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Preliminary evaluation of the WHO Special Programme on Primary Health Care

Kenya Case Study



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Abbreviations and Acronyms

CHU	community health unit
CRVS	civil registration and vital statistics
GAP	Global Action Plan
GPW	General Programme of Work
HH	households
HPA	health policy advisor
HRH	human resources for health
KI(I)	key informant (interview)
MoH	Ministry of Health
Moi	Ministry of Interior and National Administration
PCN	primary health care network
PHC	primary health care
PHCMFI	PHC measurement framework and indicators
SDG	Sustainable Development Goal
SDG3 GAP	Global Action Plan for Healthy Lives and Well-being
SP-PHC	Special Programme on Primary Health Care
UHC	universal health coverage
UHC-CN	UHC communicable and noncommunicable diseases
UHC-LC	UHC life course
UHC-P	UHC partnership
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VSP	vital signs profile
WHO	World Health Organization

1. Purpose of the case study

Three country case studies (in Chile, Kenya and Tajikistan) were conducted as part of the preliminary evaluation of the WHO Special Programme on Primary Health Care (SP-PHC).

The overall purpose of the case studies was twofold:

1. to generate evidence for the evaluation questions, including opportunities to strengthen the SP-PHC support to countries in achieving the objectives and mandate; and
2. to generate learning on how SP-PHC is working in practice to support countries in operationalizing selected strategic and operational levers of the WHO/United Nations Children’s Fund Operational Framework for Primary Health Care (PHC) (1), and/or how SP-PHC has applied an innovative approach or best practice, which could be learned and replicated elsewhere.

This case study in Kenya focused on the following four strategic and operational levers of the WHO/United Nations Children’s Fund PHC Operational Framework during the implementation period 2020–2023: “Political Commitment and Leadership”, “Governance and Policy Frameworks”, “Digital Technologies for Health” and “Monitoring and Evaluation”. This included studying how support from the three WHO levels (Headquarters, Regional Office and Country Office) has been coordinated and operationalized. The case study also explored how, through these two strategic levers, catalytic actions have been planned and implemented.

The specific levers were agreed through a collaborative process involving key stakeholders. Criteria included the potential to harvest wisdom on best practices and/or current challenges from country experiences (even if not yet related to SP-PHC support) where these were relevant to WHO’s work in supporting other countries or in collaborating with Kenya in the future.

2. Methods and approach

2.1 Data collection and analysis

The case study used a multi-methods approach. An initial document and data review was supplemented by primary data collection through key informant interviews (KIIs) and focus group discussions undertaken from 4–8 September 2023 with key stakeholders from the national and subnational levels involved in PHC.

Key stakeholders were purposely selected to take part in KIIs to collect relevant evidence and information and to encourage experience sharing for learning. This included representatives from the WHO Country Office, external international development partners, civil society organizations and associated ministry officials.

Altogether, 21 one-on-one interviews with key informants (KIs) and three focus group discussions were conducted, through which a total of 28 key stakeholders shared their experiences. Additional information on KIs is available upon request to the WHO Evaluation Office.

KIIs were conducted using a semi-structured interview guide that listed a predetermined set of questions related to the themes of this country case study. Informants in the focus group discussions were asked to reflect on the questions asked by the interviewer, provide comments, listen to what others in the group had to say and react to their observations. The interview guide/discussion group guide is available in Annex 2.

Data from KIIs and focus group discussions were recorded in notes, analysed, and organized according to themes and content. Analytical approaches included data triangulation and content analysis. The best practices and learnings were explored with emphasis on key enablers, critical factors, specific results, and their potential for replication, scale-up and sustainability.

2.2 Limitations

Timing was a key limitation of this study. The SP-PHC and associated initiatives were not yet recognized and implemented as a programme by the WHO Kenya Country Office and external partners. The ability to measure value added was therefore limited. Activities such as the PHC Measurement Framework Indicators (PHCMFI) and PHC Implementation Solutions were in the early stages of implementation; any identified benefits are only potentials.

Data availability was also a limitation. The WHO Kenya Country Office does not have access to complete information regarding which budgets and corresponding activities came from Universal Health Coverage Partnership (UHC-P) and the Global Action Plan (GAP) for Healthy Lives and Well-being for All (SDG3 GAP). This information was requested from the WHO Regional Office for Africa but was only partially available. Thus, descriptions of funding sources are from the understanding of the Country Office triangulated with limited budgetary information and global reports.

Interpretation of report findings should take into consideration these limitations. Nevertheless, important information, learnings, opportunities and gaps are presented in this report.

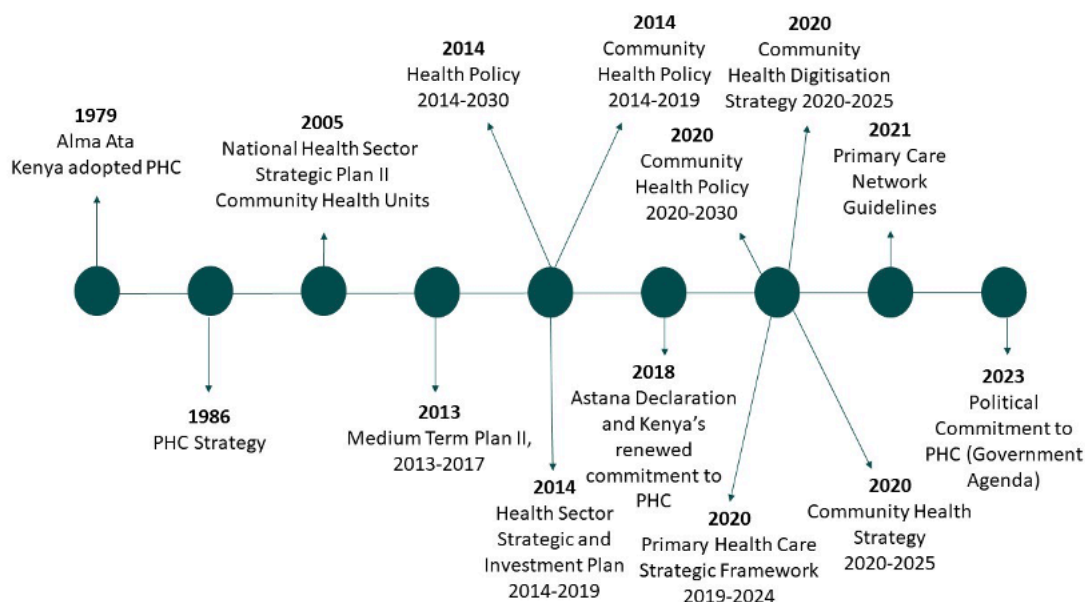
3. Background

3.1 Government of Kenya's progress on PHC for UHC

In 2018, Universal Health Coverage (UHC) was named as one of the “Big Four” priorities to accelerate socio-economic growth towards Kenya's 2030 vision. Since then, the Kenyan government has reorientated its existing health system towards achieving UHC through a PHC approach (see Fig. 1). This led to the creation of the UHC Policy 2020–2030, which outlines the strategic direction of the country in line with other key strategic documents and policies: Kenya Health Policy 2014–2030, Kenya Vision 2030, Kenya PHC Strategic Framework 2019–2024 and the Kenyan Constitution 2010. The government has also prioritized community health in recent

years, with the establishment of the Community Health Policy 2020–2030, Community Health Strategy 2020–2025 and Community Health Digitization Strategy 2020–2025.

Figure 1: Timeline for development of key national PHC policies and strategies (2)



Health system performance

While there have been significant gains in child mortality reduction in the past decade, there have only been marginal improvements in maternal mortality and life expectancy (see Table 1).

Table 1: Performance impact indicators of Kenya's health system

Indicator	2014	2022
Neonatal mortality rate (per 1 000 live births) (3, 4)	31	21
Infant mortality rate (per 1 000 live births) (4)	39	32
Under five mortality rate (per 1 000 live births) (4)	52	41
Maternal mortality rates (per 1 000 live births) (5)	507	503 (2020)
Live expectancy at birth (years) (6)	61.8	61.4 (2021)

Health financing

Progress can also be tracked on service coverage and financial risk protection (see Table 2). The majority of the resources provided to the Ministry of Health (MoH) are outsourced by the government through taxation of its citizens. Insurance coverage is increasing in aggregate; as of 2022, one in four persons in Kenya (26% of females and 27% of males) have some form of health insurance, with the National Hospital Insurance Fund being the most common (3).



Photo caption: WHO's Dr Josephine Njoroge checks the stock of cholera vaccines at Iftin Hospital in Garissa County before they are handed over to vaccination teams deployed in the region for an oral cholera vaccination campaign. February 2023

Credit: WHO/Billy Miaron

However, this has not significantly lowered the out-of-pocket settlement of health bills by Kenyan citizens, which is reflected in rising catastrophic health expenditures.

Table 2: Key health financing indicators

Financial Year	2015–16	2017–18	2019–20	2021–22
Domestic general government health expenditures (7)	8.07%	6.08%	8.23%	-
UHC service coverage index(8)	50	52	51	53
Household out-of-pocket as % total health expenditures ¹	27.7%	28%	24.06%	-
Incidence of catastrophic health expenditures ²	-	4.9%	-	16.5%
Insurance coverage ³	18.5%	19.9%	-	22.9%

The Government of Kenya allocates 8.23% of general government expenditures to health (2019–2020), which is a slight improvement on previous years (7). Kenya's health financing is highly dependent upon donor funding, which comprised 26% of the health budget in 2018. Although this has declined from previous years (from 33% in 2016–2017 to 26% in 2018–2019), it is still a substantial share of the overall budget. Donor aid is most concentrated in sexually transmitted infection control, followed by malaria control, basic health care (e.g. routine immunizations), health policy and administrative management, and reproductive health care (9).

