

Review of Health Sector Services Fund Implementation and Experience

May 2013



**Evelyn Waweru, Mary Nyikuri, Benjamin Tsofa, Sarah Kedenge,
Catherine Goodman, Sassy Molyneux**



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Abbreviations

ADEO	African Development and Emergency Organisation
AIE	Authority to Incur Expenditure
ANC	Ante-natal Care
AOP	Annual Operational Plan
AWP	Annual Work Plan
CBA	County Based Accountant
CBO	Community Based Organisation
CCQ	Cross Cutting Quality
CHW	Community Health Worker
CSO	Community Score Card
CWC	Child Welfare Clinic
DANIDA	Danish International Development Agency
DFP	Direct Facility Funding
DHAO	District Health Administrative Officer
DHMT	District Health Management Team
DHRIO	District Health Records Information Officer
DMOH	District Medical Officer of Health
DPHN	District Public Health Nurse
DPHS	Department of Primary Health Services
DTC	Diagnostic Testing and Counselling
ETR	Electronic Tax Registers
FBO	Faith Based Organisation
FCI	Family Care International
GOK	Government of Kenya
H/DMC	Health centre/Dispensary Management Committee
HBTC	Home-Based Counselling and Testing
HF	Health Facility
HFMC	Health Facility Management Committee
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HSSF	Health Sector Services Fund
ICC	Inter-agency Coordinating Committee
IFMIS	Integrated Finance Management Information System
IIFRA	Independent Integrated Fiduciary Review Agent
KEMRI-WT	Kenya Medical Research Institute- Wellcome Trust
KEMSA	Kenya Medical Supplies Agency
KSH	Kenya Shilling
LPO	Local Purchase Orders
LSO	Local Service Orders
MOH	Ministry of Health
MOMs	Ministry of Medical Services
MER	Monthly Expenditure Report
MFR	Monthly Financial Report forms

MOPHS	Ministry of Public Health and Sanitation
NGO	Non-governmental organisation
NHIF	National Health Insurance Fund
OBP	Output Based Payment
PBF	Performance Based Financing
PETS	Public Expenditure Tracking Survey
PITC	Provider-Initiated Testing and Counselling
PMTCT	Prevention of mother-to-child transmission (of HIV)
QIP	Quarterly Implementation Plan
QFR	Quarterly Financial Report forms
RAC	Resource Allocation Criteria
SAC	Social Accountability
SWAp	Sector Wide Approach
TB	Tuberculosis
UNICEF	United Nations Children’s Fund
VCT	Voluntary Counselling and Testing

1. Executive Summary

Background to HSSF and Rationale for this review

The Health Sector Services Fund (HSSF) is an innovative scheme established by the Government of Kenya (GOK) to disburse funds directly to health facilities to enable them to improve health service delivery to local communities. HSSF empowers local communities to take charge of their health by actively involving them through the Health Facility Management Committees (HFMCs) in the identification of their health priorities and in planning and implementation of initiatives responsive to the identified priorities. Following a successful pilot of a similar mechanism, the strategy was scaled up nationwide, starting in 2010. Following the recent general election in Kenya, dramatic changes to the health system are being considered and introduced, including devolution of government functions to 47 semi-autonomous counties, the merging of the two ministries of health, and the abolition of user fees at health centres and dispensaries. Given the experience of nearly 3 years of HSSF implementation, and the context of these important changes in the organisation of health service delivery, a review of experiences to date with HSSF and key issues to consider moving forward is timely.

The overall goal of HSSF is to generate sufficient resources for providing adequate curative, preventive and promotive services at community, dispensary and health centre levels, and to account for the resources in an efficient and transparent manner. HSSF can cover items such as facility operations and maintenance, refurbishment, support staff, allowances, communications, utilities, non-drug supplies, fuel and community based activities. DANIDA and the World Bank are currently partnering with the MOPHS in supporting the HSSF's phased implementation which began in October 2010 with public health centres, and public dispensaries in July 2012.

Following a facility stakeholder's forum, HFMCs should develop annual work plans (AWPs) and quarterly implementation plans (QIPs). HSSF resources are credited directly to each designated facility's bank account every quarter and to the District Health Management Team (DHMT): KSH 112,000 (1,339 USD) for health centres, KSH 27,500 (327 USD) for dispensaries and 131,500 (1,565 USD) for DHMTs. Other funds available to the facility, such as user fee revenue, and grants and donations received locally, should be banked in the same account, and managed and accounted for together with HSSF funds from national level. All funds should be managed by the Health Facility Management Committee (HFMC) which includes community representatives, according to the financial guidelines approved by the Ministry of Health (MOH). Funds can only be spent on receipt of an Authority to Incur Expenditure (AIE) from national level. Facilities must then account for funds using monthly and quarterly financial reports, and expenditures are recorded in a specific software called Navision. Facility level supervision and support is provided by the DHMT and county based accountants (CBAs) hired specifically for HSSF; and at national level HSSF oversight is provided by the National Health Sector Committee.

This review had the following objectives:

1. To describe the process of HSSF implementation to date, including facilities covered, funds disbursed, and activities undertaken.
2. To review evidence on the experience with HSSF implementation
3. To identify key issues including devolution for consideration in future planning around HSSF

These objectives have been addressed through review of policy documents, administrative reports, and research studies related to HSSF; and interviews with key stakeholders in MOPHS, DANIDA and the World Bank, to obtain updates on HSSF implementation and experience.

Experiences with HSSF implementation

A total of Ksh 1,918,707,702 (USD 22,841,758) of HSSF funds have been received since the programme began, with the largest contributors being DANIDA (44%), World Bank (42%) and GOK (14%). By January 2013, the number of DHMTs, health centres and dispensaries receiving disbursements were 262, 751 and 2349 respectively.

All health facilities were found to have properly constituted HFMCs in line with the Kenya Gazette notices, with over 90% of HFMCs having met in the previous quarter and reportedly playing an important role in decision making, though there were some complaints about the level of their allowances (KSH 500 per quarter). Nearly 9000 HFMC members and health staff had received training in management of HSSF. The importance of the training was widely recognized, though challenges were noted in terms of inadequate coverage of key people, length and depth of training, absence of refresher courses, and inadequate uptake of funds for training new staff.

All facilities and DHMTs have bank accounts for HSSF funds. However, concerns were expressed about delays in receiving funds and AIEs, AIEs not reflecting QIPs, and challenges around using budget allocations for items not required by facilities. The requirement to bank and account for user fees using HSSF mechanisms was generally seen to have had beneficial effects in terms of recording and accountability, but also to restrict facility access to user fee funds when AIEs were delayed. In July 2012, there was a shift from quarterly to annual AIEs in a bid to minimize the impact of AIE delays, though it is too early to comment on how well this has worked.

