PRIMARY HEALTH CARE IN KENYA- INTRODUCTION

HEALTH SERVICES IN KENYA
A brief historical background

- 1845 –Arrival of missionaries and establishment of Mission Institutions
- 1888 –Arrival of the Imperial British East Africa Company (IBEA Co). Construction of the Kenya/Uganda Railway
- 1895 –Medical staff of the IBEA Co. was taken over by the Government.
- 1901 –Sir Charles Elliot Commissioner of Kenya set up the first Medical Department as one of the 8 Departments. It had 3 doctors, 3 nurses and 7 medical assistants.

HEALTH SERVICES IN KENYA
A brief historical background

- 1901 – "Quarters , native hospitals, dispensaries –all grass or wattle and mud huts with earth floors religiously given their sanitary smear of cow dung once a week –all had to be replaced by permanent structures." This marked the beginning of a clear-cut health policy from the Medical Department.

- Still there was no systematic organized health service and medical emergencies prescribed the pattern of medical care.

HEALTH SERVICES IN KENYA
A brief historical background

- Medical emergencies determined the pattern of medical care.
- 1902 –Epidemic of plague Malaria outbreak in Nairobi
- World War 1, 1914 –Medical Examination for the locals revealed that among the Kikuyu alone 34% of those recruited as porters were rejected.
- 1915 –First attempts by Dr. Milne to introduce the Public Health Act.

HEALTH SERVICES IN KENYA

A brief historical background

- 1924 –The African Native Councils later to be designated county councils became responsible for Health Centres and Dispensaries.
- 1936 –The British Medical Association was appointed to define the role of a Health Centre which included Curative services, Ante Natal Care, T.B. Control and Immunization.
- 1952 –Private Family Planning Services started in Mombasa.
- 1953 –Results of 1942 Census were published.

HEALTH SERVICES IN KENYA
A brief historical background

- In 1953, the East African Royal Commission reported, "We are not of the opinion that the natural rate of increase in East Africa is such as to warrant any large scale attempt to introduce vigorous birth control methods." However, efforts to educate people on Family Planning continued.
- 1954 –The Family Planning Association of Mombasa and Nairobi were established.
- 1956 –The Family Planning Association of Kenya was established.

HEALTH SERVICES IN KENYA

A brief historical background

- 1963 –Kenya got its Independence
- 1965 –A Policy of Free Medical Services was introduced.
- 1967 –The Official Kenya Family Planning Programme started.
- 1970 –The government took over the management of Rural Health Facilities from the County Councils resulting in a strain on the MOH.

HEALTH SERVICES IN KENYA
A brief historical background

- 1971 –72 A joint GOK/WHO formulation on the "Improvement of Rural Health Services in Kenya "and the establishment of the 6 Rural Health Training Centres was undertaken. This led to the implementation of the Rural Health Development Project, 1972 –1976.
- 1974 - The integrated MCH/FP Programmes started.
- 1982The integrated Rural Health and Family Planning Programme was launched.

