The Health Sector Services Fund (HSSF) is an innovative scheme that provides funds directly to primary health facilities. It was established in 2010 by the Government of Kenya with the aim of increasing resources at peripheral health facilities to provide adequate services, and encouraging community involvement in the identification of health priorities and appropriate solutions.

Researchers from KEMRI-Wellcome Trust Research Programme and the London School of Hygiene & Tropical Medicine have been evaluating the HSSF and will continue tracking its implementation and impact in several counties until 2016. During this time, the Kenyan health system will be devolved to the county level, offering a huge opportunity for more responsive and accountable services, but also new challenges for HSSF’s design and implementation.

This research brief presents the key findings from a mixed-methodology interim evaluation of HSSF and its implementation until May 2013. It identifies impressive achievements in terms of ensuring that funds reach facilities, are spent appropriately, and are overseen and used in a way that strengthens community involvement. The evaluation also highlights obstacles to effective implementation and important issues for consideration in future HSSF planning in light of the devolved health system, and in other financing mechanisms for peripheral facilities in Kenya and beyond.

Key points
- Peripheral facility finance mechanisms can have a strong and broad positive impact on peripheral facilities.
- In Kenya, HSSF has led to improvements in the reported quality of care, staff motivation and patient satisfaction, even when funds represented less than 1% of the total health sector budget and without any link between funding and performance.
- Community members are more actively involved in the running of facilities as part of health facility management committees, which has strengthened accountability.
- Challenges to effective implementation remain, in particular delays in receiving funds and arduous financial reporting requirements, both of which can affect the ability of facilities to deliver services effectively.
- In any low income setting, there are limits to the possible achievements of one financing intervention in the context of wider challenges including unreliable drug supplies, poor access to emergency transportation, and shortages of qualified staff.
**How should HSSF work?**

Under HSSF, funds are paid into a facility bank account directly from the national level every three months. The money can be spent on facilities’ operations and maintenance, refurbishment, support staff, allowances, communications, utilities, non-drug supplies, fuel and community based activities.

For each facility, a Health Facility Management Committee (HFMC) oversees the funds and decides what the money is used on, preparing annual work plans and quarterly implementation plans. HFMCs are mandated to include community representatives.

Funds are spent on receipt of an Authority to Incur Expenditure (AIE) from the national level, and facilities record expenditures in monthly and quarterly financial reports. Members are supported and supervised by the District Health Management team (DHMT) and county-based accountants.

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**Key findings from the evaluation**

**Funds allocated to HSSF**

<table>
<thead>
<tr>
<th>Source</th>
<th>Percentage</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>World Bank</td>
<td>42%</td>
<td>US$9.5m</td>
</tr>
<tr>
<td>DANIDA</td>
<td>44%</td>
<td>US$9.9m</td>
</tr>
<tr>
<td>Government of Kenya</td>
<td>14%</td>
<td>US$3.1m</td>
</tr>
<tr>
<td>UNICEF</td>
<td>&lt;1%</td>
<td>US$60,000</td>
</tr>
</tbody>
</table>

- HSSF funds since inception until January 2013 (KSh1.9bn)

**Health facility quarterly revenue from HSSF**

- The largest proportion of HSSF funds was spent on health centres
  - US$1565
  - US$1339
  - US$327

**Health Facility Management Committees**

All facilities had properly formed HFMC, with many playing an important role in facility decision making. By March 2013, nearly 9000 HFMC members and health staff had received training in the management of the HSSF.

**What was the money spent on?**

- **Staff wages**: 25%
  - The largest share of HSSF money was spent on wages for support staff including accounts clerks, watchmen or security staff, groundsmen and cleaners.

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- Medical supplies: 14%
- Travelling/subsistence allowances: 13%
- Other operational costs: 13%
- Fuel/lubricants: 6%
- Maintenance: 6%
- Utilities: 6%
- Office supplies: 5%
- Meetings: 3%
- Other expenses: 3%
- Comms. including internet: 3%
- Food & rations: 3%
- Medical drugs: 2%
Now we are able to pay our bills on time. We are even able to collect drugs if we are out of stock; we can fuel a vehicle to go to the rural facilities and transport whatever excess drugs they have to our facility to make use of them - it has made many things possible.

Health centre in-charge

Of course [quality of care] has improved; initially if you didn’t have gloves you would tell a client “we are sorry, we can’t help you”.

Health centre in-charge

Financial reporting and facility performance

Most facilities prepared monthly and quarterly financial reports but completion of the many other financial management documents required by HSSF varied widely.

In September 2012 the Independent Fiduciary Review (IFR), which conducts a quarterly audit of HSSF’s fiduciary compliance, performance, governance arrangements and value for money, rated only 22% of facilities as satisfactory, although the percentage has improved over time.

