

Health facility management committees

Involving communities in healthcare delivery in Kenya

Community involvement in health facilities is a mechanism for improving the quality and use of services: it should increase facility managers' responsiveness to local needs, and improve community members' awareness of available care. In Kenya, community participation initiatives have included the involvement of community members in Health Facility Management Committees.

Whilst facility committees have in the past been responsible for overseeing the operations and management of health facilities and user fees, their roles were extended in 2010 to manage facility budgets allocated from the Health Sector Services Fund (HSSF).

This brief presents findings from research conducted before and one year after HSSF implementation. The research demonstrates that committees have played a key role in HSSF implementation, and in health centre and dispensary management more generally. Areas identified for improvement include financial management training, targeted supportive supervision and community awareness of committees and their roles.



Background

The HSSF is an innovative financing initiative that disperses funds directly from the central government into facility bank accounts. It aims to ensure funds reach facilities and to make up for shortfalls in facility-level funding following the reduction in user fees in 2004. HSSF provides facility committees with larger budgets to manage, which has required new roles and responsibilities. These are set out in box 1.

Box 1: Role and responsibilities of management committees as part of the HSSF.

- Supervise and control the administration of the funds allocated to the facilities.
- Open and operate a bank account at an approved bank.
- Prepare work plans based on estimated expenditures.
- Oversee accounts of the income, expenditure, assets and liabilities of the facility as prescribed by the officer administering the Fund.
- Prepare and submit certified periodic financial and performance reports as prescribed.
- Oversee the maintenance of a permanent record of all its deliberations.

Fundamental to HSSF implementation is having a duly formed facility committee with basic characteristics required by the government (box 2).

Box 2: Government guidelines for membership and selection of management committees

- Residents of the area including: 1 person with knowledge and experience in finance and administration; 4 persons of whom 3 are women.
- Representative from the provincial administration.
- Health facility in-charge.
- District Medical Officer of Health (DMOH) or his/her representative.
- Area councillor or person in charge of the local authority health facilities.
- All members to hold at least form four level certificate of education or equivalent.

How were facility committees functioning one year after HSSF roll out?

Composition and meetings

- By 2012 most facilities had a properly constituted committee, which was meeting at least once a quarter. Most facilities also reported monthly meetings for executive committee members.
- Strict oversight from district and national levels of centrally allocated HSSF funds and user fees, was felt to have contributed to transparency and trust between management committees and in-charges, who generally had good and supportive relationships.

Motivation and allowances

- Facility committees were generally reported to be committed to their duties (particularly chairmen and secretaries), and to have contributed centrally to HSSF's positive impact on facilities and local communities.
- Committee members were being paid an allowance of KSH 500/= (6 US\$) per quarter for attending quarterly meetings (maximum four per year).

Challenges

- There was some lack of clarity in the roles and responsibilities of committee members.
- Facility committees needed more training on the modalities of HSSF and their role in its implementation, and particular support in financial management.
- Allowance payments were considered inadequate ('peanuts'), even for an essentially voluntary role, given the amount of time involved.
- There was some tension in relationships inbetween in-charges and committee members, linked to members and their lack of role clarity.

“Some of them are not well oriented in their roles and responsibilities, most of them were, but for those who were not you'll find that they have over-stepped their mandate...[and this] brings a bad line between the facility in-charge and the committee.”

District health manager

Recommendations

This research demonstrates the strength of the facility committee mechanism in Kenya and the key role it has played in the implementation of HSSF, and management of health centres and dispensaries more generally. However, a number of areas for improvement were highlighted:

Strengthen community awareness of committees

- Strengthen public awareness of the selection process, especially for vulnerable groups.
- Improve communication between facility committees and the wider community, eg through the provision of basic information such as: names and contacts of committee members being displayed in a user-friendly manner on facility walls; and organising public meetings to identify community needs and give feedback.

Improve training and support in financial management

- Place greater emphasis on financial management training and supportive supervision.

Maintain motivation

- Carefully consider how committees are motivated, to ensure that there is an appropriate balance between extrinsic motives – both financial and nonfinancial – and intrinsic motivation such as social recognition, knowledge gain, and the opportunity to make a social contribution.

Increase representation

- A challenge in many facility committees in developing countries is selection and representation of the diverse communities they 'represent'. The secondary education requirement in Kenya potentially assists with some roles, but may undermine representation of the poorest groups on committees. This requirement needs careful tracking over time, and potentially reconsideration, at least in some areas.



About the research

This information is based primarily on two studies:

- A large-scale survey conducted in 2010 by KEMRI-Wellcome Trust and London School of Hygiene & Tropical Medicine researchers in a nationally representative sample of 248 health centres and dispensaries.
- A document review and mixed methodology interim evaluation conducted by the same team in 2012, based on qualitative interviews, facility record reviews and an exit survey.

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Related publications

Opwora A, Toda M, Waweru E, Edwards T, Fegan G, Noor A, Molyneux S, Goodman C. (2011) Health Service Delivery, Governance and Supportive Supervision under the Health Sector Services Fund: National Baseline Survey, 2010.

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Waweru E, Opwora A, Toda M, Fegan G, Edwards T, Goodman C and Molyneux S. (2013) Are Health Facility Management Committees in Kenya ready to implement financial management tasks: findings from a nationally representative survey. BMC Health Services Research 13(1): 404.

Molyneux S, Atela M, Angwenyi V, Goodman C. (2012) Community accountability at peripheral health facilities: a review of the empirical literature and development of a conceptual framework. Health Policy Plan, 27(7), 541-554.

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