

Funding Kenyan health centres: experiences of implementing direct facility financing and local budget management

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Introduction

In many African countries, primary care facilities are inadequately resourced, and user fee reduction or elimination policies have been poorly planned, without alternative sources of facility income. The Health Sector Services Fund (HSSF) is an innovative scheme established by the Kenyan Government in 2010 to disburse funds directly to health facility bank accounts. Health Facility Management Committees, which include local residents and the facility in-charge, are responsible for planning, budgeting and implementation of HSSF activities. We conducted an “open box” process evaluation of early experiences of HSSF, documenting its implementation, interactions with the broader health system, and any unintended consequences.

The Key Features of the Health Sector Services Fund

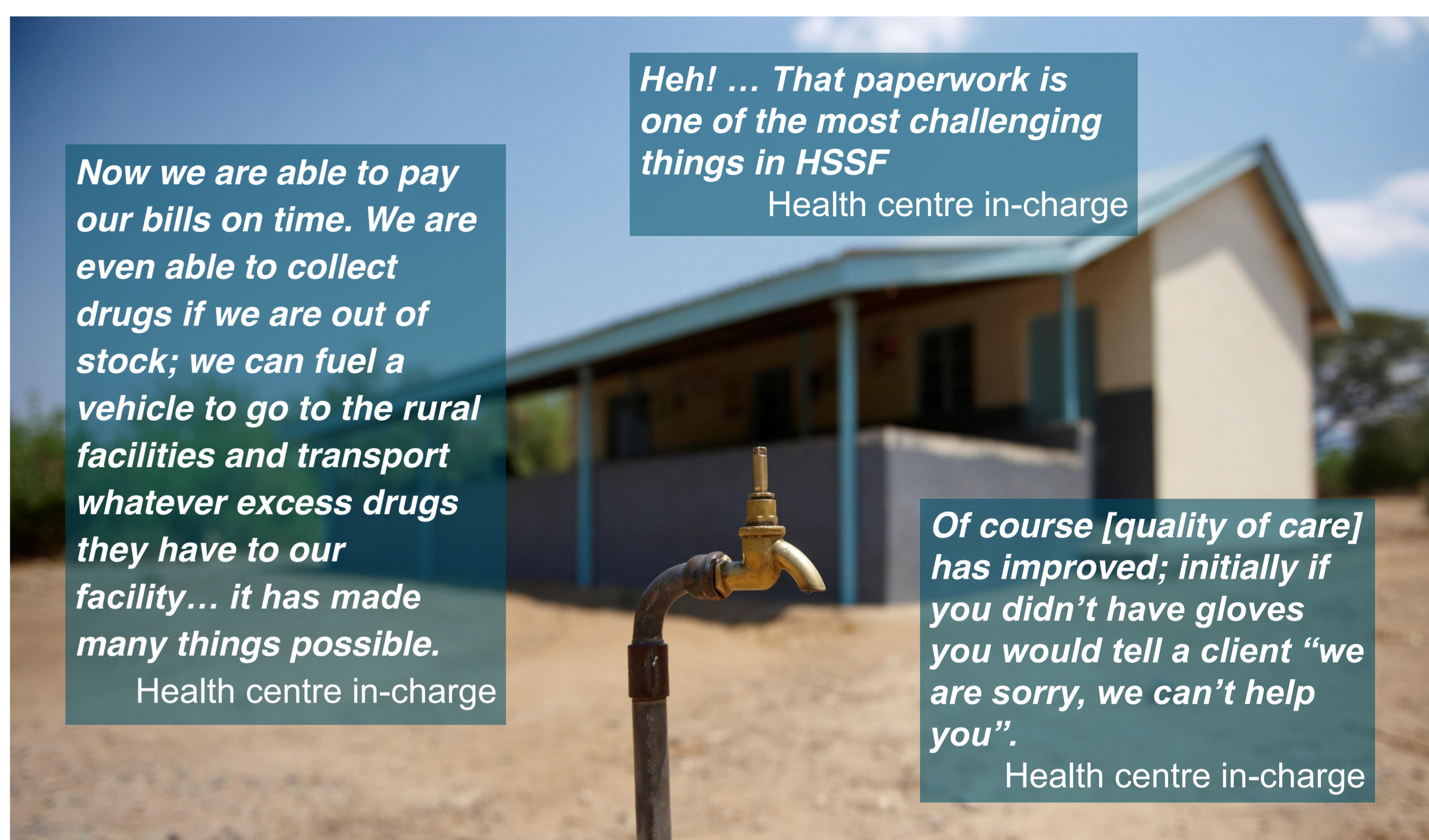
- Facility committees develop annual and quarterly work plans
- Funds flow directly to facility bank accounts each quarter: US\$1339 per health centre, US\$327 per dispensary, and US\$1565 for each District Health Management Team (DHMT). By Jan 2013 US\$ 21,4mn had been disbursed, with the main funders being DANIDA (44%), World Bank (42%) and the Kenyan Government (14%)
- User fee revenues are deposited in the same account and subject to the same financial management requirements
- Funds can be used for facility operations & maintenance, refurbishment, support staff, allowances, communications, utilities, non-drug supplies, fuel and community-based activities
- Spending permitted on receipt of quarterly “Authority to Incur Expenditure” (AIE) from national HQ
- Facilities are required to produce monthly & quarterly financial reports
- Supportive supervision of facilities by district managers and county-based accountants
- Communication strategy involving press releases, radio spots, television segments, posters