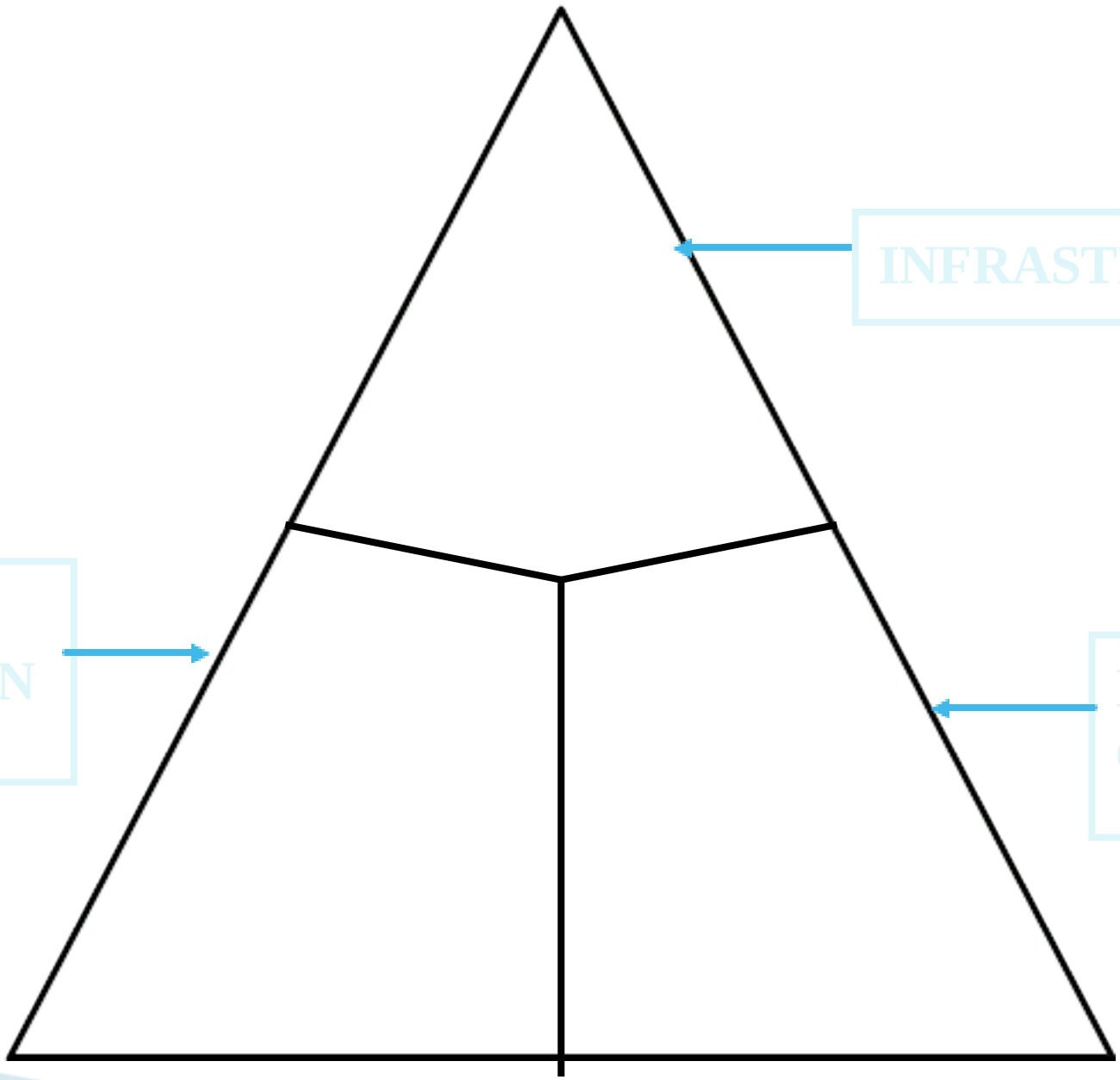
FEATURES OF THE MCH/FP PROGRAMME – 1974

- Establishment of the National Family Welfare Centre and Family Health Clinic at Kenyatta National Hospital
- Training of Family Health Field Educators
- Establishment of 400 Service Delivery Points
- Developing 8 training schools for Enrolled Community Nurses (ECN)

FEATURES OF THE MCH/FP PROGRAMME – 1974

- Construction of 27 Rural Health Demonstration Centres in Kenya to provide practical training for the Medical Training Centres.
- In-service Family Planning training
- Establishing a Health Education Unit for dissemination of Information.
- Implementation of a Supermarket approach for provision of MCH/FP services.

THE PHC TRIANGLE



INFRASTRUCTURE

COMMUNITY PARTICIPATION CBHC

INTERSECTORAL COLLABORATION

PRIMARY HEALTH CARE

THE EMPHASIS:

- Universal accessibility
- Community participation
- Individuals and Families
- Affordable
- Acceptable
- Self- reliance

PRIMARY HEALTH CARE

THE EMPHASIS:

- Self- determination
- Focus on the consumer
- Intersectoral collaboration
- Decentralization
- Equity
- Re- distribution of resources

ELEMENTS OF PRIMARY HEALTH CARE IN KENYA

- Health education
- Nutrition and food security
- Water and Sanitation
- Maternal Child Health and Family Planning
- Immunization
- Essential drugs
- Treatment of common conditions
- Control of endemic diseases

PRIMARY HEALTH CARE

THE EMPHASIS:

- Universal accessibility
- Community participation
- Individuals and Families
- Affordable
- Acceptable
- Self- reliance

THE INTEGRATED RURAL HEALTH AND FAMILY PLANNING PROJECT – 1982

This was the first attempt by the government to implement Primary Health Care in Kenya

COMPONENTS:-

- Construction –improvement and upgrading of 69 Rural Health Facilities.
- Construction of Clinical Officers School at Mombasa and one school of enrolled community nurses at Embu.

