Assessing sub-national health system’s capacity to deliver primary care for diabetes mellitus and hypertension in Kenya

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Abstract

Background

The growing burden of non-communicable diseases (NCDs) presents an emerging challenge to Kenya’s health system ability to provide interventions and services. Kenya’s health policy aims to halt and reverse the rising burden of these diseases and to strengthen primary care services. Subnational (county) governments are crucial to delivery of health services in Kenya. This study critically appraised the subnational health system’s current capacity to deliver services for diabetes and hypertension at primary care level.

Methods

We used a cross-sectional qualitative approach with primary care services at the county government level as the unit of analysis. We collected data through document reviews (policy, statutes and budgets), in-depth interviews with senior county officials (n=7) and with facility managers and front-line health workers (n=15) in one county in Kenya. Facility audits of staff numbers and mix, availability of medical equipment, and essential drugs, were conducted in 3 hospital clinics and 3 primary care facilities to triangulate interview findings. Data were analyzed using a framework approach.

Results

There were gaps in hardware elements of capacity including financing, human resources, service delivery and commodities as there were inadequate quantities of these resources to address the unique needs of diabetes and hypertension. Some tangible software elements of capacity such as organizational arrangements were present e.g. an official responsible for these diseases; though others such as treatment guidelines and adequate referral arrangements were absent. Power resided with political leaders and controllers of finance who influenced the resourcing and consequently the management of these diseases. As a result, facility managers felt unable to address the resource gaps that would have improved service delivery. Front-line workers felt the need for routine capacity building to offer the best service possible. Comprehensiveness of care was affected by the absence of equipment and the lack of staff diversity. Coordination and continuity of care were affected by poor information systems, staffing gaps and gaps in quality of care. Accessibility was supported through use of ambulances, increased investment in physical infrastructure and through waiver systems.

Conclusions

County governments should provide adequate resources required to fill in the hardware capacity gaps especially at primary care level. Tangible software capacity gaps such as standard treatment guidelines, training and supervision of front-line workers should also be urgently addressed to complement existing intangible software capacity.