Research and development

The MoH has enhanced research in collaboration with other medical and research bodies, such as such as the National Commission for Science, Technology, and Innovation, Kenya Institute of Public Policy Research and Analysis, Kenya Medical Research Institute and universities. The MoH has thus bolstered research publications pertaining to Kenya's health care system, leading to the improvement of PHC provision. This research collaboration is in line with the UHC Policy 2020–2030 stipulation to increase domestic funding for research in health and the institutionalization of evidence-informed practice (10).

Health information system

Kenya's health information system has made significant strides in providing real-time data that have informed the general public and MoH. The clinical episode data available in the health information system have been linked with the financial systems. The major drawback currently is the lack of analysis of available data to provide an informed holistic situation of Kenya's health care response and future direction. Bodies such as the Kenya Medical Supplies Authority rely on the health information system to distribute commodities to both the public and private sector health care systems. Health information system applications, including the District Health Information System 2 and Kenya Master Health Facility List (11), give the country a clear overview of the

¹ Ministry of Health. Kenya National Health Accounts 2015/2016. 2017. Ministry of Health. Kenya National Health Accounts 2017/2018. 2019. Ministry of Health. Kenya National Health Account 2019/2020. 2021. Ministry of Health. Kenya National Health Account 2021/2022. 2023.

² Ibid.

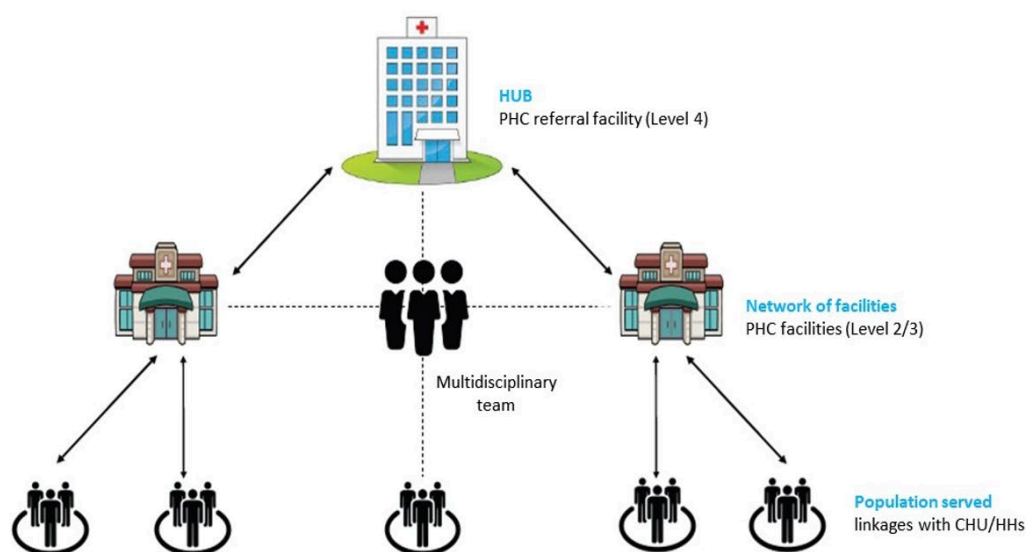
³ Ibid.

current situation. The government has also started rolling out the Electronic Community Health Information System, a data system for community health delivery that covers household enrolment, service delivery, client referral, supply chain management, community-based surveillance, messaging and routine reporting at the community, subnational and national levels (12, 13). These systems are intended to be integrated with other health and demographic data management systems within the country through an interoperability platform (14).

Health infrastructure

There has been an increase in health infrastructure in Kenya in recent years. In 2020, there was an average health facility density of 2.6 facilities per 10 000 population, with geographical variations in access (10). In an effort to increase access, in 2021, the Government of Kenya began the process of restructuring the subnational PHC system and structures through the creation of Primary Health Care Networks (PCN), with an emphasis on building more robust community networks reaching more households (15). PCNs connect households to community health units, PHC facilities (level 2–3), and PHC referral facilities (level 4) through a “hub and spokes” model (see Fig. 2). The government aims to cover 12.2 million households with 9 500 community health units by 2025, with coverage already increasing from 66% in 2019 to 96% in 2023 (16). As of June 2023, 18 PCNs have been established with the support of the United Nations Children’s Fund (UNICEF), the World Bank, AMREF Health Africa and PATH (17).

Figure 2: Primary care network model (18)



However, gaps continue to be reported in the quality of health care services, as the physical health facility infrastructure does not meet the standards prescribed in the national core standards for quality health care (16, 19, 20). For example, access to basic medical equipment is inadequate, with some out-of-date and inadequate use of information technologies in service provision as well as weak data collection. The Quality-of-Care Certification Framework for the Kenyan Health Sector 2020 was implemented to foster quality

improvement through a harmonized registration, licensing and certification process (10). There has also been recent government commitment to increasing access to electricity, waste disposal, water, sanitation and hygiene in Kenya's health care facilities (20).

Human resources for health

Great strides have been made in addressing human resources for health (HRH). The density of doctors, nurses and clinical officers per 10 000 population has doubled between 2006 and 2021, increasing from 14.47 in 2006 to 30.14 in 2021 (21). However, there is considerable variation, with more populous counties having much lower densities (e.g. 5.63 per 10 000 in Nairobi) (21). Access to HRH has increased with devolution of the health care system: for example, many counties are now able to offer health care to their population without the previously required long-distance travel. The government is also making significant efforts to bolster the community health workforce; it aims to have 10 remunerated community health promoters and one community health assistant in each community health unit by 2025, serving a population of approximately 5 000 Kenyans (16, 17).

Political commitment and resource mobilization

While the former president, Uhuru Kenyatta, highlighted UHC as part of his "Big 4" agenda to help the country achieve Strategic Development Goal 3 (SDG3) by 2030, limited resources delayed full implementation. The current president, William Ruto, has also prioritized PHC and has put strategies in place to finance this initiative since assuming office in 2022. These are evident in several draft bills to support the resource mobilization process, including the Digital Health Bill, Primary Health Care Bill, Social Health Insurance Bill and Facility Improvement Financing Bill (all in 2023).

The Primary Health Care Bill 2023 details plans to employ 100 000 community health promoters (22), who will be paid a stipend of US\$ 50/month through a 50:50 co-financing scheme between national and county governments (18). The bill stipulates that PHC will be integrated into dispensaries and health centres, and that both levels will offer free PHC services. These facilities will be reimbursed based on MoH tariffs. Funding for PHC will come from different avenues, including a consolidated fund which will be approved by the National Assembly, a county revenue fund approved by members of the county assembly, grants, gifts and donations as well as fees and levies allocated by the central government.

The government will also provide another fund, the Afya Bora Fund, which will purchase health care services from health facilities (23). Its financial sources will be appropriations by the national assembly, donations, grants, gifts, fees and levies (24).

The National Social Health Insurance Fund will have multiple financial sources (24). The government will be mandated to pay a compulsory insurance benefit scheme for public service employees and will also get funds from employers. Every Kenyan household will be expected to contribute towards this, as well as non-Kenyan residents living in Kenya for 12 months or more. County governments and employers will likewise be expected to contribute. Employers are responsible for deductions prior to payment of each employee's salary; non-salaried individuals will be required to pay annually, based on means testing. The government will pay for indigent and vulnerable populations and prisoners.

The **Chronic and Critical Illness and Emergency Fund** will become operative once the National Social Health Insurance fund has been depleted (24). It will cover emergency treatment costs, with benefits being based on tariffs. No-one will be pre-empted from taking private health insurance.

WHO Kenya structure, strategy and workstreams for health systems, PHC approach, UHC, health security

Activities related to the SP-PHC are primarily implemented through the UHC Life Course (UHC-LC) cluster, led by the health policy advisor (HPA). The health information officer sitting directly under the WHO Representative, is also closely involved with UHC-LC and SP-PHC activities, despite not officially being part of the cluster.

UHC-LC Cluster

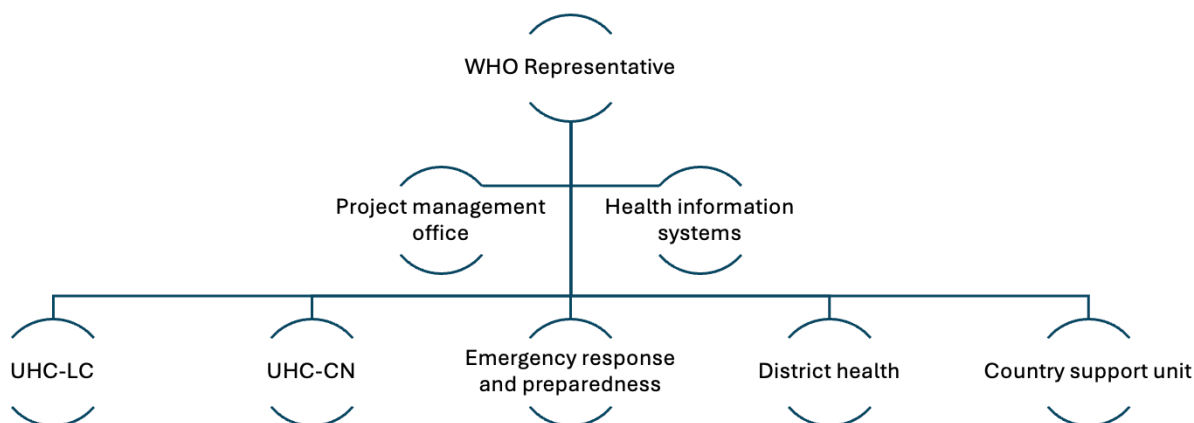
- Health policy advisor (lead)
- HRH officer
- Child health officer
- Health technology officer
- Measurement and evaluation officer
- Reproductive, maternal, newborn, child and adolescent health officer
- Nutrition officer
- Laboratories officer
- Health financing officer
- Medicine officer
- Health systems officer

Other Clusters

- Health information systems officer

*unfilled positions

Figure 3 Structure of WHO Kenya



Source: WHO Kenya organogram and KIIS

Box 1: SP-PHC staffing

The UHC-LC cluster sits in parallel with the other clusters under the WHO Representative, including UHC

Communicable and Noncommunicable Diseases (UHC-CN), Emergency Response and Preparedness, District Health and the Country Support Unit (see Fig. 3).