IFR rating of health facilities and DHMTs, Sept 2012:

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<tr>
<th></th>
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<tr>
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<td>73% satisfactory</td>
<td>27%</td>
<td></td>
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</tbody>
</table>

Positive impacts of HSSF

HSSF funds have been reaching facilities, and in general are reported to be being overseen and used in a way that strengthens transparency and community involvement.

HSSF funds have contributed to:
- Active involvement of community members in facility management through HFMCs.
- Visible improvements in facilities.
- Improved perceived quality of care, staff motivation and patient satisfaction.
- More reported outreach activities.
- Greater transparency and improved oversight of user fee revenues which are now banked with HSSF funds and managed according to the same systems.

Importantly, these positive achievements were observed when HSSF funds represented less than 1% of the total “on-budget” health sector funds, and without any link between funding and facility performance.

Challenges to effective implementation

Delays in receiving funds
Some facilities experienced delays in receiving funds and AIEs. The delays in receiving AIEs also affected facilities’ access to other sources of revenue, such as user fees, which were kept in the same bank account and incorporated into HSSF financial oversight mechanisms.

Complexity of documentation
Substantial reporting requirements for the Fund meant that completion of financial reports took up a significant amount of the in-charge’s time (estimated at 20%), detracting from their clinical work and other responsibilities. Concerns about possible sanctions resulting from inappropriate use of funds led to significant anxiety among some facility managers.

Inadequate HSSF training
Training related challenges include: inadequate coverage of key people, insufficient length and depth of financial oversight training, absence of refresher courses and inadequate uptake of funds for training new staff.

Low community awareness
Facility users’ awareness of HFMC was low, as was their understanding of HSSF. Only one third of people using health services had heard of HSSF, and of this third, only 16% could accurately describe the Fund.

Lack of clarity in roles and responsibilities
There were some relationship challenges between HFMCs and facility in-charges, and between district managers and county based accountants. A particular area of debate was the lack of involvement of the District Treasury in HSSF. While some felt this was ‘the Achilles heel’ of HSSF, others felt this was essential given Treasury failings.

Inadequate levels of funds
It was hoped that provision of HSSF funds would allow facilities to reduce user fees and to implement fee exemptions according to the national policy. However, this has not occurred, and over-charging remains common. While greatly appreciated, HSSF funds were considered to be inadequate in meeting the diverse needs of facilities.

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HSSF planning under devolution and user fee abolition

The future role of HSSF will be affected by two key developments in the Kenyan health sector: the abolition of user fees at all peripheral health facilities, and the devolution of the health system into 47 semi-autonomous counties.

Whilst HSSF may be an important mechanism to compensate facilities for lost revenue from user fees, there are new challenges in aligning the HSSF legal framework and institutional and management procedures with the devolved system of government. When designing HSSF under devolution, attention should be paid to three key areas:

- **Decision space**: HSSF design can be broken down into a list of potential key decisions across several health system domains. For each decision, ideal ‘space’ at national, county/district and facility level can then be agreed and (re)negotiated over time.

- **Accountability**: Accountability systems to managers and communities should be considered, including making sure that the total accounting responsibilities for each key actor are reasonable and do not undermine their ability to undertake other roles such as clinical care.

- **Organisational capacity**: Appropriate organizational structures and capacities should be assured each level.

Implications of HSSF experience for other peripheral facility financing mechanisms

- Peripheral facility finance mechanisms can have a strong and broad positive impact on peripheral facilities.

- Health Facility Management Committees can play a valuable role in managing facilities but there are challenges with broader links to users and communities.

- Complex and centralised accounting requirements can undermine efficiency goals, and implementation problems can have wider negative impacts.

- There is need for clarity in the roles and responsibilities of key actors, including in relation to integration into existing structures and systems.

- There are limits to the possible achievements of one financing intervention in the context of wider challenges including unreliable drug supplies, poor access to emergency transportation, and shortages of qualified staff.

- Mixed methodology process evaluations tracking (un)intended consequences of HSSF and other similar interventions can contribute to regional financing and decentralisation debates.

About the research

This information is based primarily on a document review and mixed methodology interim evaluation conducted by KEMRI-Wellcome Trust and the London School of Hygiene & Tropical Medicine in 2012.

Empirical work included qualitative interviews at national, district and facility levels, facility record reviews, and a structured exit survey. Facility based empirical work focused on ten health centres in five purposively selected districts, while national level interviews and document reviews covered HSSF in both health centres and dispensaries.

The research was funded by DANIDA, Ministry of Public Health and Sanitation in Kenya, DFID, and the Wellcome Trust.

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