford.

**Available**

The health structures and services are easily available to the community members and they also help them to assume responsibility in promoting their own health.

**Appropriate Technology**

Utilising existing methods, techniques, and resources within the community to provide adequate health services.

**The Seven Pillars of PHC**

**Aspect Definition Comment**

**Health System** Primary Health Care.The first elements of a continuing health care process,sustained by integrated, functional and mutually supportivereferral systems, leading to the progressive improvement ofthe comprehensive health care for all, and giving priority tothose in most need.

**Priority** Essential health problems. Addresses main health care problems in the community providing promotive, preventive, curative and rehabilitative services.

**Science** Practical, scientifically sound. Based on application of the relevant results of social, biomedical and health services research.

**Culture** Socially acceptable methodsand technology.Reflects and evolves from the economic conditions andsocio-cultural and political characteristics of the countryand communities.

**Equity** Made universally accessibleto individuals and families.The attainment of health care for all people of the world bythe year 2000 and beyond, of the level of health that wouldpermit them to lead socially and economically productivelives. The existing gross inequality in the health status ofthe people particularly between developing countries, aswell as within countries is politically, socially andeconomically unacceptable.

**Participatory** Through their fullparticipation.The people have the right and duty to participateindividually and collectively, in the planning andimplementation of health care.

**Sustainability** At a cost that the communitycan afford to maintain atevery stage of theirdevelopment in the spirit ofself-reliance and selfdetermination.To exercise political will to mobilise the country’s resourcesand to use available external resources rationally.

**Elements of PHC**

In the Alma Ata conference of 1978, eight essential elements of PHC were identified.

However, individual countries were given the liberty to add any other elements they felt were relevant to their own country. Kenya has added other elements.

The PHC elements listed at the Alma Ata Declaration were as follows:

1. Education concerning prevailing health problems and the methods of preventing and controlling them

2. Local disease control

3. Expanded programme of immunisation

4. Maternal and child health care and family planning

5. Essential drug supply

6. Nutrition and adequate food supply

7. Treatment and prevention of common diseases and injuries

8. Safe water supply and good sanitation

The Kenyan government added five PHC elements to the ones identified at the Alma Ata conference These are:

1. Mental health
2. Dental health
3. Community based rehabilitation
4. Malaria control
5. STI and HIV/AIDS prevention and control

**Health Education**

This is education that is intended to have a positive impact on health. It is a process of dialogue with community members to find out appropriate responses to health problems, as well as to empower them with the knowledge and insight they need, to understand how their behaviour affects their health.

**Proper Nutrition and adequate food supply**

Nutritional deficiency states are particularly noticeable among pregnant and lactating mothers, infants and children. This may be due to the prevailing cultural or economic factors in the community.

As a community health nurse, it is your responsibility to take suitable measures to prevent and treat diarrhoeal diseases, intestinal parasites and other diseases, which lead to nutritional deficiency states. It is also your responsibility to support health promotional measures such as child spacing, nutrition education, kitchen garden and food hygiene. In coordination with other sectors, you should also encourage community members to grow more foods, prevent post harvest spoilage through construction of simple food stores, and to keep poultry and dairy cattle.

**Water Supply and Basic Sanitation**

Safe water and sanitation is not available to a major section of our population, yet, it is essential for life. Many water borne diseases which are prevalent in the community can be prevented if communities gain access to safe water and adopt proper refuse and faecal disposal.

**Maternal and Child Health and Family Planning**

MCH/FP services are aimed at promoting the health of mothers and children, by reducing the maternal and child mortality rates, and enabling women of childbearing age to have the desired number of pregnancies and at the right interval.

**Expanded programme of Immunisation**

Kenya has for some time now implemented immunisation activities through the Kenya Expanded Programme on Immunisation (KEPI). Immunisation is a very effective means of primary prevention against certain endemic and epidemic diseases.

**Local Disease Control**

There are many endemic diseases in this country, some of which are confined to particular

areas. Eg malara, Schistosomiasis, Filariasis, Hookworm, Trachoma

**Treatment and Prevention of Common Diseases and Injuries**

Curative care is important in its own right as it provides a powerful mechanism for teaching preventive and promotive care. The Kenyan govt has put in place various measure to handle this

**Supply of Essential Drugs**

Essential drugs are basic drugs used to treat minor ailments or conditions at the dispensary and health centre levels.