Most facilities prepared monthly and quarterly financial reports, though completion of the numerous financial management documents required for HSSF was highly varied, with some frequently not available in facilities. In September 2012 the Independent Fiduciary Review rated 22% of facilities as "Green" or satisfactory, 62% as "Amber" or average, and 16% as "Red" or poor, though the percentage rated green had been improving over time. Of DHMTs 73% were rated "Green", 27% "Amber", and none 'Red'. It was widely noted that completion of required reports took significant amounts of in-charges' time, and that balancing the time requirements for accounting, documentation and patient care was extremely difficult. CBAs observed that there were better records and control of financial aspects of facility management in facilities with accounting clerks. Most facilities found supervisory visits from the DHMT useful but inadequate, with CBAs therefore having to offer additional informal training and supervision, which was reportedly greatly appreciated. A workshop had been held in 2012 aimed at simplifying financial management forms, but efforts have been constrained by government accounting requirements. A new reporting schedule was introduced in July 2012 to increase the amount of time to produce and submit reports from a total of 15 to 45 days though interviews indicated that still only a third of reports are received on time.

User fees and HSSF both made a very important contribution to health facility finances, each representing approximately half of total health centre income, although there was considerable variation across facilities, with the proportion from HSSF ranging from 17% to 85% across 10 health centres surveyed. In terms of expenditure of HSSF funds, the largest share (25%) was spent on wages for staff such as accounts clerks, watchmen/security staff, groundsmen and cleaners. High proportions were also allocated to medical supplies (14%), travelling accommodation and subsistence (13%) and other operational costs (11%), fuel lubricants and other costs (6%) and maintenance (6%). Only a small proportion of funds (2%) were reportedly spent on drugs, though there remained some lack of clarity about use of funds for this purpose. A limited number of cases of ineligible expenditures, or mis-use of funds had been identified, with penalties for more severe cases including salary deductions, demotions and suspension.

There was a general impression of very positive impacts of HSSF in terms of facility operations, quality of care and staff motivation, patient satisfaction, outreach activities, and utilisation. Improvements have reportedly been even more visible and impressive in dispensaries, where HSSF has been described as a 'huge success'. More negative influences highlighted for staff motivation concerned the increased paperwork, frequent inspections/ audits, and concerns about the personal consequences of inappropriate use of funds.

Although there was general agreement that community members needed to know about HSSF, awareness among facility users of the existence of HFMC and understanding of HSSF was relatively low.

In addition to the basic HSSF package, two pilot programmes have been implemented:

- A Performance Based Financing (PBF) pilot was implemented in Samburu County since October 2011, with the aim of improving coverage and quality in access to the services by incentivizing facilities for improved performance on key output and quality indicators related to reproductive and child health services, and strengthening supportive supervision provided by DHMTs. Facilities were received an average additional PBF payment of KSH 21,580 per quarter, reflecting improvements recorded in utilization and quality for some services. PBF is to be expanded to the rest of Samburu, Lamu and West Pokot Counties by mid-2013.
- A Social Accountability (SAc) pilot was implemented in nine locations from 2011-2013. The pilot tested the operational feasibility of improving transparency in sharing information about health services, enhancing participation of communities in health service delivery planning and introducing effective complaint redress mechanisms, targeting the user communities. Findings included improvements in information sharing and disclosing behavior, and an improvement in facility performance measured by community score cards.

Key issues for consideration in future HSSF planning

Our review suggests that there are some important areas that require attention moving forwards, including:

- **Financial Management** – in addition to tackling the financial management challenges highlighted above, a specific area requiring consideration is the relationship between HSSF and standard GOK financial procedures including the role of the district treasury. A recent consultancy report advocated full integration of HSSF with GOK systems including abolition of the HSSF secretariat, a shift from Navision to the GOK's IFMIS software, cessation of HSSF specific fiduciary reports, and absorption of CBAs into the District Treasury. However, some stakeholders were critical of elements of this report arguing that the creation of a parallel funding system for HSSF had been necessary because of the failings of the district treasury, that HSSF fiduciary reports were essential for HSSF credibility and that rolling out IFMIS was perceived by some to be highly costly.
- **HSSF in a devolved system** - A key priority for HSSF moving forwards is the alignment of the HSSF legal framework and institutional and management procedures with the devolved system of governance to the counties. At present, there are so many unknowns in how the wider devolution process will unfold, that the alignment of HSSF within this wider context is challenging. Three possible options would include (i) including HSSF funds in the block grant to counties which can be spent at the counties discretion (though no stakeholders favoured this); (ii) maintaining HSSF as a national programme; and (iii) considering HSSF as a conditional or earmarked grant which counties could only access if they adhered to certain conditions. However, options for HSSF under devolution may be better thought of as a continuum of choices, within the three key spheres of allocation of decision space, accountability organizational structures and capacities. Political realities should also be considered including

the willingness of County Governors to adhere to conditions and the implications of the national resource allocation criteria for allocation of HSSF funds.

- **Performance Based Financing** – Stakeholders expressed very mixed views on the role of PBF in HSSF, with some feeling it was essential, while others expressed major concerns about potential unintended consequences.
- **Social Accountability** - The future of SAc in HSSF is also undecided, with plans currently on hold as broader HSSF and health system developments evolve. Whilst successes were acknowledged with the pilot, concerns were also raised about the necessity and scale-ability of the approach.
- **Incorporating Faith Based Organisations** - The programme has been exploring modalities for including FBOs under HSSF for some time, but consensus has not been reached on a way forward, partly reflecting differing views on whether PBF should be included for such facilities.
- **User fee removal** – Experience suggests the need to ensure there are resources allocated to facilities to compensate for loss of user fees in advance. All interviewees agreed that HSSF was potentially a good platform to channel those additional funds, though determining the level of compensation for facilities is likely to be complex

Conclusions

Overall, there appear to have been impressive achievements with HSSF in terms of ensuring that funds reach facilities, are spent appropriately, and are overseen and used in a way that strengthens community involvement (HMFCs). There are also indications that this has strengthened service delivery and quality of care. Although there is less experience in dispensaries than in health centres, national level interviews suggest that positive impacts have been particularly impressive in these smaller facilities. The introduction of a devolved health care system in Kenya over the next few months and years provides a huge opportunity for offering more responsive and accountable health services, but also presents some concerns and dilemmas for the design and implementation of HSSF in future. Our review and interviews highlight some areas that require particular attention, including some aspects of financial management (such as delays in receiving funds and AIEs, complexity of documentation for in-charges, and the importance of practical and facility-based support and supervision for in-charges and HFMCs), the design of HSSF under devolution, and if, when and how to incorporate PBF, additional social accountability mechanisms and FBOs. Also critical to consider is the potential impact of user fee removal on HSSF. Finally, it is recognized that HSSF alone will not be able to ensure high quality service delivery. Other crucial influences on facilities and HSSF include drug supplies, and availability of qualified clinical staff.

2. Background to HSSF

The Health Sector Services Fund (HSSF) is an innovative scheme established by the Government of Kenya (GOK) under the Ministry of Public Health and Sanitation (MOPHS) to disburse funds directly to health centres and dispensaries (level 2 and 3 health facilities) to enable them to improve health service delivery to local communities. HSSF empowers local communities to take charge of their health by actively involving them through the Health Facility Management Committees (HFMCs) in the identification of their health priorities and in planning and implementation of initiatives responsive to the identified priorities. Following a successful pilot of a similar mechanism in Coast Province, the strategy was scaled up nationwide, starting in 2010. The Government is complementing HSSF with other reforms required to improve service delivery for the rural poor, including reforms in human resources, procurement and drug distribution. Following the enactment of the 2010 constitution and the recent general election in Kenya (March 2013) dramatic changes to the organisation and functioning of government services, including the health system, are being considered and introduced. These changes will have important implications for the design, implementation and impact of HSSF. Key changes include the devolution of health service delivery in-line with other government functions from national level to 47 semi-autonomous counties, the merging of the two Ministries of Health (MoH) – MOPHS and the Ministry of Medical Services (MOMS), the proposed abolition of user fees at health centres and dispensaries and free maternal health services in all government health facilities. Given the experience of nearly 3 years of HSSF implementation, and the context of these important changes in the organisation of health service delivery, a review of experiences to date with HSSF and key issues to consider moving forward is timely.

