



# Assessing the Implementation and Effects of Direct Facility Funding in health centres and dispensaries in Kenyan coast

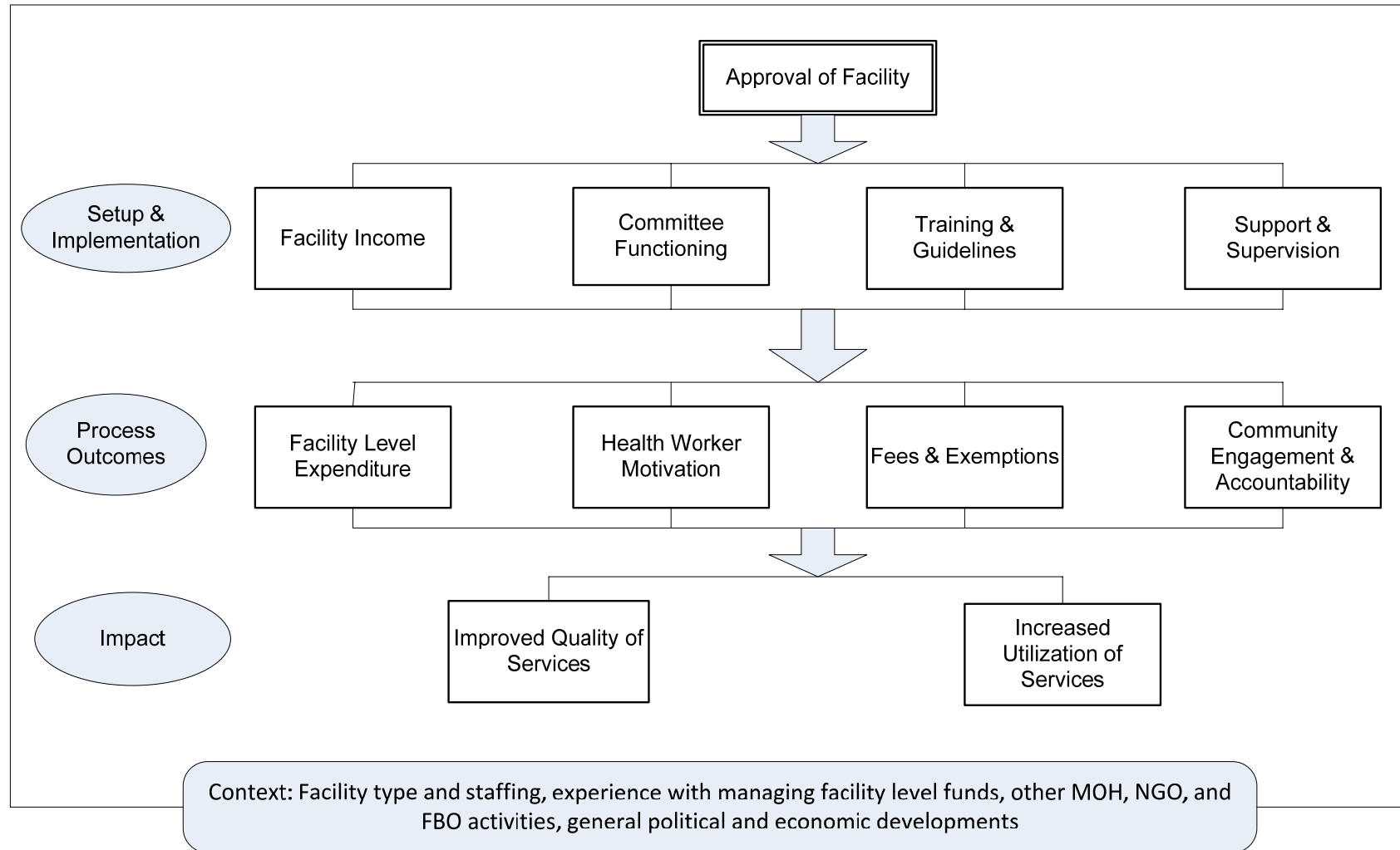
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# Background

- Kenyan government reduced user fees in 2004
- Concerns that the policy reduced facility level funds and health facility committee (HFC) activities
- Direct funding for facilities (DFF) piloted in Coast Province since 2005 with DANIDA funds, plans for nationwide rollout
- Funds transferred directly into facility accounts, and can cover operations and maintenance, refurbishment, casual staff, allowances (not drugs)
- HFCs prepare work plan of expenditure, approved by district management
- Communities empowered to monitor funds, eg accounts displayed on public notice boards
- We evaluated the way DFF was implemented and effects it had at health facility level