As a community health nurse you have a major responsibility in ensuring that patients have access to essential drugs and know how to manage their drug regimens for optimal effect.

**Mental Health**

The WHO defined health as ‘a state of complete physical, mental, spiritual and social wellbeing and not merely absence of disease or infirmity’.

Mental health services should not be viewed in isolation but as an integral part of the other PHC services that are needed to achieve the complete health of individuals, families and communities.

Health workers should therefore:

Be oriented to look at mental health as part and parcel of PHC

Promote good mental health practices through health education of the family and community in order to create awareness

Provide facilities in all health institutions and service delivery points for education, detection, treatment or referral of mental health problems

**Dental Health**

Dental health is a strategy of care focusing on the promotive and preventive care of teeth and the oral cavity.

**Malaria Control**

Each district in Kenya is required to determine malaria endemicity and plan and implement an appropriate control strategy.

**Community Based Rehabilitation**

Many developing countries such as Kenya included this element in order to give special attention to the management and prevention of disabilities arising from congenital defects, chronic non-communicable diseases such as cancers, and accidental injuries. Rehabilitation services are now being integrated at all levels of health care delivery including at the family and community level.

**STIs, HIV/AIDS Prevention and control**

The Kenyan government has set out technical and ethical approaches aimed at meeting the challenges presented by the HIV/AIDS pandemic. These include:

* Adequate and equitable provision of health care to the growing numbers of HIV patients.
* Treatment of other sexual transmitted diseases that increase peoples biological vulnerability to HIV infection
* Reduction of women’s vulnerability to HIV infection by improving their health, education, legal status and economic prospects
* A supportive socio-economic environment for HIV/AIDS prevention

**Principles of PHC**

There are five basic principles which govern the implementation of PHC. These are:

* Equity
* Manpower development
* Community participation
* Appropriate technology
* Multi-sectoral approach

**Equitable Distribution**

Equity is the fair and reasonable distribution of available resources to all individuals and families so that they can meet their fundamental and basic needs. Services should be physically, socially and financially accessible to everyone.

This principle should be considered when deciding on the location of new health facilities, outreach services points, or during introduction of new health programmes, especially those that require payment for services.

**Manpower Development**

Primary Health Care aims at mobilising the human potential of the entire community by making use of available resources. This principle facilitates the identification and deployment of the necessary health personnel as well as the training and development of new categories of health workers to serve the community.

**Community Participation**

Community participation is the process by which individuals, families and communities assume responsibility in promoting their own health and welfare. The PHC strategy underlines the importance of full community participation, especially in health decision making. Community members and health providers need to work together in partnership to seek solutions to the complex health problems facing communities today.

**Appropriate Technology**

Appropriate technology is the kind of technology that is scientifically sound and adaptable to local needs, and which the community can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It includes issues of costs and affordability of services, type of equipment and their pattern of distribution throughout the community.

**Multi-Sectoral or Intersectoral Approach**

PHC requires a coordinated effort with other health related sectors whose activities impact on health. For example, agriculture, water and sanitation, transportation, education, etc. This is necessary to achieve social and economic development of a population.

**IMPLEMENTATION OF PHC ELEMENTS**

**Health Services in Kenya before Implementation of PHC**

The major milestones achieved by the government in health care development are captured in the following chronology of events.

**In 1965** the government introduced free medical treatment in government medical facilities in line with the policy guidelines of the KANU manifesto.

**In 1967** the national family planning programme was started.

**In 1970** the central government took over the running of health services from local councils.

**In 1971 - 1972**, a joint GOK/WHO mission formulated the proposal for the improvement of rural health services in the country and established six Rural Health Training Centres (RHTCs). This was done in order to provide adequate health coverage to the rural population.

Karurumo rural training centre

Chuluaimbo rural training centre

Mbale rural training centre

Maragua rural training centre

Mosoriot rural training centre

Tiwi rural training centre

**In 1984** a community based health care unit was set up within the integrated rural health and family planning project.