2.1 Why HSSF?

Health centres and dispensaries are a major source of primary level care for poor groups in rural areas of Kenya [Maina, T., 2006]. However, a number of problems have been documented with their performance, including poor quality of care, inadequate and poorly maintained equipment and infrastructure, unreliable drug supplies, staff shortages, low staff motivation, and charging fees above official rates or to exempted groups [Kimalu et al., 2004; MOH and Aga Khan, 2005; NCPAD et al., 2004; Pearson, 2004]. Some of the causes of these problems could reflect inadequate access to resources at the facility level. Qualified staff, drugs and medical supplies and buildings for health centres and dispensaries are funded from central budgets, while facilities' other needs are catered for through the district health system. However, operational challenges for facilities in accessing funds through the district were widely noted prior to HSSF. For example, a high proportion of the funds intended for districts failed to reach them. The 2007 Public Expenditure Tracking Survey (PETS) indicated that only 67% of allocations as per Authorities to Incur Expenditure (AIE) were received at district level, and that the receipt of AIEs was often delayed [MOH, 2007]. Furthermore, problems were identified in accessing these funds by health centres and dispensaries, due to bureaucratic and liquidity problems at the District Treasury, compounded by dispensaries and health centres not recognised by law as accounting units, and hence officially able to receive support in kind only. Moreover, the majority of Government funds were spent at the district level, leaving the peripheral facilities with very limited resources.

In the past therefore, facilities relied heavily on 'cost-sharing' revenues from user fees. Resource related problems at the facility level were particularly acute after the introduction of the "10/20 policy" in 2004 which decreed that health care would be free at dispensary and health centre level with the exception of a registration fee of KSH 10 (USD 0.12) and KSH 20 (USD 0.24) respectively. These registration charges were for outpatients over 5 years only; under 5s, patients with specific conditions such as malaria, TB, HIV/AIDS and other sexually transmitted infections, and those

seeking maternal and child health or delivery services were to be treated free. Prior to the 10/20 policy, charges were higher and variable, with separate fees for drugs, injections, consultation and laboratory services. The only other funds available to health centres and dispensaries were from donations or income generating activities such as sale of patient health cards or harvested rain water.

Early implementation of the 10/20 policy was found to lead to immediate and sharp increases in utilisation and a reduction and simplification of charging levels [MOH, 2007]. These patterns were not always sustained however, with a more mixed overall impact over a year. Subsequently adherence to 10/20 was reported to be poor, with higher fees being charged in many facilities [Chuma, J., et al., 2009]. Moreover, there were concerns that where 10/20 was implemented, it had reduced facility level funds and therefore ability to be responsive to local problems [MOH, 2007; Chuma, J., et al., 2009]. In addition, facility-level resource constraints and a lack of clarity around the user fee levels appeared to be undermining relationships with communities [Molyneux, C., et al., 2007].

In 2003, similar challenges emerged in the education sector, following the introduction of free primary education. In response, direct grants were provided to each primary school to support learning materials and operations and maintenance. A similar mechanism was therefore proposed for health facilities in Kenya involving transferring funds directly from central level to facility bank accounts, to be managed by HFMCs. This HSSF mechanism was piloted by the Kenyan Government throughout Coast Province from 2005, with support from the Danish International Development Agency (DANIDA). An evaluation in 2007/8 revealed that the pilot was in general being implemented well [Opwora, A., et al.]. The HFMCs were active and met regularly, funds were being transferred and used appropriately, and accounting procedures were followed. The perceived impact according to health workers, HFMC members and managers was extremely positive, for example facilitating outreach, Health Management Information System (HMIS) reporting, referral, communication with the District Health Management Team (DHMT), facility renovation, and employment of subordinate staff to assist health workers. However, key challenges noted were inadequate training and documentation on HSSF, lack of awareness of HSSF among the broader community, and continued charging of user fees above the official regulations. Building on this experience, MOPHS decided that the HSSF mechanism should be scaled up nationwide in public sector health centres and dispensaries.

2.2 What is HSSF? How does it work?

HSSF is a fund established by the GOK for supporting a sector-wide approach to which development partners and other donors can contribute resources. The overall goal of the fund is to generate sufficient resources for providing adequate curative, preventive and promotive services at levels 1, 2, and 3 of the health sector pyramid (community, dispensary and health centre), and to account for the resources in an efficient and transparent manner according to current GOK systems. The HSSF was initially gazetted in 2007. DANIDA and the World Bank are currently partnering with the MOPHS in supporting the HSSF's phased implementation which began in October 2010 with public health centres, and public dispensaries in July 2012.

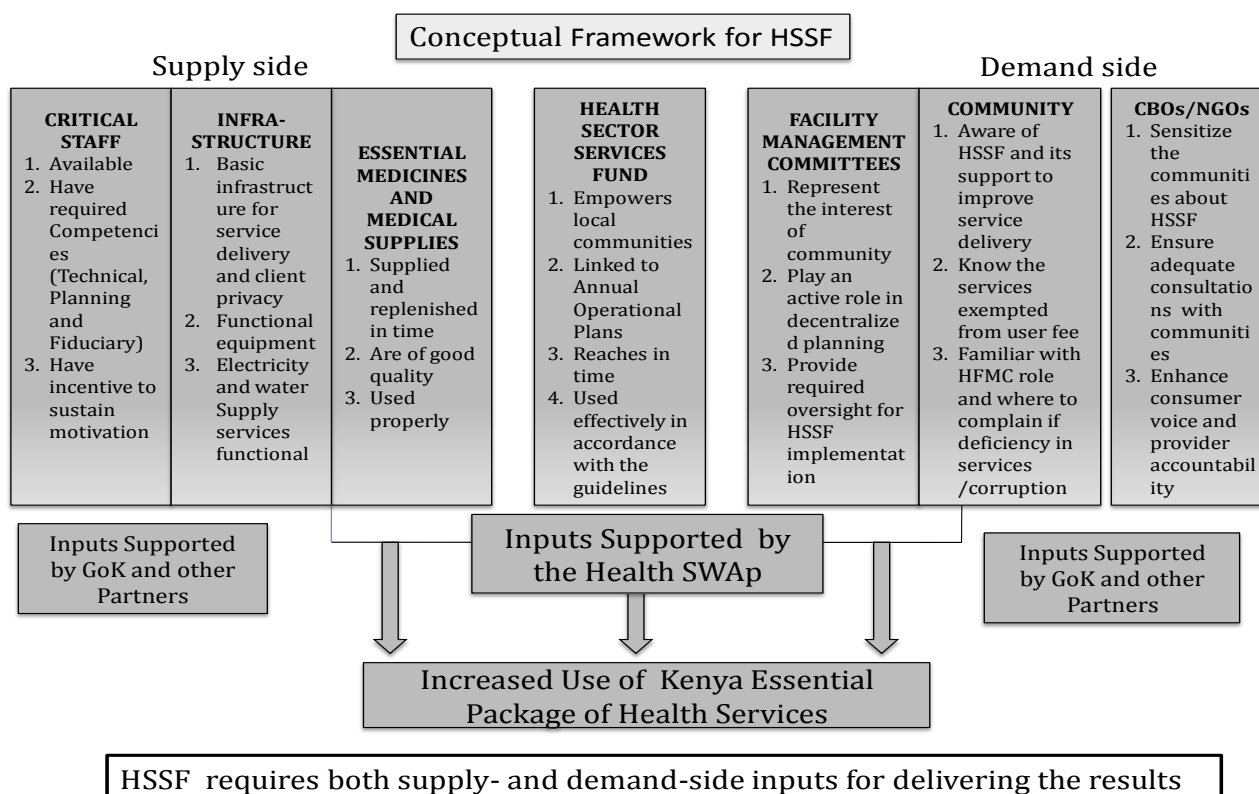
The specific objectives of HSSF, as stated in the MoPHS *Legal Notice No. 79 of 5th June, 2009*, are to:

1. Support and empower rural communities to take charge of improving their own health;
2. Support capacity building in management of health facilities in the country;
3. Provide financial resources for medical supplies, rehabilitation and equipment of health facilities in the country;

4. Provide grants for strengthening of the faith-based health facilities through their respective secretariats and;
5. Improve the quality of services delivery at the health facilities.

It is recognised that HSSF alone will not be able to improve service delivery, but that it forms an important pillar among a set of key interventions (Figure 1) [World Bank, 2013].

Figure 1: Conceptual framework for HSSF



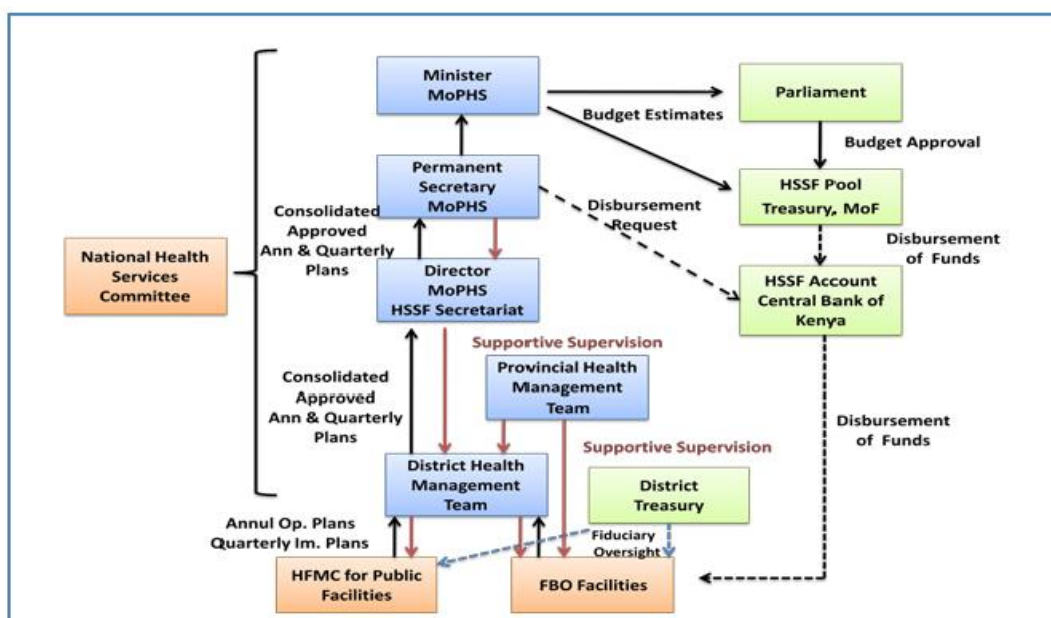
Source: [World Bank, 2013, pg10]

The funds provided from the national level include the resources allocated by GOK and the development partners supporting HSSF. The gazette notice provided a temporary administrative recognition of dispensaries and health centres as accounting units to allow them to access direct funding. HSSF resources are credited directly to each designated facility's bank account every quarter (figure 2): KSH 112,500 (1,339 USD) for health centres, KSH 27,500 (327 USD) for dispensaries and KSH 131,500 (1,565 USD) for DHMTs. Other funds available to the facility, such as user fee revenue, and grants and donations received locally, should be banked in the same account, and managed and accounted for together with HSSF funds from national level. All funds should be managed by the HFMC according to the financial guidelines approved by MOPHS. The composition, roles and responsibilities of the HFMC are defined in the Gazette Notice Supplement No. 25, of June 5th 2009. Every facility should have a 7 to 9 member committee which has full responsibility for preparing and implementing the facility's Annual Operational Plan (AOP) (also known as the Annual Work Plan (AWP)) and Quarterly Implementation Plans (QIP), including their budgets. The HFMC should also oversee implementation, supervision and control of all resources raised, received, and managed by the facility in charge, who is the ex-officio secretary to the committee. The aim is that community representation is assured by the appointment of at least 5 people who are residents of the facility catchment area (ordinary community committee members), of whom 3 should be

women, in addition to 4 ex-officio members (provincial administration representative, health facility in-charge, District Medical Officer of Health (DMOH) representative, and local authority facilities' representative) [MoPHS, 2009].

The planning process at the facility level is supposed to be supported by a facility stakeholder's forum organised by the facility in charge, consisting of the HFMC, development partners supporting the health sector in the locality, representatives of the constituency development fund, the divisional water officer, the agricultural extension officer and the head teachers of the primary school [World Bank, 2013]. This forum should review the performance of the facility during the previous year, discuss the implementation challenges and how the facility tackled them, and the government's identified priorities in the sector, and list the key issues to be addressed by the facility during the next financial year. These key issues guide the AWP prepared by the facility in charge together with the HFMC. After the AWP has been approved by the DHMT, the HFMC prepares the QIP, which describes specific activities to be implemented during each quarter. The QIPs are approved by the HFMC and submitted to the DHMT.

Figure 2: Funding and disbursement pathways for HSSF



Source: [World Bank, 2013, pg7]

HSSF can cover items such as facility operations and maintenance, refurbishment, support staff, allowances, communications, utilities, non-drug supplies, fuel and community based activities. The DHMT is responsible for assisting facilities in preparing facility plans and budgets as well as supervising and monitoring use of grants. All facilities should be visited by the DHMT at least once per quarter. All facilities should submit Monthly Expenditure Returns, Monthly Financial Reports and Quarterly Financial Reports using standard formats to the DHMT within the prescribed deadline for review and consolidation. Worth noting is that these returns and reports are only some of the many documents that the Operational Guide to the Management of HSSF for health facilities, specifies that facilities require for the management of HSSF funds (figure 3). To offer additional accounting support services to facilities, county based accountants (CBAs) were hired and distributed across the country. Their role was to provide “hand-holding” to facility and DHMT staff in financial management activities, and to provide a link between the accounting units and the HSSF

secretariat for submission of financial reports. There are currently around 100 CBAs employed i.e. around 2 per county. Health facilities can also use HSSF funds to contract accounts clerks.