# Conceptual Framework



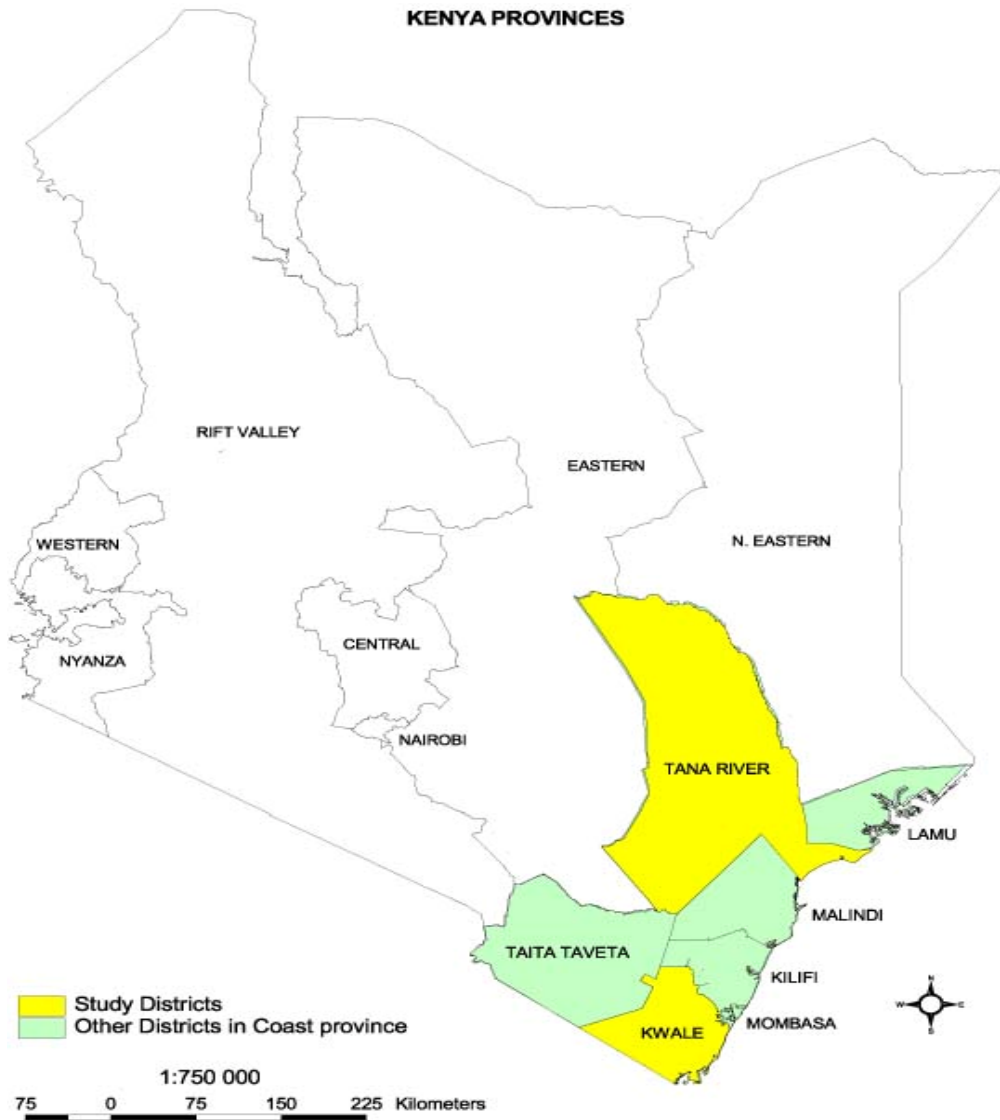
# Methodological Challenges

- No baseline data collected prior to pilot
- HMIS data incomplete & unreliable

Challenges addressed through:

- Focus quantitative analysis on intermediate and process outcomes outlined in the conceptual framework
- Qualitative methods to explore perceived impact

# Methods – Sampling



- 2 districts
- Sampling frame
  - All MOH health centres and dispensaries
- Selected
  - All 9 health centres
  - Random sample of 21 dispensaries