**Major Health Policies Guiding Current Health Development Plan**

The steady development of PHC has necessitated a continuous review of existing policies in the health sector eg;

1. The district focus for rural development strategy
2. Increasing coverage and accessibility of health services in rural areas
3. Consolidating urban and rural curative, preventive and promotive services
4. Intersectoral collaboration

**The District Focus for Rural Development Strategy**

This policy was introduced by the government in July 1985, to decentralise decision making to the grass roots, and turn the district into a centre for the planning and implementation of government projects.

As a result of this strategy, the management capabilities of health personnel at the district level were strengthened, thus reducing many challenges which they experienced before.

Problems that were resolved by the introduction of the district focus strategy were:

Facilities management

Drug supplies

Transport

Maintenance of equipment

The role of the District Health Management Teams (DHMT) was strengthened in line with the district focus for rural development strategy.

**Increasing Coverage and Accessibility of Health Services in Rural Areas**

It was realised that development of the rural health infrastructure had lagged behind because of financial constraints. Yet experience had shown that preventive and promotive health programmes were more cost effective if adequately supported. So the government made a deliberate effort to redirect capital from major capital projects to small scale projects at the district and sub-district levels.

Efforts were also made to support preventive and promotive health programmes, and further investment in the rural health infrastructure, by improving service delivery methods, and increasing the number and quality of trained health manpower.

**Consolidating Urban/Rural, Curative, Preventive and Promotive Services**

Here emphasis was put on training all health cadres in preventive and promotive methods alongside curative sercvices.

Personnel located at hospitals and other static facilities were encouraged to include health education as a routine component of PHC.

**Intersectoral Collaboration**

Intersectoral collaboration means working together with other sectors whose activities have a direct influence on health. Health is too important to be the responsibility of the health sector alone. Other sectors whose activities have a direct influence on health include ministries of agriculture, water, housing, culture and social services etc

**Implementation of PHC Elements at Different Levels of Health Care Provision**

The seven levels of health care provision are:

1. Family level

2. Community level

3. Locational level

4. Divisional level

5. District level

6. Provincial level

7. National level

**Family and community Level**

Being the basic unit in a community, the family is therefore the nucleus and main focus of each essential element of PHC.

**Education**

The family gives its members basic education in language, beliefs and customs. Families have a strong influence on what each member does, thus when educating families on how to promote their health and prevent disease it impacts positively on the health of the entire community. Education and demonstration for the promotion of health and the prevention of disease, is most effective in the home environment because it creates an ideal atmosphere for effective teaching.

**Nutrition and Food Supply**

In order to strengthen food and nutrition activities at the family level, you need to teach the members about good food and nutrition practices including appropriate methods of growing and storing food.

**Water and Sanitation**

You should motivate the family to start the ‘three pots’ system where applicable. They should also be trained on how to protect springs and wells; how to construct and use latrines; simple personal hygiene measures such as hand washing and the use of rain roof catchments to harvest water.

**Maternal, Child Health and Family Planning**

Families need to be educated on the importance of antenatal care, immunisation and family planning. This can be done through community health workers and opinion leaders such as teachers, religious leaders, social workers. Model families in the community can also be used to reinforce our teachings.

**Immunisation**

It is the responsibility of families to take children for immunisation. Your role as a health worker is to educate them on how to read the road to health card, the need for immunisation and how it works. With the assistance of CHWs, you should also assess and refer children in the homes for immunisation.

**Control of Endemic Disease (Malaria)**

The role of the family is to identify the nearest source of anti malarial treatment; determine the dosage for the treatment of various age groups in the family; manage fever by tepid sponging and know when to take the patient to the nearest health facility; continue feeding the sick person as normally as possible; determine where and when to seek help; recognise and use simple protection methods such as mosquito treated nets; ensure family members at risk of dying from malaria receive chemoprophylaxis; and clear bushes and stagnant water around the dwelling.

**Treatment of Common Conditions**

Common conditions are diseases which tend to occur very often in the family. They include:

* Malnutrition
* Anaemia
* Malaria
* Diarrhoeal diseases
* Acute respiratory infection
* Worm infestation
* Schistosomiasis
* Scabies
* Conjunctivitis
* Otitis media

The role of the family here is to recognise the signs and symptoms of these conditions, and seek help from the nearest health facility.