Of the 10 officer positions in the UHC-LC cluster, six (60%) are currently not filled (see Box 1). Under the HPA, there are currently only Child Health, HRH and health technology officers.

Support received by Kenya from the WHO SP-PHC since 2020

Since 2020⁴ the SP-PHC has provided support to Kenya for the following activities (see also Table 3):

- SP-PHC/UHC-Partnership technical and financial support (including EU and Canadian funds) to promote the PHC approach in Kenya through the operationalization of key levers;
- SP-PHC support to Kenya through the PHC-Accelerator of the SDG3 GAP (Kenya being one of 20 PHC-Accelerator countries);
- SP-PHC support for the development and utilization of the WHO/UNICEF PHCMFI; and
- SP-PHC support to Kenya as a pathfinder country on PHC Implementation Solutions, which potentially provides a mechanism to harvest wisdom from country experience.

Table 3 Overview of SP-PHC support to Kenya from 2020-2023

Start and status of activity implementation	Lever involved	Description of activities and actual or potential achievements and results	Potential funding source (sums in US\$)
2022–present	Measurement and evaluation	PHC measurement framework and indicators	None
2023–present	PHC-orientated research	PHC implementation solutions	Consultant hired by headquarters
2020–present	Political commitment and leadership Governance and policy frameworks	UHC-P and SDG3 GAP technical and financial support (including EU and Canadian funds)	US\$ 2 466 982

4. Key findings

Key findings are reported against evaluation questions.

Design of the SP-PHC – Relevance and coherence

⁴ The time frame of the evaluation is from 2020 to the present.

1 Design (relevance and coherence): These questions are concerned with the design of the SP-PHC and the extent to which the SP-PHC design and objectives respond to global, regional, country and partner needs, and support the achievement of the SP-PHC mandate. The coherence of the design, objectives and interventions of the SP-PHC and the degree to which this supports the PHC approach internally within WHO and with external partners also need to be examined.

1.1 How relevant and appropriate is the design of the SP-PHC for achieving its aims and objectives and for supporting the wider aims of the General Programme of Work (GPW)13?

Finding 1: The design of the SP-PHC is interpreted as top-down, with little awareness of the Programme at the country level. There was a general lack of knowledge of the SP-PHC amongst all KIs, both within WHO and externally. Only 3 out of 28 (10.7%) KIs working closely with PHC in Kenya had knowledge of the SP-PHC prior to the interview, and those who were aware of the SP-PHC were internal WHO staff.⁵ The limited KIs who had heard of the SP-PHC had done so “by chance” and were particularly close to key activities, such as the UHC-P and PHC-Accelerator. The few KIs who were aware of the SP-PHC all reported a lack of knowledge about its design and objectives. One key PHC-Accelerator partner staff member said,

“Top-down management does not work well; we have not heard of the SP-PHC yet it’s happening in the country. We don’t know the aims and the objectives for SP-PHC. There is a lack of clarity around this.”⁶

Informants described limited communications about the SP-PHC. While the HPA and select UHC-LC cluster technical officers were invited to regular meetings and webinars for SP-PHC initiatives – namely the UHC-P, PHC-Accelerator and SDG3 GAP – they were reportedly not informed that the initiatives were under the SP-PHC. WHO staff described a desire for trainings about PHC in general and webinars on the SP-PHC.

While the design of the SP-PHC was interpreted as a top-down process, certain activities within the SP-PHC were seen as more bottom-up and country-driven by WHO and MoH KIs: UHC-P activities and support from the HPA, for instance. Others, such as the PHCMFI and PHC Implementation Solutions, were interpreted as primarily being driven by WHO Headquarters.

Finding 2: There was little to no involvement of the Country Office in the design of the SP-PHC. Several KIs in WHO country leadership described the misalignment of the SP-PHC with country priorities and needs. A KI close to the process said,

“The first step if WHO headquarter office wants the Special Programme to be useful to the country is to move into the country. They cannot sit at the headquarters, come up with special programmes and select 20 countries to implement without discussing with the Country Office.”⁷

⁵ 15 WHO staff were interviewed.

⁶ High-level WHO KI.

⁷ WHO KI.

The KI expressed a desire to co-create a programme for PHC with strategic planning, budgeting and results-based management for a higher impact.

Kenya's current reorientation of its health system towards a PHC approach may present an opportunity for the SP-PHC to provide and amplify support for WHO Kenya in meeting needs identified by the MoH and other stakeholders. It could, for example, provide technical and financial assistance for collaborative support of PCN implementation and for the monitoring and evaluation of such efforts.

Finding 3: Branding of the Programme as a "Special Programme" was found to be inappropriate for its objectives. It was thought that labelling it as a Special Programme made it seem temporary, which is not fitting given the integral role of PHC in the future of global health, and more specifically in the reorientation of Kenya's health system. In addition, some KIs found that this created another silo, whereas PHC is a cross-cutting issue and the "foundation of every programme."⁸

Finding 4: The GPW was described as key to steering biennial planning for the WHO Country Office, and it was identified that having a stronger focus on PHC would help further the PHC agenda. The GPW13 was thought to be well-aligned with current government objectives related to the achievement of UHC through PHC. Multiple cluster leads described the GPW13 as directing their work, with monthly meetings to assess how they were aligning with the GPW. To that extent, multiple WHO informants found that the country office would be more inclined to include PHC-related plans and activities if it was clearly prioritized in the GPW14 with adequate resourcing and buy-in. Senior WHO leadership agreed that it is insufficient to have PHC as an outcome area and that it needs to be included as a primary objective.

1.2 How coherent is the design of the SP-PHC (its objectives, activities, products) "internally" across WHO at global, regional and country levels?

Finding 5: There are limited mechanisms for collaboration and coordination regarding the SP-PHC and related objectives across the three levels of the Organization. WHO KIs reported that the regional office did not have a Special Programme for PHC, and that the latter tends to sit at Headquarters level. KIs also reported very limited communication about the SP-PHC and no consultations, saying that "there has never been clear communication between the two WHO levels on SP-PHC." Some mechanisms were identified as potential enablers for increased communication between the three levels in general, such as the recent repositioning of the WHO Regional Office for Africa to have a team of staff sitting in the WHO Kenya Country Office and the WHO Director-General's announcement of the upcoming reorientation to locate more resources and decision-making power at the Country Office level.

Country Office staff also reported a lack of clarity around the focal point for the SP-PHC at headquarters and regional levels. WHO Kenya's PHC-related activities had multiple headquarters focal points outside of the SP-PHC, such as the Integrated Health Services department's work on PHCMFI and the Division of Data, Analytics, and Delivery for Impact for data-strengthening initiatives. Some KIs described the confusion caused by this, as they do not know whom to contact at headquarters for support. KIs also reported not having a SP-PHC focal point at the WHO Regional Office for Africa, where there is "no Special Programme." This has impeded coordination between the three levels on the SP-PHC and PHC-related objectives in general.

⁸ WHO KI.

Finding 6: There is limited coherence about PHC as a cross-cutting concept and its operationalization across “siloes” clusters at WHO Kenya. PHC-related activities under the SP-PHC – including the PHCMFI, UHC-P and SDG3 GAP activities and PHC Implementation Solutions – are centred in the UHC-LC cluster. While other clusters have been pulled in for specific SP-PHC activities, such as those under UHC-P, the clusters are described by the majority of KIs as working in “silos.” KIs described cross-cutting PHC-related areas sitting under different clusters, including social determinants of health, community health, pandemic preparedness and resilience, and district health, which could be tapped into for Organization-wide PHC collaboration and alignment.

Understanding of PHC and its contributions varies across departments, with some equating it to community health and others to integrated service delivery. There have not been wider PHC-specific trainings, although there was a recent presentation about PHC by the UHC-LC cluster through a Country Office meeting attended by all technical officers. Several KIs identified that this type of support would be useful.

1.3 How coherent is the design of the SP-PHC (its objectives, activities, products) “externally” with wider development partners and country partners (e.g. UNICEF, other UN agencies, Global Fund, GAVI, World Bank, governments, non-governmental organizations, civil society organizations, others)?

Finding 7: The MoH currently has a strong commitment to PHC that can be tapped into by the SP-PHC for further innovations and learnings. The government has collaborated with WHO for multiple PHC-related activities, primarily through interactions with the UHC-LC cluster. Many MoH informants described frequent interactions with the HPA for technical support to develop recent policies and strategies, including the UHC Policy, PHC Strategy, Community Health Worker Policy and PCN Strategy. WHO, and especially the HPA, was described by government KIs as a trusted source of guidance and technical assistance to the MoH.

Government KIs also highlighted the usefulness of UHC-P-funded technical support and capacity-building activities to support areas such as HRH, health financing, reproductive, maternal, newborn, child and adolescent health, guideline and strategy development, and digitization (see Finding 14), which are initiated through the MoH and WHO Kenya partnership. Many KIs emphasized the necessity to align any SP-PHC support with government priorities in a bottom-up approach for buy-in and sustainability.

Finding 8: However, WHO Kenya has had limited opportunities to collaborate with other ministries, subnational governments and civil society organizations on PHC, as they are required to work directly with the MoH. Due to devolution and the increasing autonomy of the subnational governments, multiple stakeholders emphasized the importance of engagement directly with the counties, either through the Council of Governors connecting the national and county governments, or directly with county cluster leads. While subnational bodies are engaged by the Country Office to some extent, this is done indirectly through the MoH. This was also recognized as important by WHO KIs, who pointed out the difficulties in engaging directly at decentralized levels, as it is WHO Kenya’s mandate to work directly only with the MoH. Many other partners, including UNICEF, AMREF Health Africa and USAID, are working directly with counties and may also be leveraged for direct support.