# Methods

- **Data collection in 2007/8, in two districts**
- **Structured survey at MOH health centres and dispensaries (n=30)**
  - Interview with facility in-charge
  - Record review: Utilization, Income & Expenditure
  - Exit interviews: Target was 10 per facility; obtained total of 292
- **In-depth interviews in sub-set of facilities (12 facilities)**
  - Facility in-charge
  - HFC members
- **In-depth interviews with managers and stakeholders**
  - District staff and other stakeholders

# *Results*

Setup & Implementation

Process Outcomes

Perceived Impact

# Setup & Implementation

- In general, DFF procedures were well established
- Bank accounts opened by each facility and money transferred
- HFCs met more regularly, produced & implemented work plans
- Accounting procedures followed
- Teething problems reported in one district in first year now resolved



# Training & Documentation

- **HFC Training conducted in both districts and highly valued, but problems identified:**
  - Training coverage not comprehensive
  - Inadequate coverage of key elements of DFF operation (e.g. rules of scheme, completing cash book, financial management)
- **Neither DHMT or HFC had clear documentation on DFF operation**
- **Led to confusion:**
  - Which facilities are eligible?
  - How was allocation of funds across facilities decided?
  - What DFF can be spent on?
  - Committee roles in relation DFF expenditure and user fees

# Facility Income

**Average annual income per facility by source** (Ksh, to nearest thousand)  
(July 2006 – June 2007)

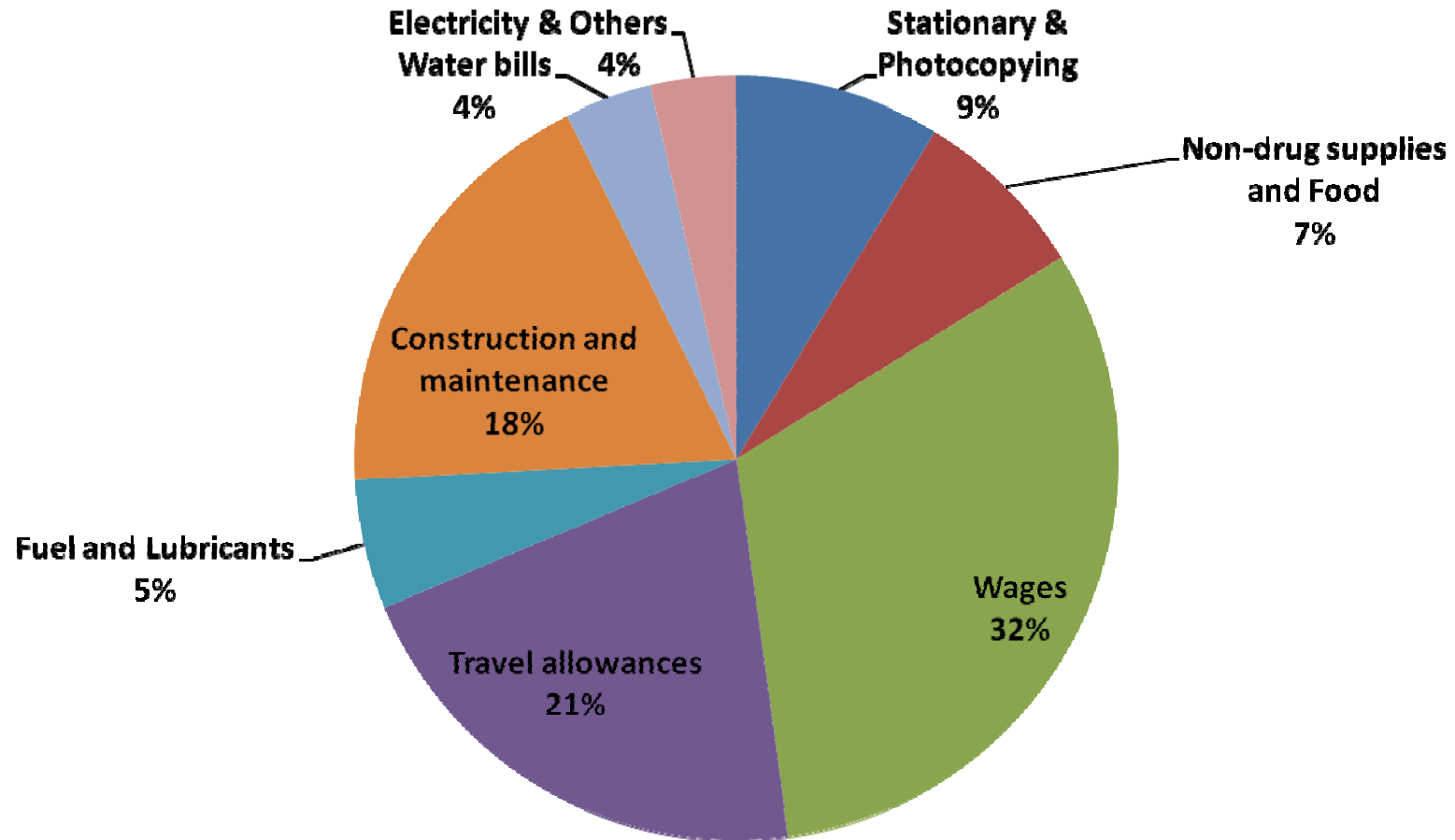
	<b>DFF</b>	<b>User fees</b>	<b>ITNs</b>	<b>Other</b>	<b>Total</b>
Dispensary	190,000 62%	65,000 22%	15,000 5%	35,000 11%	305,000 100%
Health Centre	320,000 47%	328,000 49%	19,000 3%	3,000 1%	670,000 100%
<b>All facilities</b>	<b>230,000</b> <b>56%</b>	<b>142,000</b> <b>34%</b>	<b>16,000</b> <b>4%</b>	<b>23,000</b> <b>6%</b>	<b>411,000</b> <b>100%</b>