In addition it is their responsibility to ensure the prescribed treatment is taken correctly and to fully support the patient until they fully recover.

They should also understand the causes of these diseases, and take the necessary measures to prevent them.

**Mental Health**

The role of the family in the implementation of the mental health element is as follows:

Recognising and accepting that mental health problems are like any other disease

Seeking help as soon as abnormal behaviour is detected among any of the family members

Adopting practices that promote good mental health, such as breast feeding and family support in times of crisis

Avoiding behaviour and practices that contribute to poor mental health such as over permissiveness and rejection of their young ones

**Dental Care**

The family plays a very important role in the implementation of dental health care element by

reinforcing habits that lead to healthy teeth and gums, such as the use of local tooth sticks; eating of indigenous foods, regular dental checkups and avoiding consumption of large amounts of

refined sugar.

**Community Based Rehabilitation (CBR)**

Family members should be educated and sensitised by CHWs on how they can reduce disability in the community. They should take their children for immunisation to prevent diseases like polio; attend antenatal clinics for early detection and management of those with complicated pregnancies; participate in the care of members with rehabilitative needs and seek support from organizations whenever necessary.

**HIV/AIDS/TB Prevention**

The family can achieve a lot in HIV/AIDS/TB prevention by encouraging single sex partners; talking openly to their children about the importance preventing HIV/AIDS; nursing their members with HIV/AIDS at home and referring appropriately for medical care; advocating the use of condoms; accepting family members with HIV/AIDS; and helping them to socialise and interact in the community.

**Location and Divisional Level**

These two levels have been consolidated and shall be referred to as the community level.

**Education**

Individuals and communities can protect themselves against diseases and improve their health if they are well informed. Thus the role of the community here is to seek information and education from health care providers on how they can improve their health, and also accept to change negative habits and customs which are harmful to their health.

**Nutrition and Food Supply**

The activities at this level include: supervision of the CHWs by health committees; identification of high risk individuals and groups; providing relevant information to the District Development

Committees (DDCs); and providing food security, promoting better food production, storage and marketing.

**Water and Sanitation**

The role of the community in the implementation is to work closely with the public health technician to protect and improve sources of clean water. They should also promote the construction and use of VIP latrines in the community, and identify leaders to represent them in village health committees, where issues of water sanitation are discussed.

**Maternal, Child Health and Family Planning (MCH/FP)**

Health workers should ensure availability of contraceptives and create awareness on the need to fully utilize the MCH/FP services available in the community.

**Immunisation**

The role of the community in the implementation is to ensure that they take all the children for immunisation. Health workers at the community level should ensure that there is a constant supply of vaccines and that the cold chain is well maintained. Immunization should be provided on a daily basis at all health service delivery points and should be integrated with other MCH/FP services. Health workers should also train and supervise CHWs and provide outreach and mobile services where there are no static facilities.

**Control of Endemic Disease (Malaria)**

The role of the dispensary and health centre is to support the malaria control activities at the community level.

* Training, supervision and follow up of CHWs and any other field staff
* Ensuring constant supply of drugs and other supplies required by the community
* Keeping records of clinical cases, parasitological cases, treatments and results of treatment given at this level
* Compiling reports from CHWs and providing them with feedback
* Setting out the criterion for referral and how to deal with emergencies due to malaria

**Treatment of Common Conditions**

The role of the CHWs should be strengthened so that they can diagnose these conditions and refer or treat them early before complications set in.

The health centre or dispensary should train and monitor CHWs; maintain records and reports of activities as well as forward them to higher levels.

**Essential Drugs**

At the community level, the health centres are responsible for technical supervision of the use of drugs by CHW. They should train the community on rational use of drugs.

**Dental Health**

At this level the role of health workers is providing health education to the other community members on good dental health practices.

**Community Based Rehabilitation (CBR)**

The role of health workers is to mobilise the community to adopt measures that promote good physical health, and accept people with disabilities. They should also train CHWs on how to identify and prevent disabilities; basic techniques of disability rehabilitation at the community level; referral methods and integration techniques of the disabled.