Primary Health Care in Kenya

Definition:

Essential health care made available and accessible to individuals, households and communities, through their participation; services that are that acceptable to them and a cost they can afford.

THE INTEGRATED RURAL HEALTH AND FAMILY PLANNING PROJECT – 1982

- Continuing Education in form of refresher courses and in-service training was established at the MTC, Nairobi.

- Construction of schools for maintenance technicians –one at Meru and one in Kilifi.

- Establishment of 300-Service Delivery Points by training providing MCH/FP equipment.

THE INTEGRATED RURAL HEALTH AND FAMILY PLANNING PROJECT

- Establishment of 10 Community Based Health Care (CBHC) project areas in 10 districts. Strengthening environmental health, water and sanitation, nutrition and food security.
- Provision of basic drugs to Rural Health Centres and Dispensaries through the Essential Drugs Programme.
- Strengthening Health Education by establishing the Health Education Unit.
- Strengthening the Health Management Information System.

THE INTEGRATED RURAL HEALTH AND FAMILY PLANNING PROJECT

- Provision of vehicles for the districts and MoH departments.
- Upgrading 3 schools of nursing for NGOs construction of 3 Rural Health Demonstration Centers. Renovation of 30 NGO health centers and dispensaries with provision of vehicles.
- Training the DHMTs in management in line with the District Focus for Rural Development

HEALTH REFORMS

The Health Sector Vision is to:

- Create an enabling environment for the provision of sustainable quality health care that is acceptable, affordable and accessible to all Kenyans.

The Mission of the Ministry is to:

- Promote and provide quality, curative, preventive, promotive and rehabilitative health care services to all Kenyans.

HEALTH REFORMS

- Create an environment where quality promotive, preventive, curative and rehabilitative services are provided.
- Reduce the burden of disease resulting from vaccine –preventable diseases, HIV/AIDS, malaria and other diseases.
- Expand safe water supply, improve food control measure and sanitation facilities.

HIGH PRIORITY PACKAGES

- Malaria prevention and treatment package
- Reproductive health package
- HIV/AIDS/TB prevention and management
- IMCI package
- EPI
- Control and prevention of communicable diseases

MEDIUM PRIORITY PACKAGES

- Non-communicable diseases
- Reproductive cancers
- Mental health.drug & substance abuse
- Injuries and accidents
- Control of other vector borne diseases

INTERSECTORAL COLLABORATION

- National Health Bodies such as the Central Board of Health
- National Health Development Committees
- Provincial Authorities or Councils
- District Health Management Boards
- Divisional Development/Health Committees

INTERSECTORAL COLLABORATION

- Locational Development/Health Committees
- Village Health Development Committees
- Formation of Cooperative Societies
- Formation of Harambee (Self-help) Groups.
- Promoting the formation of Communities Own Resource Persons (CORPS) and Community Based Organisations (CBOs).

INTERSECTORAL COLLABORATION

- Health
- Agriculture
- Education
- Culture and Social Services
- Water Development

INTERSECTORAL COLLABORATION

- Transport and Communications
- Finance and Planning
- Non-Government Organizations
- Information and Broadcast
- The Administration

SOME FACTORS THAT ENHANCE OTHER SECTORS PARTICIPATION IN HEALTH

- Existing local structures or institutions.
- Political commitment and appropriate policies that facilitates collaboration.
- Literacy (education) especially for women.

COMMUNITY PARTICIPATION:

DEFINING WHAT CONSTITUTES A COMMUNITY

A community is defined as a social entity made of people who feel they belong together. The following factors may enhance this togetherness.

- A group of families falling into a small geographical area.
- Sharing common goals and problems and a common system of communication.
- Having common leadership, cultural beliefs and traditions.

COMMUNITY PARTICIPATION:
What can communities do?

- Liaise with health workers to help in solving problem.
- Help improve environmental sanitation and water supply for health units and the community.
- Help with transport for referral of patients.
- Visit health facilities and see what assistance they can provide.

COMMUNITY PARTICIPATION:

Community Health Workers – Roles and Activities

The Community Health Worker will be:

- A motivator through education and communication.
- An example and model of good health behaviour.
- A link with the health system and to liaise with other sectors.
- A technician with certain health skills e.g. latrine construction or treatment with Oral Rehydration Therapy.

COMMUNITY PARTICIPATION:

Community Health Workers – Roles and Activities

- An observer and recorder capable of making observations, responding to them and assessing progress.
- An organizer and mobilizer for community activities.
- Providing leadership and management within the community.
- A person responsive to new ideas and a channel through which new health information reaches the community.