Following the receipt of facility reports, the DHMT submits the consolidated monthly financial report, which includes reports from both the facilities and the DHMT to the MOPHS head of accounting unit through the HSSF secretariat. The HSSF secretariat, in turn, produces a summarized and consolidated HSSF-wide financial report, which it uses to prepare its interim financial reports and annual accounts. Copies of these reports are submitted to the Health SWAp for monitoring purposes (figure 4). The facilities requisition funds on a quarterly basis; however, the first two quarters for a new facility participating in the programme are released in one instalment, and releases for the third and fourth quarters are released only after the facilities prepare and share their quarterly financial reports. After the reports have been approved the money for the next quarter is transferred to the facility's bank account (figure 2).

Figure 3: List of documents required at the facility level for the management of HSSF funds

Guidelines and Reference Documents	Forms / Vouchers
<ul style="list-style-type: none"> • Managing the HSSF – An Operations Guide • Guidelines on Financial Management for HSSF • Chart of Accounts 	<ul style="list-style-type: none"> • Receipt Vouchers (F017) • Payment Vouchers (F021) • Travel Imprest Form (F022) • Local Purchase Orders (LPO) • Local Service Orders (LSO) • Request for Quotations (RFQ) • Stock Cards for all items in stores • Imprest Warrants • Bank Reconciliation forms (F030) • Counter Requisition and Issue Vouchers (S11) • Counter Receipt Vouchers (S13) • Handover Forms • Monthly Service Delivery Report Forms (MOH105) • Monthly Financial Report forms (MFR) • Monthly Expenditure Report forms (MER) • Quarterly Financial Report forms (QFR)
<p>Registers / Books to be completed</p> <ul style="list-style-type: none"> • Memorandum Vote Book (MVB) • Receipt Book • Facility Service Register (FSR) • Cash Book • Cheque Book Register • Fixed Assets Register • Imprest Register • Consumables Stock Register • Store Register • Counter Receipt Book Register 	
<p>Other items</p> <ul style="list-style-type: none"> • Cheque book 	

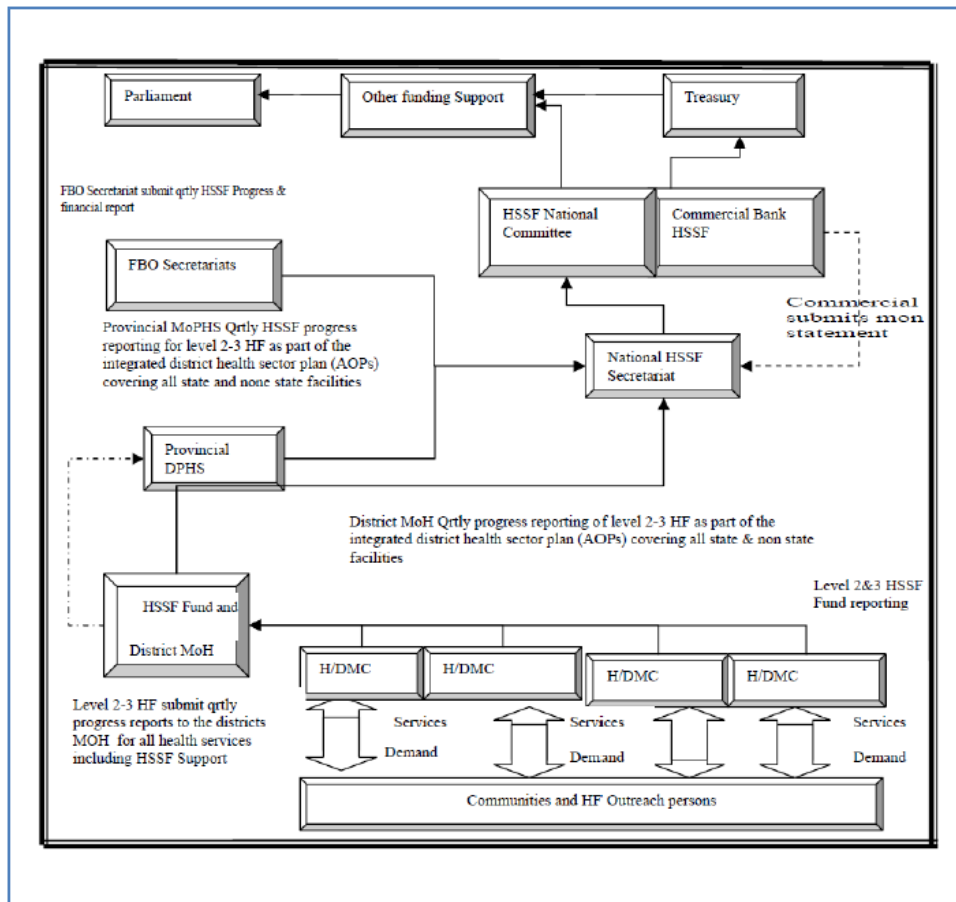
Source: Operational Guide to the Management of HSSF for Health Facilities

At the district level the DHMT should check how facilities are banking user fees, functioning of the HFMC (minutes), AWP and QIPs, budgeting, facility income and expenditure processes, records and reports. At the national level, the oversight for HSSF is provided by a seven-member National Health Sector Committee that includes representatives of civil society, the private sector, and the Permanent Secretaries of Public Health and Finance. The Director of Public Health Services functions as the Secretary for the National Health Sector Committee. Prior to devolution, the eight Provincial Health Teams were to provide strategic oversight for the fund in their respective jurisdictions, including capacity building for fund management and reporting. With the proposed devolution in the health sector guided by Kenya's new constitution, the counties are expected to take over this function and play a more proactive role [World Bank, 2013].

A communication strategy was launched in April 2011 led by APEX communications group who made and distributed posters about HSSF to health facilities. They also ran infomercials on radio and

television stations at least once per quarter, and the HSSF secretariat published a quarterly newsletter “afya ya jamii”. The HSSF secretariat also published disbursement schedules in the national newspapers and on the MOPHS and HSSF secretariat website.

Figure 4: HSSF reporting process



Source: [World Bank, 2013, pg8]

2.3 A transforming context: key health sector reforms in Kenya

In Kenya, there have been a series of major health sector reforms over the last three decades based on the principles of decentralisation, community participation and intersectoral collaboration. Important changes in the last five years were the creation in 2008 of two Ministries of Health (MoH) - MOPHS and MOMS - as part of the National Accord and Reconciliation Act following the post election violence. This vertical split of the MoH significantly complicated the coordination, management and functions of district level health systems, with MOMS in charge of national, provincial and district hospitals and MOPHS in charge of the community, dispensary and health centre levels.