**HIV/AIDS, TB/STI Control**

At the community level health workers should facilitate health promotion activities; carry out outreach services including immunisation and distribution of condoms; provide the correct treatment using national guidelines; promote early diagnosis and treatment; support home based care givers; and implement the HIV/AIDS and TB package.

**District Level**

The District Health Management Team (DHMT)coordinates PHC at the district level.

**Health Education**

The DHMT has a duty to coordinate and integrate the various health education programmes in the district as well as produce and distribute simple learning materials to health facilities at the community level.

**Nutrition and Food Supply**

The role of the DHMT is to ensure food security for the district, establish an early warning system and analyse district nutrition surveillance data.

**Water and Sanitation**

The DHMT works closely with the District Development Committee (DDC) to evaluate coverage of safe water supply. The DHMT also organises training for public health technicians in water systems, maintenance and latrine construction; procures the necessary materials and ensures coordination of water and sanitation activities with other sectors and NGOs.

**Maternal and Child Health and Family Planning**

The role of the DHMT is mainly training and continuing education of health workers. They also monitor and evaluate MCH/FP activities in the district and share their findings at the DDC meeting. The DDC also plays an important role through its subcommittee on family planning and population and selects priority areas and allocates resources to ensure adequate coverage. **Immunisation**

The DHMT is responsible for the distribution of supplies, evaluation of district immunisation coverage, and assisting the community level to maintain and repair their cold chain equipment.

**Control of Endemic Diseases (especially Malaria)**

They keep records and recognise outbreaks of endemic diseases and take the appropriate action. They also provide adequate and appropriate malaria diagnostic and management referral.

**Treatment of Common Conditions**

The DHMT is responsible for the monitoring and training of health workers in the field; recognising outbreaks and epidemics and taking appropriate action; production and upgrading of operational manuals for use in the communities; distribution of supplies and the management of referrals.

**Essential Drugs**

The district level ensures delivery of drug kits to all health units and is responsible for continuing education and monitoring.

**Mental Health**

It is the responsibility of the district level to ensure that the mental health policy is implemented in the district. In addition, they provide training and continuing education of health workers in mental health; provide transport for mobile community based mental health activities; maintain a register of mental health activities at inpatient and outpatient levels and regularly evaluate mental health activities in the district.

**Dental Health**

Therefore the district level acts as a major referral centre for the management of dental conditions beyond the scope of the community health facilities and refers dental patients to the provincial hospital where better equipment for dental x-ray and laboratory services for dentures are found.

**Community Based Rehabilitation**

The responsibility of the district level is to integrate community based rehabilitation services with other health services in the district.

**Provincial /National Level**

The provincial/national level is the highest level in the hierarchy of PHC implementation. The responsibility here is shared between the provincial teams and national programme managers.

* Provision of training and continuing education programmes for all health personnel
* Development of mass media, using materials and language relevant to specific provinces and districts
* Preparation of health education material,(posters and pamphlets)
* Formulation of policy guidelines on food and nutrition, immunisation, family planning and the management and control of diseases
* Collaboration with other relevant ministries and NGOs
* Monitoring and evaluation of activities at the district level
* National and provincial disease surveillance and monitoring of drug resistance
* Participation in planning national immunisation activities
* Provision of logistical support (financial, transport, material, and manpower)
* Ensuring a steady supply of contraceptives, essential drugs, and other supplies
* Coordination of donor assistance and technical expertise
* Making provision for renovations and modernisation of hospitals as referral and teaching hospitals as well as introduction of psychiatric and dental units in provincial and district levels
* Implementing strategies for promotion and propagation of good mental health practices
* Ensuring implementation of HIV/AIDS policies, creating awareness and undertaking advocacy in respective sectors

**SECTION 3: RESPONSIBILITIES OF THE KEY IMPLEMENTERS OF PHC**

1. Community health workers
2. The community
3. The government
4. Other government ministries
5. Non-governmental organisations

**Community Health Workers**

Community Health Workers (CHWs), are individuals who are selected by their communities for training on how to deal with community health problems and treat common diseases. Once they are trained they work part time as volunteers.