COMMUNITY PARTICIPATION:
NUTRITION AND FOOD SECURITY

- Start where the people are and with what the communities know and are attempting to do.
- People do have some knowledge: listen and learn from the community –the community beliefs, culture and ideas about diseases and their causes.
- Communities will often have existing structures through which active learning starts.
- "Folk media" that involves active participation, enjoyment and expression is very useful in delivering health messages.
- Audio visual means –T.V., Videos and Posters that portray health and health –related messages.

COMMUNITY PARTICIPATION:
NUTRITION AND FOOD SECURITY

- Nutrition education, directed at locally available and affordable food.
- Preparation of weaning foods and increasing energy giving diet.
- Disease prevention e.g., malaria, diarrhoeal diseases.
- Improved food production and storage

COMMUNITY PARTICIPATION:
WATER AND SANITATION

- To protect springs and wells.
- To dig and maintain VIP latrines for all community buildings e.g. churches and schools.
- To ensure that polluted water does not gain access into the drinking water.
- To increase the quality and availability of water by planting trees and conducting regular tests of the water. This will also prevent soil erosion.
- To promote the building of roof rain-catchments for schools and the households.

COMMUNITY PARTICIPATION:
MATERNAL & CHILD HEALTH AND FAMILY PLANNING

- Identification of high-risk mothers/children.
- Encouraging mothers to visit antenatal clinic and have Tetanus Toxoid immunization.
- Improving conditions under which deliveries are conducted by promoting hygienic and safe deliveries.

COMMUNITY PARTICIPATION:
IMMUNIZATION

- Assess coverage of immunization;
- Identify prevailing preventable diseases; and
- Raise awareness of the community through barazas.

COMMUNITY PARTICIPATION:
IMMUNIZATION

- Providing support to the CHWs.
- Providing a link between the community and health facilities (dispensary and health centre), as members of the Health Facilities Management Committees.
- Participating in planning immunization campaigns.

TREATMENT OF COMMON CONDITIONS

- First aid on common emergencies and accidents.
- Recognition of early signs and symptoms of common diseases such as malaria.
- Record keeping.
- Early recognition of danger signs for referral.

TREATMENT OF COMMON CONDITIONS

- Simple management of common conditions with drugs available in local shops or in the CHW kit.
- Follow- up of cases on treatment including T.B., epilepsy, mental cases, STDs, HIV/AIDS.

THE ISSUES

- Planning horizon for Health-for-All by 2000 was long
- Declining health budgets especially in Africa
- Poor maintenance of the infrastructure and equipment
- Staff shortages especially in hardship areas
- Emerging diseases –HIV/AIDS/TB, Malaria

THE ISSUES

- New terminologies e.g., RH, IMCI, SMI, FP
- Verticalization, vis a vis integration
- The Systems Approach e.g. District Health System is yet to be fully implemented
- Need for Management training especially the district, Health Centres and Community levels
- Support to communities (technical or financial)

THE CHANGES

- The guidelines for PHC
- MOH/NGO Forum –national, district
- Grants to NGOs from the MOH and donors
- Priority setting from the community level
- Intersectoral collaboration

THE CHANGES

- Good governance, transparency, accountability
- Budget rationalization
- Standards documented, Department of Standards and Regulatory Services (DSRS) set up with a Decentralized Inspectorate
- Institutional memory through Information Technology
- Central Medical Stores, MSCU, Kenya Medical Supplies Agency

CHALLENGES

- PHC in conflict situations, natural disasters and emergencies e.g., Sudan, Ethiopia, Somalia, and Kenya
- Nomadic populations –designing Nomadic PHC Projects e.g., by UNICEF AND AMREF

CHALLENGES

- Social-cultural Factors related to FP, HIV/AIDS
- Gender Issues i.e. Place of women in society
- Literacy especially for women
- Composition of the Village Health Committees and the gender mix
- Project funding duration and scaling up for NGOs

CHALLENGES

- Policy guidelines for the CORPS
- Involving institutions of Higher Learning
- Donor dependency and fatigue
- Partnership and sustainability
- Institutionalization of PHC –the gap between policy and implementation

CHALLENGES

- Need for more focused strategic planning
- Continuous review of policies and strategies with the changing times
- Monitoring, Evaluation and feedback
- The need for appropriate indicators

OUR ROLE

- As catalysts
- In partnerships

THANK YOU!!!