In 2010, a new constitution was passed through a nationwide public referendum, which is being implemented following the election of a new government in March 2013. The new constitution includes the devolution of government functions from national level to semi-autonomous counties countrywide; managed by elected county leaders. Counties have the authority to set priorities, allocate resources received from the national level, levy local-level taxes and undertake other forms of local resource mobilization to strengthen service provision. This initiative is expected to significantly change government operations across all sectors, including health, in ways that are still being discussed nationally. The new constitution also created a maximum number of ministries for the country, and therefore the coordination of health services has reverted back to one Ministry of Health [Government of Kenya, 2010]. The incoming government has also pledged to abolish the

current 10/20 user fee policy making services free in health centres and dispensaries, and to introduce free maternity care throughout the health system, although if, when and how this will happen remains unclear.

These health governance and finance changes have important implications for the design, implementation and impact of HSSF. A review of implementation experience to date should assist in future planning for HSSF, including identification of key issues arising as a result of these reforms.

2.4 Terms of Reference for Review of HSSF Implementation and Experience

The DANIDA Kenya office is undertaking a Sector Review in May 2013, where future support for HSSF will be considered. DANIDA commissioned the KEMRI-Wellcome Trust Research Programme to review the process of HSSF rollout and experiences with HSSF implementation to date, in order to assist with planning for future support to HSSF and the health sector more generally (the Terms of Reference is provided in Appendix A) . The specific objectives are to:

1. To describe the process of HSSF implementation to date, including facilities covered, funds disbursed, and activities undertaken.
2. To review evidence on the experience with HSSF implementation
3. To identify key issues including devolution for consideration in future planning around HSSF

These objectives have been addressed through the following approaches:

A - Document review of policy documents, administrative reports, and studies related to HSSF. Those identified were as follows (see Appendix B for table summarising each document):

- Bellows, B., Child, M., Mutai, R., Odoyo, E, Obare, F. 2012. Performance Based Financing (PBF) Pilot in Samburu County, Kenya: Verification Report for October 2011 – June 2012. Ministry of Public Health and Sanitation [Kenya] and the Population Council, Nairobi.
- Independent Integrated Fiduciary Review Agent (IFFRA) Reports of Implementing Agencies, including the Annual report for the period ended 30th June (Report date Jan 2012), and for the quarter that ended September 2012 (Report date Feb 2012).
- Family Care International, 2012. Direct Facility Funding and quality of care: Assessing perceptions and building evidence for advocacy. Citizen Report Card Report, Family Care International, October 2012.
- KEMRI-Wellcome Trust Research Programme, 2013. HSSF Process Tracking in Health Centres: a qualitative study of implementation and perceived impact by mid 2012. March, 2013.
- MOPHS, 2011. Aide – Memoire. Joint DANIDA and World Bank Implementation Support Mission to Kenya Health Sector Support Programme between December 1-9 2011, Kenya.
- MOPHS 2012. Piloting Integration of Social Accountability Approaches in the Health Sector Services Fund (HSSF) - Brief of Visits to Eight (8) Pilot Sites between September and December 2012.
- MOPHS 2013. Aide – Memoire; Joint DANIDA and World Bank Implementation Support Mission to Kenya Health Sector Support Programme between 12-20 February 2012, Kenya.
- MOPHS 2013; Integration of Health Sector Services Fund (HSSF) Financial Management Information System into the Government of Kenya Country Systems, March 2013.
- World Bank, 2013. Improving Universal Primary Health Care by Kenya; a case study of the Health Sector Services Fund; Universal Health Coverage Studies Series (UNICO) series No. 5 January, Washington DC.

B – Holding interviews with key stakeholders in MOPHS, DANIDA and the World Bank, to obtain updates on HSSF implementation and experience. We supplemented the 8 national key informant

interviews we conducted in 2012 as part of the KEMRI study listed under A, with an additional 5 interviews in May 2013.

In this report we draw on all of the above documents and interviews to present findings on the process of HSSF implementation to date, followed by experiences of that implementation at facility, district and national level, and to identify key issues for consideration moving forward.

3. The process of HSSF implementation

3.1 What has been dispersed and to whom

A total of KSH 1,918,707,702 of HSSF funds have been received since the programme began, with the largest contributors being DANIDA (44%), World Bank (42%) and GOK (14%) (table 1). In 2012/13 HSSF disbursements represented 0.9% of the total "on-budget" funding for the Kenyan health sector budget of KSH 85 billion (substantial additional resources are available "off-budget" from NGOs and certain donors) (Health Sector Working Group Report, October 2012).

Table 1: Total HSSF funds received by source as of January 2013

Source of funds	KSH	USD	%
GOK	264,502,150	3,148,835	14
DANIDA	835,000,000	9,940,476	44
World Bank	796,682,863	9,484,319	42
UNICEF	5,000,000	59,523	<1
Others Returned Funds	16,534,494	196,839	1
Salary Recovery	988,195	11,764	<1
Total KSH	1,918,707,702	22,841,758	100

Source: data from the HSSF secretariat May 2013

Roll out of funds was initially to government health centres (from 2010/11), and subsequently to government dispensaries (from 2012). The number of DHMTs, health centres and dispensaries receiving disbursements by January 2013 were 262, 751 and 2349 respectively (table 2).

Table 2: Total number of DHMTs and facilities receiving HSSF disbursements: Oct 2010 – Jan 2013

Fin Year	Period of disbursement	DHMTs	Health Centres	Dispensaries
2010/11	1st Disbursement Oct/Nov 2010	232	589	
	2nd Disbursement March 2011	265	589	
	3rd Disbursement June 2011	265	653	
2011/12	1st Disbursement 2011-12	263	673	482
	2nd Disbursement 2011-12	266	706	2092
	3rd Disbursement 2011-12	267	718	2291
	4th Disbursement 2011-12	241	720	2296
2012/13	1st Disbursement 2012-13	268	765	2330
	2nd Disbursement 2012-13	268	770	2384
	3rd Disbursement 2012-13	262	751	2349

Source: data from the HSSF secretariat May 2013

The highest proportion of funds to date have been dispersed to health centres (52%), followed by dispensaries (22%) and DHMTs (21%) (table 3).

Table 3: Summary of HSSF funds disbursed by recipient: Oct 2010 to Jan 2013

Summary of disbursements	KSH	USD	%
HSSF Secretariat + NHSC	66,481,869	791,451	4
DHMTs	378,576,000	4,506,857	21
Health Centres	929,506,500	11,065,554	52
Dispensaries	403,677,500	4,805,685	22
UNICEF	5,000,000	59,524	<1
PBF	1,862,819	22,176	<1
Social Accountability	1,179,810	14,045	<1
Replacement of cheques	11,868,200	141,288	1
Grand total	1,798,152,698	21,406,580	100

Source: data from the HSSF secretariat May 2013

Prior to introduction of HSSF in 2010, the HSSF secretariat, with the support of Price Waterhouse Coopers, facilitated a 5 day training course for PHMTs/DHMT, who in turn organised 4-5 day training workshops in their respective districts for facility in-charges and 2-3 HFMC members per facility (usually the HFMC chair and treasurer). Training included the use of Electronic Tax Register (ETR) machines which were introduced in health centres early 2011 to keep track of user fees. County Based accountants were also trained first on government accounting procedures, and then in a separate training course on Navision software (used to prepare facility income and expenditure reports under HSSF). Two manuals were supplied on HSSF: the Financial Management of HSSF funds for the DHMTs, and the Operational Guide to the Management of HSSF for Health Facilities. These have been updated once since their introduction.