Results

Positive perception of impact:

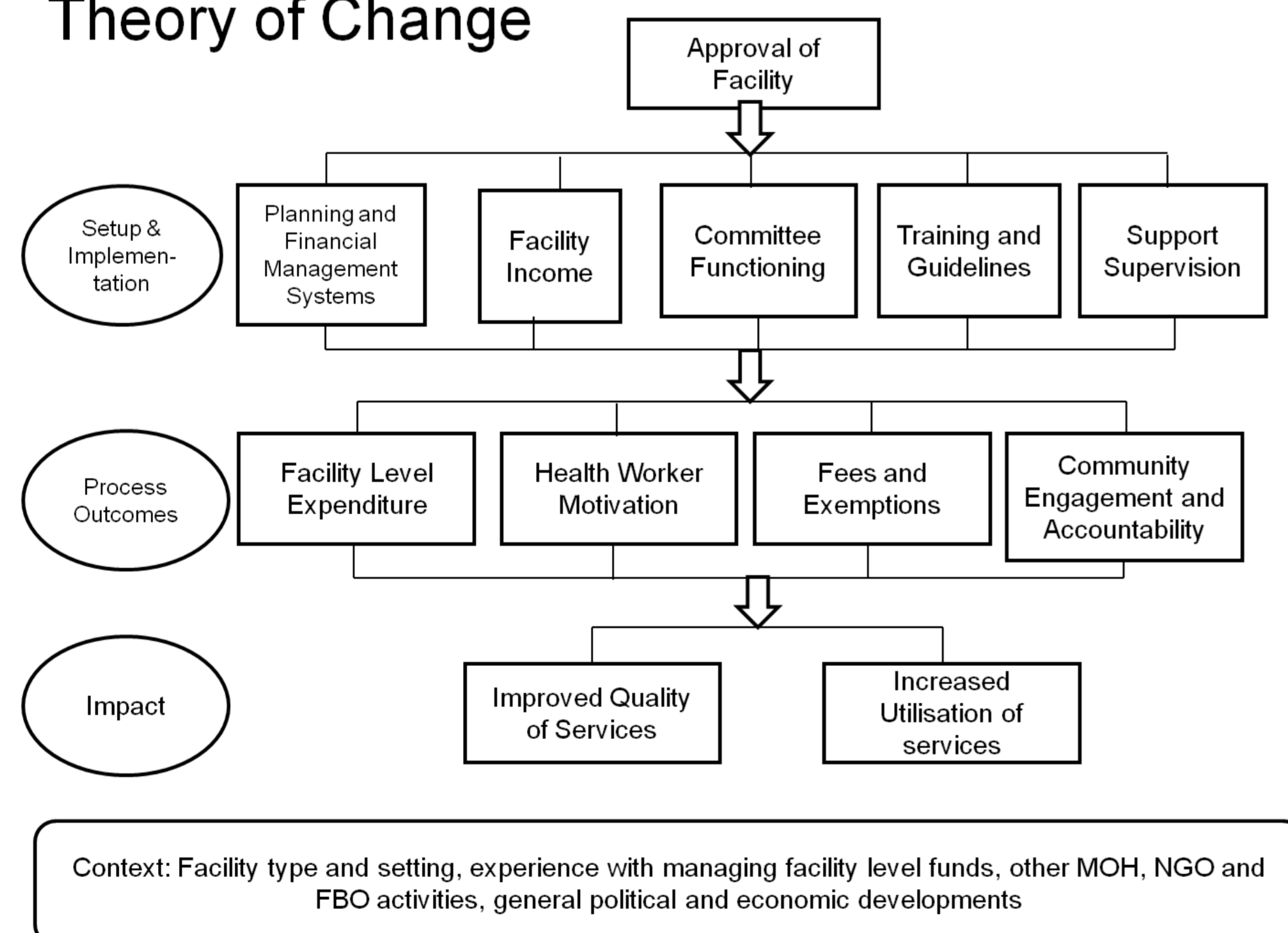
HSSF was felt to have had a positive impact on facilities. The funds were reaching facilities regularly, and were said to have had a positive impact in terms of ensuring that funds reach facilities, and facility committees were playing a key role in their management. Urban facilities reported water, sanitation (toilets and cleaners) and minor renovations as their most important uses of HSSF funds, while rural facilities named casual labourers, essential drugs, food and referrals. Although we did not measure technical quality of care, interviewees reported perceived improvements in the condition of facilities, health workers’ motivation, outreach and patient satisfaction.