Multisectoral engagement has also proven challenging due to the limitations of engagement outside of the MoH. For example, while civil registration services are managed through the Ministry of Interior and National Administration (MoI), WHO Kenya faced barriers to engaging directly with the MoI when implementing the SDG3 GAP-funded civil registration and vital statistics (CRVS) project. However, they eventually established a Memorandum of Understanding with the MoI to work with them.

Finding 9: Some external partners do not see WHO as a PHC-focused organization due to the lack of clear PHC leadership. External partner KIs (including those involved in UHC-P and SDG3 GAP) were unaware of the SP-PHC prior to the evaluation, and furthermore had limited awareness of WHO involvement in PHC beyond technical support for policies and strategies. This includes a general lack of awareness about WHO's strategy on PHC as well as limited knowledge (outside of implementing partners) of SP-PHC activities such as the UHC-P, the PHC-Accelerator, PHC Implementation Solutions and PHCMFI.

WHO primarily coordinates with other partners on a wider scale through the Development Partners for Health in Kenya platform, and UHC/PHC was one of the platform's 2022–2023 priorities for coordination and collaboration.⁹ However, many partners reported that WHO was not invited to other key PHC partner meetings due to the perception that it was not one of the big "PHC partners" – which are primarily seen as UNICEF, AMREF Health Africa and USAID.

A key factor identified by the majority of internal and external KIs was the lack of a country-level focal person for PHC (equivalent to the PHC focal point in USAID and UNICEF, for example). Many external KIs saw the lack of a PHC focal point as an indication that PHC is not a priority for WHO. While the HPA role was understood and appreciated, it was not associated with PHC internally or externally. One KI also indicated that the WHO Representative and HPA are so senior that they miss invitations to key PHC partnership meetings.

Finding 10: Country-level partnerships through SP-PHC initiatives may be impacted by a perceived lack of coordination at the global level. For example, the PHCMFI was initiated in 2022 through a regional meeting with UNICEF and WHO representatives from the Kenya Country Office but has since stalled due to challenges in coordination. UNICEF and WHO had previously collaborated on the creation of PHC Vital Signs Profiles (VSPs) with PHC Performance Initiative support (with WHO leading), which was successfully implemented at the national and subnational levels. When PHCMFI was initiated, they were in the process of updating subnational VSPs and were missing data to complete the PHC progression model for the capacity pillar.

After agreeing to switch to the PHCMFI, UNICEF secured additional funding and collaborated on its own with the MoH to finish updating the VSPs, which further delayed the process. As a result, the PHCMFI is still in the convening phase and has not yet been adapted or piloted.

KIs identified a lack of perceived collaboration and clear instruction from WHO and UNICEF at headquarters about the process of switching the indicators behind the well-established national and subnational VSPs from the PHC Performance Initiative to the PHCMFI. For them, this led to the misalignment of partner understanding at the country level. It was also understood that there was no sustainability and transition plan in place when the PHC Performance Initiative was disbanded and funding dried up, leading to challenges in maintaining and continuing to update the VSPs and concerns about resourcing the switch to PHCMFI. This misalignment led to a lack of clarity about the role of the PHCMFI amongst WHO and partners, including the MoH, and also resulted in delayed implementation.

Implementation – Efficiency and effectiveness of the SP-PHC

2: Implementation (efficiency and effectiveness): These questions are concerned with the implementation of the SP-PHC, including the efficient use of funds, progress implementing

⁹ Development Partners in Kenya (DPHK) Brief [PowerPoint]. WHO Kenya, n.d.

the SP-PHC activities, results achieved and key factors that are helping or hindering SP-PHC performance.

2.1 What evidence is there to suggest that resources are adequate for the SP-PHC to achieve its mandate?

Finding 11: Resources were described as a limitation for PHC-related activities in the WHO Kenya Country Office. In general, KIs found that the PHC agenda was not well-financed compared to other programmatic areas. Funding for the SP-PHC usually stays within the UHC-LC cluster due to resource constraints, impacting the sustainability of the programme and ongoing activities. The cluster has limited human and financial resources. Despite having ten officer positions, (HRH; reproductive, maternal, newborn, child and adolescent health; child health; nutrition; laboratories; health financing; medicine; technology; measurement and evaluation; and health systems officers), under the UHC-LC cluster, only four are currently filled. These positions include the child health, HRH, measurement and evaluation, and technology officers. The cluster interacts closely with the health information officer, who also receives SP-PHC funding (e.g. the PHCMFI and CRVS projects). As UHC-P funding is necessary to cover ongoing projects in this cluster, KIs stated that they were limited in funding for broader PHC initiatives.

The UHC-LC cluster lead is the HPA, who has a large workload which is partially exacerbated by the limited size of the team. Concerns were also raised about the sustainability of the UHC-LC cluster lead position, the HPA, as funds have reportedly only been secured until 2025.

Outside of the UHC-LC, cluster leads and technical officers working with PHC-related areas reported a necessity to focus on two areas due to lack of funding – for example pairing health promotion with social determinants of health and HIV, and district health with polio.

Overall, lack of funding for PHC was identified as a barrier to focusing on PHC and strongly engaging with the government.

Finding 12: The Health Policy Advisor job description has not changed since the SP-PHC began in 2020. While the existing job description references technical assistance with PHC policies and strategies to support UHC, it does not explicitly mention the SP-PHC or new initiatives, such as PHC Implementation Solutions or the PHCMFI. The HPA was not informed that the position was moved under the SP-PHC and was not offered new trainings on PHC or the SP-PHC.

In addition, the HPA role (previously positioned as the health systems strengthening officer) was not originally designed as a team lead position. However, it has now transitioned to a cluster lead role with associated management responsibilities following the operationalization of the functional review. This added responsibility, to an already overburdened HPA role, requires additional technical and managerial responsibilities within WHO, which are not reflected in the job description.

Finding 13: The current host of the SP-PHC, the UHC-LC cluster, sits parallel to other clusters despite having cross-cutting health system strengthening, PHC and UHC functions. The siloed nature of the programme (see Finding 6) has been raised as a concern by KIs, who found that the SP-PHC and PHC focal persons would be best placed directly under the WHO Representative, as “PHC is the core business.”

Programme silos were found to be a resource concern. Some KIs identified the silos as primarily donor-driven, for instance “HIV and noncommunicable diseases integrate at some points, but the funds cannot

cross over from one programme to the other,” and “funding is a barrier to collaborations.”¹⁰ Other KIs identified a potential opportunity to pool resources for PHC across clusters if they were less siloed and if funding was more flexible.

2.2. To what extent are SP-PHC activities being implemented as intended and achieving or expected to achieve their objectives and results?

Finding 14: Funding from UHC-P and SDG3 GAP is seen as highly beneficial in resourcing technical support for UHC and PHC-related policies and strategies and for PHC-related activities such as HRH, health information systems, noncommunicable diseases and health financing. The UHC-P-funded HPA position was referenced as instrumental to the development of key government PHC and UHC policies and strategies by many internal and external KIs. UHC-P and SDG3 GAP funds were also used for the catalytic support of MoH and WHO Kenya-commissioned projects that covered **health system strengthening** and PHC-related areas, including HRH, digital health, health financing and reproductive, maternal, newborn, child and adolescent health. Supported projects since 2020 include (but are not limited to) (25-28):^{11, 12, 13, 14, 15}

- **HRH:** use of workload indicators for staffing needs tool to determine staffing requirements for service continuity during COVID-19; infection prevention and control training for health care workers, including community health volunteers; a study on gender and COVID-19 vaccination access; capacity-building of the technical working group of the national health workforce accounts and a roadmap towards institutionalization; use of the national health workforce accounts tool to inform health workforce optimization for the COVID-19 response and continuity of services; and a survey on home care for COVID-19
- **Integrated data management:** technical and financial support for implementing the Kenya Demographic Household Survey 2021; mid-term review of the Civil Registration and Vital Statistics Strategy 2018–2023 and dissemination of findings; scale-up of Rapid Mortality Surveillance; training and technical support on the Kenya Digital Health Platform and development of the eHealth Bill.
- **Health financing:** technical assistance for implementing programme-based budgeting in the health sector and reorientation of budgetary arrangements for COVID-19 response at the national and subnational levels; development and dissemination of country health financing profiles based on National Health Accounts data; technical assistance for estimating PHC based on National Health Accounts; financial and technical support for National Health Accounts analysis and institutionalization (including recruitment of consultants); support for organizing an intergovernmental health forum; support for drafting and disseminating facility improvement fund and facility governance guidelines; convening the Thematic Technical Committee/Health Financing Interagency Coordinating Committee; estimating the distribution of health care benefits and comparison with burden of financing across equity dimensions using existing household surveys; and comprehensive costing of health services.
- **Guidelines and strategies:** development of the PHC package and guidelines; development, validation and dissemination of clinical essential health service guidelines to ensure continuity of services during COVID-19; development of a roadmap for operationalizing the Kenya Partnership and Coordination Framework 2018–2030; developing the SDG Progress Report; establishing an Intergovernmental Partnership Agreement on UHC rollout; and developing multiple national policies and strategies, including the Kenya Primary Health Care Strategic Framework (2020–2024), Community Health Policy (2020–2023),

¹⁰ WHO KIs.

¹¹ UHC-LC KIs.

¹² WHO Kenya. ACT-A Health Systems Connector Progress Report April-September 2021 [unpublished], n.d.

¹³ WHO AFRO. Reporting template SDG3 GAP 2021 recovery challenge funding for regional/country offices [unpublished]. 20 January 2022.

¹⁴ WHO AFRO. KENYA-SDG GAP 2021 Health Financing Activities Kenya [unpublished]. n.d.

¹⁵ WHO AFRO. Reporting template SDG3 GAP catalytic funding for regional/country offices [unpublished]. n.d.