**Selection Criteria for Community Health Workers**

* Be a permanent resident in the community
* Be a mature responsible individual
* Be acceptable and respected by the whole community
* Be self supporting and ready to volunteer
* Be able to relate to others and a good communicator
* Be physically fit
* Be of a gender acceptable to the local culture for the kind of health activities to be undertaken
* Be intelligent with education/literacy that suits the community
* Be ready to learn
* Be of an age suitable for training and for continued work in the community

**Roles**

A motivator through education and communication

An example and model of good health behaviour

A link with the health system and other sectors

A technician with certain skills of community importance e.g.basic treatment of common ailments

An observer and recorder who is capable of thinking, reacting and assessing progress

An organiser and mobiliser for community activities

A leader and manager

A person who is receptive to new ideasso as to form a channel through which new health information can reach the community

An advisor and a counsellor

**The Community**

Therefore, its responsibilities include the following:

* To recognise priority problems relating to health
* Decide on what needs to be done to overcome the problems
* Decide on what the community itself can do to solve the problems
* To organise and implement whatever they themselves can do either on their own or with the support of governmental or non-governmental agencies
* To monitor and evaluate their activities as necessary
* The community meets these responsibilities through the following activities:
* Community participation
* Community awareness
* Community involvement

**The Government**

The political and economic stability of the government has significantly contributed to the successful development of PHC in Kenya.

1. Strengthening the elements of PHC and their implementation

2. Encouraging widespread community participation and the mutual social responsibility of all Kenyans in health and development through PHC

3. Increasing provision of preventive and promotive services and improving methods of early detection and treatment of communicable and vector borne diseases with an emphasis on high risk groups

4. Increasing the number of health workers trained in preventive and promotive health methods

5. Pursuing an intersectoral and multidisciplinary approach to health care at all levels.

6. Improving manpower development policies in order to increase the number of skilled manpower in hospitals, health centres and dispensaries

7. Designing development projects which favour construction of smaller but more cost effective facilities aimed at increasing coverage and accessibility of health services.

8. Selectively increasing the number of district and sub-district hospitals

9. Increasing basic and post-basic opportunities for all health workers

10. Strengthening the overall management capability of the Ministry of Health in the provinces and districts

11. Developing and strengthening logistics and the drug supply system

12. Improving and consolidating various components of the national health information system

13. Improving the facilities, management of out patient services and the quality of care for in-patient services

14. Standardising treatment and operational procedures in hospitals, health centres and dispensaries

15. Consolidating existing facilities with an emphasis on maintenance and rehabilitation

**Non-Governmental Organisations**

Non-Governmental Organisations (NGOs) have been actively involved in developing Community Based Health Care (CBHC) projects since the mid 1970’s.

Indeed, it was through such joint efforts with assistance from WHO and UNICEF that National Guidelines for the implementation of PHC in Kenya were formulated.

Some of the NGOs actively involved in CBHC programmes include the following:

* African Medical and Research Foundation (AMREF)
* Aga Khan Health services
* Christian Health Association of Kenya (CHAK)
* Kenya Red Cross society
* Action Aid - Kenya
* Catholic Relief Services - Kenya
* Family Planning Association of Kenya
* Institute of Cultural Affairs
* National Christian Churches of Kenya (NCCK)
* The Undugu Society
* World Vision

**Achievements of PHC**

1. The shift in emphasis from curative to preventive programmes has led to a reduction in mortality and morbidity.

Five preventive programmes were introduced through the PHC strategy, these are:

* Kenya Expanded Programme of Immunisation (KEPI)
* Environmental health
* Nutrition
* Maternal child health and family planning
* Control of communicable and vector borne diseases.

2. PHC has won widespread acceptance among government ministries, NGOs and international agencies. Formal commitment has been made to 'Health for All' (HFA) by most countries, including Kenya.

3. PHC has had considerable influence in promoting a more equitable distribution of health resources and in the development of new types of health workers in the country. There has been extensive expansion of coverage of several PHC elements.

4. Epidemiologically, childhood diseases such as poliomyelitis, measles, tetanus and pertussis have decreased owing to the rapid expansion of immunisation coverage. This decrease has contributed significantly to the overall decline in infant and child mortality rates.

5. PHC has led to encouraging achievements in the global targets for eradication and control of selected communicable diseases.