Methods

Following a document review and key informant interviews with national stakeholders (n=9), we collected data at district and facility levels. We purposively selected 5 districts (2 urban, 2 rural, 1 mixed), and in each district, selected one weak and one strong performing health centre. We conducted semi-structured interviews with district managers, county-based accountants and facility in-charges (n=22), focus group discussions with committee members (n=10 FGD), an exit survey with users of curative outpatient services (n=99), and reviewed facility income and expenditure data. Interview guides were based on a Theory of Change, and qualitative data were analysed using the framework approach.

Theory of Change



Challenges and unintended outcomes:

- Little impact on user fees charged, with all facilities exceeding the official charges, arguing that HSSF funds were insufficient to cover their needs.
- Delays in receiving AIEs which sometimes did not reflect facility needs, meant less flexibility in use of both centrally allocated HSSF funds and user fees, termed a “straight-jacket” by one interviewee.
- Complex and centralised accounting processes, putting a high burden on facility in-charges, with completion of required reports taking up to 20% of their time.
- In-charges concerned about being accused of mis-use, with some feeling they were “kwamad [blocked] by terror”, and that it was safer not to spend.
- Low community awareness, with only 6% of exit interviewees being able to correctly describe HSSF.
- Bypassing of existing management structures at district level:
 - Some DHMTs felt bypassed / undermined, as in-charges worked with accountants who reported directly to the central HSSF secretariat.
 - Lack of involvement of the District Treasury, argued by some to be the ‘Achilles heel’ of HSSF, leading to verticalisation, while others felt this was necessary and the rationale for HSSF, given the District Treasury’s failings.

Conclusions

- Peripheral facility finance mechanisms can have a strong and broad positive impact on peripheral facilities, even without performance incentives. Since this study Kenya has officially removed all user fees from health centres and dispensaries. The HSSF approach has the potential to fill the gap created by lost user fee revenue, in Kenya and elsewhere, while encouraging community participation.
- Funds can be managed by local committees, but additional efforts are required to ensure that the broader community are well informed and can participate.
- Careful design is essential to ensure that reporting requirements are not over-burdensome and that the mechanism strengthens existing management relationships.
- Ensuring user fee policy adherence requires increased levels of compensatory funding and additional strategies.

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Use of Facility Funds (July 11 – Dec 12)