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MSOffice2 do in USD  
, 11/03/2009

# Expenditure of DFF Income



# Examples of DFF expenditure

- Salaries for casual staff
- Fuel/ transport and allowances for outreach & referrals
- Scratch cards for calling district management
- Renovation and maintenance to facility buildings



In-charge (far right) with HFC member (2<sup>nd</sup> left) & 2 DFF funded casual staff: nurse assistant (far left) & caretaker (2<sup>nd</sup> right)



DFF funded maintenance - Fixing gutter for rainwater collection

# Incomplete adherence to user fee policy

Health worker reports of fees charged for specific cases  
(n=30)

<b>Case</b>	<b>Adherent (exc. lab costs)</b>
Child with malaria	22
Adult with malaria	5
Child with pneumonia	20
Adult with pneumonia	23
Adult with TB	22
Adult with gonorrhoea	3
Woman at first ANC visit	28
Mother requiring delivery	30
<b>All above cases</b>	<b>0</b>

# Causes of non-adherence to user fee policy

- Confusion over what fees should be charged
- Lack of capacity of district or community to monitor actual charging practices
- HFC feel that additional funds are still required

*“...When we waive the under 5’s then it means we will almost be running nil of user fee because most of the patients are these under 5’s... when you don’t charge the under 5’s then definitely you get nothing...” (health worker, Tana River)*
- Many health workers and HFC do not feel that 10 or 20 KSH has a deterrent effect for patients

# Community Engagement

- Lack of awareness of HFCs:
  - 46% ever heard of the HFC
  - 16% knew who the chairman was & 26% knew who any of the members were
  - Names of HFC members displayed at only 7/30 facilities
- Little knowledge on DFF



# DFF Impact

- Impact perceived to be “highly positive”
- Most facilities are able to conduct outreaches, increasing access to immunization and ANC
  - “...Previously it was very hard to go for outreaches but now that there is allowance –though just a small amount- the committee members are more willing to organize outreaches in their villages...” (HFC member, Kwale)*
- Employment of casual staff has ensured that the facilities are well maintained
- Stationery & transport facilitate compliance with HMIS reporting requirements

# DFF Impact 2

- Facilitated referral of severe cases to the district hospital
- Reported positive impact on health worker motivation despite increased administrative workload, due to increased support staff, improved supplies & work environment, and more allowances
- Withdrawal of DFF would have a dramatically negative impact of facility operation

*“...so we feel if it were not for DANIDA there would be no facilities...many would have collapsed. We really thank DANIDA...” (Health worker)*

# Conclusions

- DFF equivalent to 13% of recurrent costs in dispensaries and 2% in health centres => small increases in funding at the periphery may have a significant impact
- Current system is working well and can be replicated elsewhere
- Training of HFCs is paramount with simple and clear manual for HFC members
- Need to clarify what community needs to know, and decide on appropriate communication mechanisms
- User fees: clarify policy; emphasise adherence
- Consider DFF as potential mechanism to compensate facilities if charges abolished in future