Community Health Strategy (2020–2025) and Community Health Digitization Strategy, UHC Policy (2020–2030), and Primary Health Care Network Guidance (2021).

The CRVS project (see Section 4.4), which was viewed as a success, received key funding in the shape of a CA\$ 30 million Canadian Grant (29),^{16, 17} as well as other SDG3 GAP, UHC-P and external funding. This support was requested by the MoH and actioned by the WHO in partnership with the MoH, MoI and external partners (e.g. Washington State University and the Kenya Medical Research Institute). This support to strengthen the CRVS system and the quality, completeness and timeliness of data was essential during the COVID-19 pandemic and allowed the country to begin measuring excess mortality.

As discussed in Finding 16, whilst funding is seen as catalytic, its staggered availability has resulted in ad-hoc PHC-related projects and posed a barrier to using the funding in more strategic biennial plans to strengthen WHO efforts towards PHC, **health system strengthening** and UHC.

Finding 15: SP-PHC activities, including PHC Implementation Solutions and the PHCMFI, are still in the early stages but have the potential for positive impact. The country report for PHC Implementation Solutions is still in the drafting stage, yet KIs identified the potential for generating learnings within Kenya and between countries as the country is reorientating its health care system to PHC. One KI from the MoH indicated the need for a cross-country learning platform, using case studies like those produced by PHC Implementation Solutions. In addition, a non-WHO KI who was involved in the case study suggested a broader dissemination to the counties to encourage in-country learning from areas that had made more progress in PCN implementation. It was suggested that if key stakeholders are sufficiently sensitized about the PHC Implementation Solutions platform and the results are disseminated to the subnational level, the platform could be a useful learning tool.

The PHCMFI was also seen as potentially having more detailed and disaggregated indicators than those for the PHC Performance Initiative. However, the delays in implementation and barriers to partner collaboration (see Finding 10) have resulted in these benefits being unrealized. Progress has also been limited since the team is still in the process of mapping indicators and has not yet adapted the tool and piloted it in-country. The VSPs based on the PHC Performance Initiative indicators are still actively being utilized at the national and subnational level, with many KIs highlighting the successes of the programme: the utility of monitoring PHC implementation with data, ease of a user-friendly interface, rollout to 47 counties, and subsequent learning opportunities to generate improvements in PHC. There are also partner and government efforts underway to update the profiles on a quarterly basis and expand them to the PCN level. A KI close to the process stated that they are prioritizing the current VSP indicators to ensure that they have current data for decision-making and will likely not pilot the PHCMFI until next year.

Most government and implementing partner KIs who were involved in the VSPs noted a lack of clarity regarding the role of the PHCMFI. For example, a government KI stated that they did not see it being adaptable for the VSPs at the subnational level due to the level of detail and number of indicators, whereas the WHO objective was to integrate it into subnational VSPs.

Finding 16: The benefits of the PHC-Accelerator are not yet clear to KIs from WHO Kenya and SDG3 GAP partners. They were informed about the initiative from headquarters and are not aware of the selection criteria that informed Kenya's inclusion. The objectives of the technical working groups and partnership activities were not well-understood. The only PHC-Accelerator activity identified by KIs was a presentation at a Global PHC-Accelerator Webinar in June 2023 in which MoH representatives, WHO and UNICEF gave a

¹⁶ Internal email from WHO Regional Office for Africa to WHO Kenya.

¹⁷ World Health Organization. WHO Primary Health Care Systems Strengthening in the Context of COVID-19: CA\$ 30.38 M Proposal [unpublished]. 11 May 2021.

progress update on PHC progress in Kenya and SDG3 GAP partner contributions (30).¹⁸ Involved KIs did not see the benefits or any follow-up after the presentation.

2.3 How efficiently are SP-PHC resources being utilized (e.g. are activities being implemented in a timely and economic way)?

Finding 17: Funding is distributed ad-hoc during biennium periods, limiting opportunities for strategic planning and resulting in a lack of clarity surrounding the source, distribution and prioritization of funds. SP-PHC funding is regionally awarded. Funding is sent from WHO Headquarters to the WHO Regional Office for Africa, which then allocates and distributes the funds to the country offices. They are not always informed of where the funding is coming from (e.g. UHC-P, SDG3 GAP), with KIs under the impression that they are sometimes sent grants for specific activities at the last minute to use additional funding before the end of the fiscal year. This has led to a lack of clarity at the country level:

“Funding stops in Geneva and at the regional office... they can then for example just dispatch an amount of money for implementation of a programme and you have no idea of how the proposal was designed.”¹⁹

Reports on activities and expenditures are then sent to the WHO Regional Office for Africa, which compiles them for Headquarters, and the final narrative reports are not generally sent back to the Country Office.

This has led to questions about how SP-PHC funding is allocated by WHO headquarters and the Regional Office for Africa. For example, there was frustration about the way the CA\$ 100 million Canadian Grant was divided equally amongst all countries in the African Region “like a pie,”²⁰ regardless of the size of the country or ongoing initiatives.

Finding 18: UHC-P and SDG3 GAP funding is generally seen as flexible and catalytic. KIs identified SP-PHC funding sources as being more flexible than funds designated for specific disease programmes, e.g. specific funding for HIV testing. WHO and implementing partners close to the process found that they were able to design activities to meet country needs with minimal constraints or requirements, allowing them to receive necessary additional funding for projects related to, for example, health financing, digitization, reproductive, maternal, newborn, child and adolescent health and HRH. The HPA position (funded via UHC-P) was seen also as a particularly catalytic source of support, putting WHO “on the frontline to ensure that PHC components and child health systems being implemented aligned with government strategies.”

Finding 19: Technical support for SP-PHC activities has been available to the WHO Kenya Country Office, with variation based on the initiative. Internal KIs generally found it easy to access support from Who Headquarters and the WHO Regional Office for Africa, which is factored into biennial workplans when possible. KIs did not identify the SP-PHC as a source of technical support; for example, support for PHCMFI came from the Health Information System Department at headquarters.

Some projects, particularly those coming from headquarters, were perceived as having a higher level of access to more technical support than others. For example, PHC Implementation Solutions, which was initiated by headquarters, came with a relatively high amount of external support – including the hiring of a national consultant and technical support from both the WHO Regional Office for Africa and Headquarters to ensure that the study is aligned with overall objectives. They also received technical support for the Health Facility Assessments, where they were allocated consultants from WHO Headquarters and the Regional Office for Africa. KIs from the Country Office expressed the usefulness of technical support in

¹⁸ Hussein SA. PHC in Kenya: Update on Progress [PowerPoint]. n.d.

¹⁹ WHO KI.

²⁰ WHO KI.

general but highlighted the desire to have more resources to hire national consultants to support PHC activities.

2.3. How is the SP-PHC adding value to the work of WHO and external partners at country level?

Finding 20: Technical support from WHO is seen as instrumental in the formation of PHC-related strategies, policies and guidance in Kenya. Most external KIs described this as WHO's strongest comparative advantage in working with PHC in Kenya. WHO has provided technical support for the development of recent strategy, policy and guidance documents shaping the reorientation of the Kenyan health system to PHC. As detailed in Section 4.4, WHO has contributed to the development of the UHC Policy (2020–2030), PHC Strategic Framework (2019–2024) and PCN Guidance (2023). The HPA role is described as key to providing this “catalytic” support, with government stakeholders identifying the HPA as a critical liaison.

Finding 21: It is challenging to assess the added value of the SP-PHC at country level due to the low degree of implementation in Kenya. The SP-PHC primarily has visibility as a series of WHO-led activities and projects related to PHC. Only a limited number of KIs were aware of the SP-PHC, which is still seen to be an headquarter-level initiative that has not yet been implemented in the country. Some KIs had varying awareness of initiatives under UHC-P, SDG3 GAP, PHC Implementation Solutions and PHCMFI, depending on their areas of work, but did not connect the initiatives to an overarching programme.

The added value of the SP-PHC has primarily been identified as an increase in financial resources designated for PHC since 2020, primarily through the UHC-P and SDG3 GAP. Some KIs, both internal and external, have described seeing an increase in WHO financial and technical support for PHC in the past three years. One ministry KI noted that if the increased support is due to the SP-PHC, then it is valuable. A WHO KI close to the process said: *“We benefitted by getting extra resources and this enabled us to fund some of our activities, e.g. around health financing.”*

Finding 22: The WHO/UNICEF Operational Framework for PHC was seen as a useful theoretical framework but could be coupled with stronger guidance on implementation. KIs close to the SP-PHC and associated activities found the Operational Framework useful and applicable as an instrument to strengthen their work, for example by framing the PHC Implementation Solutions study and the PHC-Accelerator country presentation in June 2023. However, they indicated that there could be stronger instruction regarding its practical use in implementation, including contextualization at the country level.

2.4. How sustainable are the SP-PHC interventions?

Finding 23: Bottom-up initiatives from WHO Kenya and the government were seen as more sustainable than top-down initiatives from WHO Headquarters. Some KIs noted that initiatives from headquarters, such as the PHCMFI, PHC-Accelerator and PHC Implementation Solutions, are not as sustainable as those requested by the government, such as technical support for policy, strategy and guidance development and UHC-P and SDG3 GAP-funded initiatives.

For example, some KIs have seen the switch from the PHC Performance Initiative to PHCMFI indicators as a sustainability concern. PHC Performance Initiative funding ended in 2022 and PHCMFI does not have additional funding attached, which has led to some concern from donors about the availability of resources to continue updating and scaling up VSPs. While UNICEF provided additional funding to finish developing

VSPs through the end of 2022, KIs described no knowledge of plans for transition and sustainability to sustain VSPs at the national and subnational levels beyond donor funding.