6. PHC has made an important contribution to greater social justice and equity by reducing the gap between those who have access to an appropriate level of health care and those who do not.

There are also other features of Primary Health Care which are increasingly being adopted.

**1. Focus on the Community**

Emphasis on health care at the village or community level

Use of local community workers at the first level of health care, drawn from and supported by the community

Involvement of the community in the planning and running of their own health services

Use of traditional methods and resources, e.g. the traditional birth attendant

**2. Hygiene and Prevention of Disease**

Promotion of mother and child health services including immunisation and nutrition

Environmental and public health given equal stress as curative care

Emphasis on health education

**3.Planning for Services**

**4. Organisation of Services**

5.**Training**

**Challenges Faced in PHC Implementation**

**1. Morbidity and Mortality**

The major causes of morbidity and mortality in Kenya still remains diseases and conditions that can be easily prevented through immunisation, improved personal hygiene and environmental manipulation. For example, it has been documented that 36% of the under five population die before their fifth birthday due to preventable diseases and conditions.

**2. Curative Services**

Curative services remain an expensive aspect of Kenya’s health care delivery accounting for about 70% of health budget. Most of these funds are held up in tertiary and secondary level facilities, which are mainly located in urban areas. This situation has tended to impact negatively on the allocation of resources thereby undermining the principle of equity in health delivery.

**3. Disease Burden**

The burden of diseases due to emerging and reemerging diseases, as well as natural and human disasters.

**4. Safe Water and Sanitation**

Studies have shown that 55% of Kenyans lack access to safe water and sanitation, a situation that puts the population at risk of contracting diarrhoea and other communicable diseases.

Air pollution, poor waste management and poor food control measures have also been on the increase.

**5. Malaria and Respiratory Diseases**

Malaria and respiratory diseases combined account for almost 50% of all reported diagnosis in public health facilities with diarrhea increasing this to almost 60%.

**6. Guidelines**

Despite the seven tier system in health care delivery, there are no clear guidelines on the referral procedures from one level to the other.

**7. Sustainability**

Maintenance of the present level of coverage achieved by many PHC programmes, such as

KEPI, has remained highly dependent on continued support from donors, thus raising concern about their sustainability.

**8. Integration**

Improper translation of PHC as primary level of care (first level health care in the pyramid), which ignores the overall integrated nature of PHC.

**Others**

* The community may not be willing to take responsibility for the health care system
* Drugs may not be available at lower levels of the PHC system. Therefore, patients will go directly to hospitals
* Prolonged delays in health worker salaries may result in hostile attitudes towards patients
* Lack of supervision and training may result in poor quality of services
* Different sectors may not be used to working together

**Adopting PHC in the year 2000 and beyond.**

Even five years later, health for all has not been achieved. For this target to be met, a number of things need to change that continue to get in the way. These are:

* A change in the attitude of health personnel and the community
* A change in the motivation of both health workers and the community
* Greater intersectoral collaboration
* Political will
* Equitable redistribution of the available resources
* More appropriate and affordable health technology

There are certain rational steps which can be adopted in order to effect the necessary changes at the community and location level.

1. Training and retraining of health personnel, the community and community leaders, using appropriate methodology and exposure of health personnel to the communities.

2. Strengthening intersectoral collaboration at the community level.

3. Good governance and greater commitment of our political leadership to the concepts of Primary Health Care.

4. Intensification of community involvement and existing community initiatives, for health and development through increased awareness.

5. Extension of the existing health services infrastructure, in support of PHC, to remote areas through outreach programmes or creation of new health units.

**Way Forward**

The government is committed to improving the country’s health status. It has introduced policies and constantly reviewed and revised its strategies in order to implement PHC. However,

* Rational and effective use of resources such as drugs, time, and funds which are allocated to the health facility. One way of ensuring the rational use of drugs is for example, by making the correct clinical diagnosis and prescribing appropriately.
* Continuously updating our knowledge, skills, and attitudes to ensure that we are current in terms of new diseases, treatment regimes, and government policies.
* Advocating for policy change and good governance at all levels.
* Effective disease surveillance and reporting so that measures can be taken in good time.
* Implementing the primary health care elements at every level.