Several initial aspects of HSSF that were envisioned have not yet been implemented [World Bank, 2013]:

- The approved scope for HSSF includes public primary health facilities and facilities operated by faith-based organizations (FBOs). The programme has only been expanded to date to government primary health facilities. Building on the implementation experiences so far, the programme is now reportedly exploring specific modalities for contracting faith-based organizations, including the option of using performance-based financing.
- The HSSF design envisaged equity-based resource allocation criteria to provide additional funding to facilities in areas where poverty levels are high, population density low, and costs of providing services relatively high. Although approved in parliament, the equity-based resource allocation has not yet been made operational so to date there has been a fixed disbursement to all health centres of KSH 112,500 (1339 USD) per quarter and to all dispensaries of KSH 27,500 (327 USD) per quarter.

In addition to the basic HSSF package, there has been interest in including the option of using performance-based financing, and in strengthening social accountability elements of HSSF in moving forwards. Two pilot projects have therefore been implemented:

- A Performance Based Financing (PBF) pilot. PBF involves payment to facilities and/ or individual health workers based on the achievement of certain pre-defined targets. Design of a PBF programme involves consideration of a range of issues, including who receives payments, the magnitude of the incentives, the targets and how they are measured, the amount of additional funding offered, other ancillary components such as technical support, and contextual factors, including the organisational context in which it is implemented [Witter, S., et al., 2012]. A PBF mechanism has been added into the design of HSSF in Samburu since October 2011.
- A Social Accountability pilot. Social accountability (SAc) is an approach in governance aimed at building accountability among public officials through engagement. It encompasses interventions aimed at informing citizens both individually and collectively about their rights, the services and benefits they are entitled to receive, the performance standards they should expect, and the grievance redress channels they can use when things go wrong [Family Care International, 2012]. Between November 2011 and February 2013 a social accountability pilot has been conducted in nine locations reflecting different socio-economic settings in Kenya.

3.2 Experiences of HSSF implementation

This section reviews HSSF implementation, covering training and manuals, and experience with implementation at facility, district and national levels. We draw mainly on the most recent quarterly and annual IFFRA reports, and on the KEMRI HSSF interim tracking study and the FCI report, both of which have relatively detailed information on experience in health centres. We incorporate

additional information where available from the other documents reviewed, and from national level interviews conducted in May 2013. Although most of our data are from health centres as the studies were conducted at a time when HSSF funding was very new in dispensaries, we have incorporated where possible impressions on experiences with dispensaries obtained through recent interviews.

3.2.1 Training and manuals

By 2013, it was reported in the 2013 Aide Memoire that nearly 9,000 HFMC members and health staff had received training in management of HSSF. In both the KEMRI and FCI studies, interviewees repeatedly highlighted the importance of initial formal training in HSSF for DHMT and HFMC members. Although the trainings held were generally greatly appreciated, a range of concerns were raised, including inadequate coverage of key people, length and depth of training, and absence of refresher courses.

Regarding coverage of key people, 7/10 health centre in-charges had received formal HSSF training [KEMRI, 2013], and in the FCI report, although all HFMCs reported at least two trained persons, the majority of committee members had no training. The length and depth of training sessions were reportedly too short (or 'sketchy') to cover all of the required accounting procedures. More practical training using real financial documents or at health facilities was recommended by many [KEMRI, 2013]:

You know it's 1 week and we are not accountants so I think everything was rushed (KEMRI Study, In Charge).

[At the DHMT level] you are actually doing an accountant's work and you've never trained for it . . . there are so many challenges with using the government's accounting system....you can be taught for 3 days or for 5 days and you think you get it, [but] you keep on forgetting how this thing was supposed to be filled, [and] what were you supposed to fill when. . . ok those are the challenges (KEMRI Study, DHMT member).

The importance of refresher courses and of continued mentoring in facilities was highlighted in both the KEMRI and FCI reports. As one FCI study participant noted:

The first training was meant to build our capacity to roll [HSSF] out... we rolled it out... [Now] I think we need a follow up training to build us up more to streamline [handling] the challenges (FCI study, DHMT member; p33).

As discussed more below, this mentoring and support was in practice often being given by CBAs to in-charges, but it was noted by several CBAs in the KEMRI study that it is not entirely clear who is formally responsible for conducting and funding the day to day training and support for in-charges.

In recent interviews (May 2013) it was explained that a new single manual for HSSF is being developed but this cannot be finalized until there is greater clarity on the next steps for HSSF under devolution (discussed more below). Also noted was that training for new staff and HFMC members should be run by DHMTs, who can draw on a national budget for this (KSH 12 million for 2013). These funds are reportedly not being drawn upon, however, possibly due to a lack of awareness among DHMTs of their existence. One national interviewee commented that formal training in a central place can be over-rated; they argued that there is a high risk of fraud in training organization, and therefore the less formal training and the more on-the-job facility based supervision, the better.

3.2.2 Facility level experience

3.2.2.1 Access to, financial planning and management of HSSF funds

AWPs, QIPs, and AIEs

All facilities audited in the quarter ending September 2012 had opened and were operating bank accounts specifically for HSSF programme funds [IIFRA, 2012]. However, only 46% of facilities had received the HSSF funds for the quarter in good time. Over the same period, the majority of the health facilities (89%) had received the AIEs on time. The proportion with delayed receipt of funds in the previous year were 67% (Q1), 91% (Q2), 78% (Q3) and 51% (Q4), and corresponding figures for delayed AIEs were 78% (Q2) 81% (Q3) and 74% (Q4). In the quarter ending September 2012, most audited facilities (62%) had AWPs in place; an increase on the previous quarter from 59%. However some did not have copies of the AWPs and were therefore 'implementing the program without any plans, targets and indicators' (pxii; vii).

In the KEMRI and FCI studies, there were overwhelmingly positive responses overall about having received HSSF funds in facility bank accounts, with funds having a strongly positive impact on facilities as described in more detail below. In the KEMRI study, interviewees also mentioned an important spill over effect of HSSF banking and reporting requirements for user fees. User fees collected were now all being better recorded through the introduction of new ETR machines, and all funds were now being banked, budgeted, spent and reported on, together with HSSF funds. This differed significantly with the previous approach of user fees being managed within facilities as petty cash. Several facilities which were located far from a bank were allowed by the DHMT to keep a fraction of their user fee money in facilities for emergency purposes. In general this spill over effect to user fees was felt to have improved overall reporting and accountability, including to HFMCs by in-charges. It is an effect also noted in the 2013 World Bank report.

Concerns raised about access to HSSF and user fee funds in both the KEMRI and FCI studies included delays in receiving funds and especially AIEs, AIEs not reflecting QIPs, and use of money allocated to items non-essential to the facility. *Regarding delays*, these were attributed by KEMRI interviewees to: 'haphazard' annual working plans by facilities; all facilities having to wait for others in the district before QIPs or monthly reports were forwarded to the national level by DHMTs; and there being only three people at national level to sign and approve a central level AIE. In both studies, these delays were considered a major concern, not least because they had the potential to undermine one of the key goals of HSSF: to reduce the complexity and delays in access to funds for facilities.