Finding 24: There is a need for greater support to develop sustainability plans for PHC as the country begins to transition out of donor funding. While there is currently government commitment to financing PHC, many KIs stated the need to ensure sustainability after the launch. Kenya’s health system is donor-dependent. However, as Kenya’s GNI increases, the country will begin to transition from some sources of donor funding.²¹ For example, Kenya aims to transition from Gavi funding (which includes investments for **health system strengthening**) by 2030.²² In this context, KIs identified the importance of ensuring that SP-PHC technical and financial support is accompanied by sustainability plans. One KI gave an example of a task team formed by the previous government that could be regenerated to ensure the sustainability of PHC activities, and another suggested further collaboration with partners to leverage resources.

Gender, equity and human rights considerations

3: Gender, equity and human rights. This question is concerned with how well the SP-PHC is addressing the most vulnerable populations in its promotion of PHC.

3.1. How well has the SP-PHC supported the inclusion of gender, equity and human rights considerations across its core functions and technical products?

Finding 25: Opportunities were identified for stronger engagement with civil society organizations in SP-PHC activities. Direct engagement of civil society in SP-PHC initiatives was described as limited. Civil society KIs stated the importance of increasing engagement with civil society organizations which are working closely with equity. For example, there are opportunities to tap into the work of the umbrella non-governmental organization HENNET in advocating for equity based on gender, poverty level and geographical location in policies such as the recent PHC Bill.

Finding 26: WHO has primarily supported gender, equity and human rights in PHC through technical products, rather than through SP-PHC activities. Many KIs described WHO support to equity through strategies and guidance with a “leaving no one behind” lens and disaggregating VSP data to measure equity by geographical area and gender.

However, equity-specific SP-PHC activities are limited. An example of a UHC-P-funded activity is a study looking at gender integration in the COVID-19 response, including in vaccine equity, response teams, and policies. One KI said that gender integration, inclusion and equity issues are still “new ideas” in Kenya.²³ This is an area that could be explored further through collaboration with partners working within this space, e.g. other SDG3 GAP organizations including the United Nations Family Planning Association, UN Women, UNAIDS and civil society organizations.

²¹ McDade K., Kokwaro G., Munge K., & Ogbuoji O. February 2021. Development finance in transition: Donor dependency and concentration in Kenya’s health sector. https://centerforpolicyimpact.org/wp-content/uploads/sites/18/2021/03/Kenya-Donor-Dependency_FINAL.pdf.

²² MoH. 30 March 2023. Kenya Works Towards Transitioning from Gavi Support for National Vaccination Program. <https://www.health.go.ke/index.php/kenya-works-towards-transitioning-gavi-support-national-vaccination-program#:~:text=However%2C%20the%20Kenyan%20government%20is,from%20Gavi%20support%20by%202030.>

²³ WHO KI.

Lessons learned and best practices in advancing selected PHC levers in Kenya

Governance and policy frameworks

Introduction/background

Kenya is currently undergoing a health system reorientation towards PHC. There is strong political commitment to achieving UHC through PHC, especially under the current President William Ruto (who assumed office in September 2022). Since 2020, multiple PHC strategies, policies and guidelines have been developed, including:

- Kenya Primary Health Care Strategic Framework (2019–2024);
- Kenya Community Health Policy (2020–2023);
- Kenya Community Health Strategy (2020–2025) and Community Health Digitization Strategy
- UHC Policy (2020–2030); and
- PHC Network Guidance (2021).

Most KIs identified WHO's technical support to strategies, policies and guidelines as its most essential contribution to the ongoing PHC reform in Kenya.

Results/expected results

WHO Kenya has been involved in the development of multiple key national PHC and UHC policies enacted in recent years, including the UHC Policy, PHC Strategic Framework and National Health Promotion Policy. Alongside other partners, WHO Kenya has also provided support for the development of the PCN Guidance published in May 2021, which has created the framework for the "hub and spoke" model connecting PHC referral facilities, PHC facilities and community health units. These policies and strategies have been key to the reorientation of the Kenyan health system towards PHC, particularly through a focus on strengthening community outreach and engagement.

WHO has provided key strategic guidance regarding the inclusion of PHC and UHC in national strategies, including the Kenya Health Sector Strategic Plan 2023–2027 and the Annual Work Plan 2023–2024. WHO has also assisted the Kenyan government in developing the Kenya Essential Package for Health and the UHC Essential Benefit package. These packages are expected to contribute to improved access to quality essential health services, ensure financial risk protection for all Kenyans – especially those who are at-risk – and improve quality of health care.

WHO has also provided technical and financial support (through UHC-P funding) in developing normative tools and guidance in Child Health, for instance through the Early Childhood Development Policy.

Gaps and challenges

Most external KIs identified the need for a PHC Focal Point in addition to the HPA to attend critical PHC partnership meetings, to provide focused technical support on PHC and to make the government aware of the potential for PHC-related technical support, policies and capacity building.

Some KIs also described missing components in WHO's support to the PHC response in Kenya, stating that it would be useful to have more guidance on the operationalization of PHC strategies and policies, as well as more support for monitoring and evaluation of guideline implementation.

Key enablers, critical factors and lessons learned

WHO is seen as the “giant in policy, guidelines and strategy formulation globally,”²⁴ with many external KIs highlighting the high regard in which WHO guidelines and technical support are held. The WHO Kenya Country Office has been essential in successfully leveraging the strengths of WHO in the establishment of a PHC policy framework in-country. Many KIs described the HPA position as essential in liaising with the government and key partners to provide catalytic support for the development of UHC and PHC policies, strategies and guidelines. One external KI closely involved with PHC implementation said, “*WHO is catalytic... when we came up with some of those documents, WHO was right in the middle offering technical support.*”

Another enabler has been a strong relationship with the MoH, which frequently contacts the Country Office for support on various initiatives and which feels that the Country Office response is timely and efficient. The Country Office has also partnered with UNICEF on multiple occasions, including in the development of the PHC Strategic Plan (2019–2024) and the PCN Guidelines.

Potential of replication, scale up and sustainability

Technical support for the establishment of a robust policy framework in Kenya has been described by KIs as one of the most sustainable forms of support provided by WHO. Technical support is generally commissioned by the MoH, making the support bottom-up and designed to fit country needs. However, some KIs noted the need to integrate sustainability plans into national strategies to adequately prepare the country for the transition away from donor support, for example the end of Gavi support in 2027.

Replication may be possible in similar contexts through the sharing of “lessons learned” from the reorientation of Kenya's health system to a PHC approach. For example, at the time of this publication, WHO Kenya was to publish a case study through the PHC Implementation Solutions platform in Q4 2023/Q1 2024, aiming to highlight the “what” and “how” of the PHC reform in Kenya, as well as enablers and barriers, with a specific focus on PCN implementation.²⁵ If they are disseminated to relevant stakeholders, platforms such as PHC Implementation Solutions can provide key insights into policy reforms in Kenya with the potential for replication in other contexts.

Another factor that may enable replication is the vast nature of the HPA network, with over 100 HPAs now spread across many WHO Member States who may provide technical support for developing UHC/PHC policies and strategies.

Digital health transformation

²⁴ Partner KI.

²⁵ WHO Kenya. PHC Case study sensitization meeting [PowerPoint]. n.d.

Introduction/background

Historically, Kenya has faced challenges in counting births, deaths and causes of deaths through a civil registration system. The latest Kenya Vital Statistics report showed that 14% of births and 45% of deaths were unregistered (2021) (31). During COVID-19, the country faced challenges in counting excess deaths due to the lack of a robust CRVS. The MoI approached WHO Kenya for assistance in urgently strengthening their CRVS system.

In partnership with the MoH and MoI, WHO Kenya is now providing technical support to strengthen CRVS in Kenya. This was accomplished through strategic partnerships with UN organizations, multilateral and bilateral donors, academic institutions, the private sector and civil society. WHO leveraged existing platforms, such as the Health Data Collaborative and SDG3 GAP, and established task teams. A UN Legal Identity Agenda Taskforce consisting of SDG3 GAP partners, including the United Nations Development Programme, UNICEF, WHO, the United Nations Family Planning Association and UN Women, was created to coordinate the implementation of CRVS activities. A CRVS Technical Working Group was also established with a range of multilateral, civil society organization, academic and private sector partners. A Mortality Statistics Working Group, chaired by the department of Civil Registration Services, was also established by WHO to strengthen coordination for notification and registration of deaths.

Results/expected results

In the short term, WHO support to CRVS strengthened Kenya's response to the COVID-19 pandemic by enhancing data surrounding excess mortality, risk factors associated with severe illness and death from COVID-19, and epidemiological trends. July 2021, a rapid mortality surveillance was implemented in six counties with a high burden of COVID-19, increasing the coverage of death and cause-of-death registration. By June 2022, there were several significant results (31):

- 31 000 deaths had been notified using the rapid mortality surveillance system.
- Disaggregated rapid mortality surveillance data revealed trends in mortality data by location, gender and age.
- Improved mortality data allowed for more evidence-based COVID-19 response measures and health initiatives.

WHO Kenya has been working in collaboration with partners to provide technical support and capacity building to strengthen CRVS for the long term. Activities through the partnerships with WHO involvement include:²⁶

- mid-term review of the CRVS Strategy 2018–2030;
- dissemination of 500 copies of the CRVS Strategy to subnational level;
- development of a roadmap to operationalize the Kenya Partnership and Coordination Framework 2018–2030;
- annual Kenya Vital Statistics Reports;
- capacity strengthening on Medical Certification of Causes of Deaths; and
- technical support for strengthening systems for notification and registration of deaths.

Long-term benefits of strengthening CRVS lie in the contribution of a robust CRVS system to strengthening PHC for UHC by allowing the government to collect disaggregated data about births, deaths, cause of deaths,

²⁶ WHO Kenya. Canadian Grant Country Support Plan [unpublished]. n.d.

and marriages. The government can use this data to properly allocate resources and monitor progress in achieving the SDGs, PHC and UHC.

Gaps and challenges

A key identified challenge was the lack of pre-established mechanisms for working directly with the Mol, which manages the Civil Registration Services system. According to KIs, WHO Kenya's mandate of only working through the MoH has limited its ability to work directly with other ministries. While the personnel responsible were able to create a Memorandum of Understanding with the Mol and work with both the Mol and MoH for this project, this is a key limiting factor to the implementation of PHC initiatives.

Key enablers, critical factors and lessons learned

An identified key enabler was the rapid and catalytic access to funding and technical support during the health emergency context. WHO Kenya was able to rapidly access funding through the CA\$ 30 million Canadian Grant as well as external funding from the USA Center for Disease Control and Prevention. The coordination and convening power of WHO were identified as key enablers to this success. WHO leveraged key partnerships with SDG3 GAP organizations (UNICEF, the United Nations Family Planning Association, the United Nations Development Programme, UN Women), and external organizations (including the Kenya Medical Research Institute, Washington State University and the USA Center for Disease Control and Prevention), which brought increased funding and enabled a rapid response.

Potential of replication, scale up and sustainability

While some aspects of the CRVS response, such as the rapid mortality surveillance, are not sustainable, capacity-building and support to the Ministries of Health and Interior are sustainable activities. Sustainability and the ability to scale up CRVS activities may be increased through more direct structures to engage cross-sectorally with ministries beyond the MoH.

This could be replicated in other countries with similar weaknesses in their civil registration systems. It was included as a SDG3 GAP case study and published on the WHO website, which may allow for cross-country learning if sufficiently disseminated.

5. Conclusions and opportunities for future SP-PHC support to Kenya

Design and coherence of the WHO SP-PHC

The SP-PHC should have clear communication and support structures across the three levels. This should include:

- **Clear designation of SP-PHC focal points at the headquarters, regional and country levels.** Country Office KIs were unclear about contact points for PHC-related activities at the headquarters level, where they perceived multiple departments with PHC responsibilities. They also identified the need for a clear PHC focal point at the Regional Office and the urgent need for a SP-PHC focal point at WHO Kenya.

There should be clear lines of communication between the focal points.

- **Webinars and trainings about WHO's definition of and guidance on PHC across programmes and about use of the Operational Framework on PHC.** This should be available to all technical officers across departments to ensure alignment of the Organization.
- **Timely dissemination of information regarding available SP-PHC funding and initiatives.** Ideally, the Country Office should know about available funding and support in due time to consider available SP-PHC resources in its biennial planning. This would enable it to strategically plan cross-cutting PHC activities as part of its core work.

The SP-PHC activities should be co-created with country offices and tailored to their context and capacities. As it currently stands, in Kenya, the SP-PHC is largely seen as a headquarters initiative that has not yet trickled down to the country. The majority of KIs, even those close to SP-PHC initiatives, were not aware of the programme prior to the evaluation. Furthermore, some initiatives under the programme, such as the PHC-Accelerator, were not clear to country stakeholders and did not seem to add value.

Moving forward, the SP-PHC could maximize utility by handing over ownership to country offices. Activities should be tailored to the needs of the country office, with the country more involved in the back end of available initiatives and funding sources, including the initial conception, budgeting and reporting. Capacity should be considered in this process: in the WHO Kenya UHC-LC cluster for example, only four out of ten positions are currently filled, and staff have multiple roles to cover gaps (e.g. the HPA filling a technical role as well as a cluster lead position).

At WHO Kenya, planning for the 2024–2025 biennium presents an opportunity for Headquarters to support the Country Office to take ownership of the SP-PHC in Kenya and strategically plan for the contribution of associated funding streams, technical support and initiatives to their broader **health system strengthening**, PHC and UHC objectives. For the long term, the GPW14 may include PHC as an objective instead of an output to demonstrate its clear prioritization to countries.

The WHO Kenya Country Office may consider repositioning the UHC-LC cluster to maximize its cross-cutting functions. The current positioning of the UHC-LC as a cluster parallel to others may have diminished its ability to exist as a cross-cutting structure. The country office may consider repositioning the UHC-LC to sit directly under the WHO Representative with clear coordinating mechanisms with other departments to enable collaboration between clusters on overarching core issues including PHC, UHC, **health system strengthening** and the health system building blocks. In addition, UHC-LC could be more systematically linked to related clusters, including the District Health Cluster and health information system personnel.

Strategic partnerships

WHO should leverage partnerships to increase the utility of SP-PHC initiatives. Fostering strengthened partnerships with UN organizations, external multilateral and bilateral development partners, civil society organizations and the private sector would allow WHO to pool limited resources and maximize their value added by leveraging their competitive advantages to strengthen PHC, including their convening power, technical support and coordination. This could be achieved through several mechanisms:

- **Establishing a PHC Focal Point at the WHO Kenya Country Office who consistently sits in PHC partnership forums.** Having a consistent WHO focal point for PHC was described by several partners as key to facilitating collaboration and heightening the visibility of WHO's engagement with and prioritization

of PHC.

- **Further utilizing the Development Partners for Health in Kenya forum and other partner coordination platforms to coordinate SP-PHC initiatives with PHC initiatives in other organizations.** This may be particularly helpful in coordinating with organizations which have a stronger subnational presence and increased resources for implementation, such as UNICEF, AMREF Health Africa and USAID.
- **Engaging more closely with civil society organizations.** This may allow WHO to tap into certain issues close to the community, including advocacy for equity and access in policies and strategies.

In the context of Kenya's devolved governance system and the multisectoral nature of PHC, it may be necessary for WHO to engage beyond the MoH, directly or through strategic partnerships. Engaging with ministries outside of the MoH has reportedly been challenging for WHO Kenya; however, it is seen as essential to implementing some SP-PHC activities (such as the bolstering of CRVS). There would be a need to establish mechanisms for WHO Kenya's direct engagement with other ministries, or for strategic leveraging of partnerships with organizations that work across governmental sectors, such as UNICEF.

In addition, WHO Kenya only directly engages at the national level, which may not be appropriate in the context of the devolution of Kenya's health system in 2013 and subsequent county control of health budgets and activities. Stronger structures for engagement with subnational actors, such as the Council of Governors or county cluster leads, could strengthen coordination, which could be beneficial for furthering the PHC agenda. Alternatively, this may be accomplished through stronger partnerships with organizations that engage subnationally, such as UNICEF, AMREF Health Africa and USAID.

While strong engagement with the national MoH was seen as an enabler of WHO's PHC efforts, KIs have suggested that the multisectoral nature of PHC and the significant devolution of Kenya's health care system may necessitate direct engagement with other ministries and subnational actors. High-level advocacy is needed at all three levels (headquarters, the WHO Regional Office for Africa, and the office of the WHO Representative) to expand WHO Kenya's mandate so as to allow them to work directly with the national MoH as well as other ministries and government bodies, as needed.

Maximizing utility and value added by the SP-PHC

To maximize value added and sustainability, the SP-PHC should prioritize bottom-up and tailored initiatives.

The utility of activities initiated by the government and/or WHO Kenya – including technical support for the development of strategies, policies and guidance as well as UHC-P and SDG3 GAP support for health digitization, human resources for health, health financing, monitoring and evaluation, and reproductive, maternal, newborn, child and adolescent health – are recognized. While some headquarters-initiated SP-PHC activities were seen as useful, such as the PHCMFI and PHC Implementation Solutions, they need to be tailored to the country with adequate sensitization to maximize their potential.

Sustainability

Sustainability of SP-PHC initiatives should be considered at the design phase, with clear sustainability plans or exit strategies. The end of PHC Performance Initiative funding was perceived as a threat to sustainability for the VSPs in Kenya, which were consistently seen by stakeholders as an essential component of the PHC response. While PHCMFI took its place under the SP-PHC, it did not come with funding and was delayed due to

issues with partner coordination and the vast number of indicators. It is important to consider aspects of sustainability when implementing SP-PHC initiatives, especially as Kenya begins to transition out of some donor support.

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Annex 2: Discussion guides for interviews and focus groups

Internal WHO staff

Introduction

Euro Health Group has been commissioned by the WHO Evaluation Office, at the request of the Director of the Special Programme on Primary Health Care (SP-PHC), to conduct a **forward-looking evaluation**. The evaluation comes three years after the establishment of the SP-PHC in 2020. Its purpose is to **review progress to date** and **generate learning** that can be used to enhance future implementation and performance of the SP-PHC, as well as inform relevant discussions and decisions both within WHO and with partners.

The evaluation is based on the theory of change of the SP-PHC. A set of evaluation questions has been developed based on the expected results of the SP-PHC. Data collection methods include an online survey, KIIs and focus group discussions, and a literature and data review. Analytical approaches and tools are used to examine evidence and findings, such as the Forcefield Analysis to identify factors helping and hindering change, and the strength of each factor. Evidence generated from all data sources will be triangulated to answer the evaluation questions and generate recommendations. Finally, a workshop will be organized to consider, generate and/or refine forward-looking recommendations.

The Kenya country case study will focus on answering the evaluation questions, including through exploring strategic and operational levers of the PHC operational framework, which the SP-PHC has been identified as having supported (**Political Commitment and Leadership, Governance and Policy Frameworks, Digital Technologies for Health, and Monitoring and Evaluation**), as well as **how support from the three levels of the organization (WHO Headquarters, WHO Regional Office and WHO Country Office)** have been coordinated and operationalized.

Confidentiality

Please note that all information shared for this evaluation will be treated with **confidentiality and anonymized**. Any **citations and quotes will not be traceable** to individuals or their titles/positions.

Specific activities in Kenya with direct line of sight to the SP-PHC

- SP-PHC/UHC-Partnership technical and financial support (including EU and Canadian funds) to promote the PHC Approach in Kenya through the operationalization of key levers (to be identified with WHO Kenya). Relevant to strategic levers 1 and 2 and operational level 11 (Political Commitment and Leadership; Governance and Policy Frameworks; Digital Technologies for Hhealth)
- SP-PHC support to Kenya through the PHC-Accelerator of the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP), Kenya being one of the 20 PHC-Accelerator countries). Relevant to strategic levers 1 and 2 (Political Commitment and Leadership; Governance and Policy Frameworks)
- SP-PHC support for the development and utilization of the WHO/UNICEF PHC measurement framework and indicators. Relevant to strategic lever 14 (Monitoring and Evaluation)
- SP-PHC support to Kenya as a pathfinder country on PHC Implementation Solutions, which potentially provides a mechanism to harvest wisdom from country experience. Relevant to the SP's role in generating evidence and lessons

learned on the emergency of the Government of Kenya PHC strategy and related policy frameworks; potentially related to operational level 13 PHC-oriented research.

Interview guide

3. Introductory question

- Please introduce yourself, your role, and *the nature of your engagement* with the SP-PHC.
 - What activities have you undertaken with the support of the SP- PHC?
 - What relations have you developed/do you have with the SP-PHC?

2. Relevance and coherence of the SP-PHC design

- **In your opinion, what are the aims and objectives of the WHO SP-PHC?**
- **How relevant and appropriate is the design of the SP-PHC for achieving its aims and objectives?**
 - Overall, how well does the SP-PHC facilitate the PHC approach, that is integrated health services, multisectoral policy and action, and empowered people and communities? Is the SP-PHC well placed to do this?
 - To what extent is there a clear vision, clear targets and clear articulation of the PHC approach across WHO? (versus 'primary care' for instance)
 - To what extent is the SP-PHC agile, with a focus on country support, and to what extent does it provide "a one-stop mechanism" on PHC?
 - How does the design of the SP-PHC (reflected in its three workstreams, namely evidence and innovation, policy and partnership, and country impact) respond to country needs and context?
 - Has the merger of the SP-PHC with the UHC partnership been beneficial to the PHC agenda and if so, how?
 - What factors are helping or hindering the ability of the SP-PHC to fulfil its mandate and objectives? DONE TO HEREHERE
- **How does the SP-PHC align and coordinate internally within the WHO architecture (headquarters and 3 levels)? Please provide examples**
 - To what extent has the SP-PHC managed to function as a cross cutting platform for PHC in WHO at all three levels?
 - How far is the PHC approach integrated with WHO strategic priorities and in other departments work in WHO? (UHC, health Emergencies, disease-specific programmes, etc – at the three levels)?
 - Was the support provided to Kenya by the SP-PHC well-coordinated internally?
 - How would you describe the collaboration and coordination by the SP-PHC between the 3 levels –e.g., Was it proactive, coherent and synergistic?
 - To what extent are SP-PHC activities aligned to country and regional priorities, requests, policy frameworks, country/regional activities? (Was SP-PHC support in line with WHO's work, with the country's work?)
 - What were the enabling factors to the internal coordination?
 - Do you perceive some challenges to the internal coordination?
- **How does the SP-PHC align and coordinate its work externally with partners? Does the SP-PHC facilitate synergies and/or duplicate any other global efforts?**

- To what extent do you think the SP-PHC has facilitated, aligned with and leveraged global health partnerships' work in Kenya? With what achievements and results? (UHC-P funding etc?)
- What has been the role of UNICEF or other UN agencies, Govt or other external partners/funders in Kenya on the PHC agenda?

4. Efficiency and effectiveness of the implementation of the SP-PHC activities

- When did the SP-PHC start supporting Kenya/WHO CO/WHO regional office?
- How has the SP-PHC provided support?
- Who initiated the request to the SP-PHC?
- What was the process followed?
- What about timelines of the SP-PHC activities? Were they adhered to?
- Has the SP-PHC support been adequate in responding to the country 's needs? And were all initial support suggestions provided?
- What have been the main achievements/ anticipated results of the support provided by the SP-PHC? Please provide examples.
- More specifically:
 - How have political commitment and leadership towards PHC been affected by this support?
 - How has the governance and policy framework for PHC been changed? (or prospects on being changed)
 - Has the support been catalytic or innovating? Has the support accelerated actions? Improved national interventions? Has it had a multiplier effect?
 - If too early to say what is in your perspective the potential of change -impact at national level?
- Has the SP-PHC support added value to the PHC work undertaken in Kenya? Examples?
- How does the support provided by the SP-PHC promote equity, gender and human rights?
- How does the support provided by SP-PHC promote sustainability?
 - For example, how will the funding provided through the UHC partnership promote sustainability?

5. Context, learnings, best practices?

- Which learnings/best practices do you wish to highlight from Kenya in relation to the PHC levers: "political commitment and leadership towards PHC," "governance and policy framework for PHC," "digital technologies for health," and "monitoring and evaluation"?
- What has been the biggest challenge, in your opinion, in the re-orientation of the Kenyan health system towards Primary Health Care? How was/is this barrier overcome? Enablers? Critical factors?
- What are the potential outstanding main challenges or hindrances to achieving UHC through PHC in Kenya? (probe: equity? Other areas?)

6. Future of SP-PHC support

- What additional support could the SP-PHC provide to WHO CO, Kenya Govt, WHO regional office, and other partners?
- Do you have thoughts or recommendations for the future direction of the SP-PHC, including in relation to other relevant departments that also "do" PHC at headquarters and regional level?

Do you wish to add anything further? Any comments or questions for us.

External to WHO

Introduction

Euro Health Group has been commissioned by the WHO Evaluation Office at the request of the Director of the Special Programme on Primary Health Care (SP-PHC), to conduct a **forward-looking evaluation**. The evaluation comes three years since the establishment of the SP-PHC in 2020. Its purpose is to **review progress to date** and **generate learning** that can be used to enhance future implementation and performance of the SP-PHC, as well as inform relevant discussions and decisions both within WHO and with partners.

The evaluation is based on the theory of change of the SP-PHC. A set of evaluation questions has been developed based on the expected results of the SP-PHC. Data collection methods include an online survey; KIIs and focus group discussions, literature and data review. Analytical approaches and tools are used to examine evidence and findings such as for example the Forcefield Analysis to identify factors helping and hindering change and the strength of each factor. Evidence generated from all data sources will be triangulated to answer the evaluation questions and generate recommendations. Finally, a workshop will be organized to consider, generate and/or refine forward-looking recommendations.

Confidentiality

Please note that all information shared for this evaluation will be treated with **confidentiality and anonymized**. Any **citations and quotes will not be traceable** to individuals nor their titles/positions.

We will limit this interview to 45-60 minutes.

Specific activities in Kenya with direct line of sight to the SP-PHC:

- SP-PHC/UHC-Partnership technical and financial support (including EU and Canada funds) to promote the PHC Approach in Kenya through the operationalization of key levers (to be identified with WHO Kenya). Relevant to strategic levers 1 and 2 and operational level 11 (political commitment and leadership; governance and policy frameworks; digital technologies for health)
- SP-PHC support to Kenya through the PHC-Accelerator of the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP – Kenya being one of twenty PHC-Accelerator countries). Relevant to strategic levers 1 and 2 (political commitment and leadership; governance and policy frameworks)
- SP-PHC support for the development and utilization of the WHO/UNICEF PHC measurement framework and indicators. Relevant to strategic lever 14 (monitoring and evaluation)
- SP-PHC support to Kenya as a pathfinder country on PHC Implementation Solutions, which potentially provides a mechanism to harvest wisdom from country experience Relevant to the SP's role on generating evidence and lessons

learned on the emergency of the GOK PHC strategy and related policy frameworks; potentially related to operational level 13 PHC-oriented research.

Interview guide

1. Introductory question

- Please introduce yourself, your role
- Were you aware of the SP-PHC before this interview?
- What relations have you developed/do you have with WHO CO Kenya and/or the SP-PHC?

2. Efficiency and effectiveness of the implementation the support received from WHO/SP-PHC

- What PHC-related activities have you undertaken with support of WHO since 2020? (probe and especially concentrate on specific SP-PHC activities (e.g., policy dialogue on health reforms, the high-level mission in 2022? with the WHO SP-PHC from Geneva and the **Health System Strengthening** Regional Director at the inception of these reforms, UHC-Partnership support.)
- Who initiated the request for support for this activity?
- What was the process followed/was it timely? What kind of concrete support have you received? Has the support been adequate in responding to your country 's needs?
- What have been the main achievements/ anticipated results of the support provided? Please provide examples.
- More specifically:
 - How has the political commitment and leadership towards PHC been affected by this support?
 - How has the governance and policy framework for PHC been changed? (or prospects on being changed)
 - Has the support been catalytic (e.g., had a multiplier or accelerator effect), or innovating? Has the support accelerated actions? Improved national interventions?
 - If too early to say, what is in your perspective the potential for change/impact at national level?
- Has the support provided by WHO CO/ SP-PHC added value to your work on PHC in Kenya? Examples?

To what extent was the support provided by WHO to Kenya well-coordinated and aligned with support provided by other partners? Are there examples of support provided by WHO leveraging or catalyzing other partner expertise and resources for PHC?

- How does the support provided promote equity, gender and human rights?
- How does the support provided promote sustainability?
Is WHO well placed to offer this support?

3. Context, learnings, best practices?

- Which learnings/best practice do you wish to highlight from Kenya in relation to reorienting health systems towards PHC – specifically political commitment and leadership towards PHC and governance and policy framework for PHC.
- What has been the biggest challenge, in your opinion, in the **radical re-orientation of the Kenyan health system towards Primary Health Care?** How was/is this barrier overcome? Enablers? Critical factors?
- What are the potential outstanding main challenges or hinderances to **achieving UHC through PHC** in Kenya? (probe: equity? Other areas?)

4. Future support from WHO/SP-PHC?

- Are there better or different ways for WHO/SP-PHC to support Kenya to implement the PHC approach and achieve country progress towards UHC than the support provided so far? /What additional support could WHO/SP-PHC provide in Kenya?
- Do you have other thoughts or recommendations?

Do you wish to add anything further? Any comments or questions for us?

Any enquiries about this evaluation should be addressed to:
Evaluation Office, World Health Organization
Email: evaluation@who.int
Website: Evaluation (who.int)