...HSSF is supposed to solve this aspect but has made it worse. Facilities are told to collect money for three months and not to spend. QIPs are sent to Nairobi and they take a month to receive an AIE, then another month to be funded... (FCI Study, DHMT member, p35).

Regarding *AIEs not always reflecting QIPs*, the concern was that items and amounts were sometimes specified centrally rather than based on QIPs. While some in-charges in the KEMRI study felt that this approach helped reduce fraud, ensure expenses were balanced, and ease in-charge negotiations with HFMCs, others were concerned that this undermined HFMCs' efforts to involve community members in making a locally tailored QIP.

There is a straight jacket on HSSF because they had given us sort of an AIE ...it has to be utilized on the item which is indicated ... even if there is a shortage you can't supply or you can't provide the service out of that context (KEMRI Study, HFMC member).

Madam Treasurer's problem is complex because we draw our budget on what we want to spend on but Nairobi tells you not to spend. So I think we should be given that...authority... we spend as we have budgeted. Because we do a budget and take it to Nairobi but when it comes back they have changed it... (FCI study; HFMC member, p30)

Some in charges interviewed by KEMRI were unclear on *how line items non-essential to the facility could be used* (for example electricity for a facility without, or fuel for a facility with no vehicle). Several reported working closely with the CBA to allocate funds to the right codes or vote-heads. In two districts, facilities were allocating fuel money to the DHMT to fuel and maintain a district ambulance; a strategy designed by the DHMT to overcome their perceived underfunding. A related concern, discussed more below, was CBA reports that delays in funds or AIEs, and concerns about how these funds could be spent, were leading to the accumulation of unspent funds in bank accounts.

In July 2012, in an effort to address late arrivals of AIEs in facilities blocking both HSSF and user spending, there was a change in planning procedures from relying on QIPs for quarterly AIEs to relying to AWP for annual AIEs. Supplementary AIEs can still be issued mid-year for instance in response to donations, and funds are still disbursed quarterly. This was felt to be an important development to prevent 'everything coming to a standstill' with late AIEs, as had been the case in the past, but it is too early to comment on how well this has worked.

Financial reporting and documentation

In the IIFRA report for the quarter ending September 2012 most audited facilities (79%) had not prepared the Monthly Financial Reports (MFRs) and the Quarterly Financial Reports (QFRs) for the quarter ended 30th September 2012. 46% had maintained Vote Books, 32% had prepared bank reconciliation statements, and 1% had analysed and compared actual performance with the AWPs. Most facilities (61%) had maintained their cash books properly. On the basis of selected key performance indicators, 22% of facilities were rated "Green", 62% "Amber" and 16% "Red"¹. This suggests that the majority of the audited health facilities had weaknesses especially in preparation of monthly bank reconciliation statements, vote book maintenance, preparation of monthly and quarterly financial reports and availability of the AWPs. Of interest is that the proportion coded green increased in each quarter of the year up to June 2012 (2%; 3%; 14%; 21%). This general improvement of accountability over time was noted by the World Bank [World Bank, 2013].

Many IIFRA reports, including the most recent, raise concerns about a lack of adequate segregation of compatible duties, as the in-charges were directly involved in the whole transaction cycle from ordering of goods and services to approval and even accounting. This opens up the potential for misuse of funds. There are therefore frequent and strong recommendations in IIFRAs as follows:

HFMCs should identify suitable staff to assign accounting duties or hire Accounts Clerks to be maintaining the books of account, thereby ensuring some acceptable level of segregation of compatible duties. In addition, the HFMCs should authorize and provide the necessary oversight over all transactions of the health facilities (2012; pxi;i).

In recent interviews it was noted that in-charges are spending an estimated 20% of their time on accounts. KEMRI and FCI interviewees reported that completion of required reports took significant amounts of in-charges' time, and that balancing the time requirements for accounting, documentation and patient care was extremely difficult.

Heh.... That [paperwork] is one of the most challenging things in HSSF; one thing I cannot say I'm 100% sure how they are supposed to be done. But I believe somehow I'm trying... and I have signed a performance contract with the government, so I'm [still] supposed to see

¹ Green represents satisfactory performance and indicates that the health facility can improve through self-assessment. Amber represents average performance and indicates that the facility requires some capacity building help in order to improve; and red represents poor performance and indicates that the facility requires urgent hand-holding interventions in order to improve.

maybe per day still 30 clients you see. Now balancing the two it's a challenge (KEMRI study, In Charge).

...the staff there has no knowledge on finance management, [and] you will realize that a staff member in the facility is almost always occupied with issues of HSSF. Trying to do the required documentation, he/she is hardly available for clinical work... (FCI study, DHMT member; p35).

CBA's observed that there were better records and control of financial aspects of facility management in facilities with accounting clerks, and advocated for accounting clerks to be employed in every facility to help with the financial reporting and documentation. Although nearly all (9/10) health centres visited by KEMRI had hired an accounts clerk, this did not always solve the challenges however. CBA's still had to offer in-charges and accounts clerks significant support; in some cases having to correct the books after the money had been spent. CBA's and in-charges mentioned that flexible AIEs at least until the end of the year would ensure that the money that was available was spent, and spent on what was most needed locally.

In both the KEMRI and FCI studies, it was clear the numerous documents required in the guidelines were often not available in facilities (see Table 4 for FCI data). In recent interviews (May 2013), it was noted that a workshop had been held in 2012 aimed at simplifying forms, but efforts have been constrained by government accounting requirements. Meanwhile, it was seen as important for facilities to continue focusing on key documents, because in-charges are still spending a high proportion of their time on accounts - a particularly important problem for dispensaries given limited staff.

In-charges in the KEMRI study reported coping with the difficulty of obtaining government documents through improvising with a standard black exercise book. They also sought advice from CBA's on the most important documents to fill, which were said to include payment vouchers, cashbooks, receipt books (combining ETR totals), QIPs and monthly financial reports.

In the 2013 World Bank report, poor record keeping was attributed to a heavy workload for in-charges, capacity constraints and inadequate support from accountants. A new reporting schedule was introduced in July to increase the amount of time to produce and submit reports; an increase from a total of 15 days (5 each at facility, district and national level), to a total of one month, two weeks, and one week respectively). However interviews in May 2013 suggested that still only a third of reports are received on time, given the large number of spending units (approximately 3500), the time taken to get bank statements, and the few accountants available to assist. The 2013 Aide Memoire highlighted the challenge of frequent breakdown of cash registers in one district, but also noted that prompt actions were being taken by the SWAp secretariat to address identified weaknesses, especially on specific instances of inappropriate use of HSSF.

Regarding procurement specifically, in the IIFRA for the quarter ending September 2012 it was noted that 58% of health facilities reviewed carried out their procurement per the HSSF guidelines (pxii;v). In the KEMRI study, only 2/10 health centres had a procurement sub-committee, and only one of these was described as functional. In most facilities (8/10), the executive committee – typically the office holders of the HFMC – instead played the role of procurement committee. A list of pre-qualified suppliers was made available within every district, but there was an appeal by facilities to be allowed to tender locally as many pre-qualified suppliers were far away and therefore their use was expensive and inconvenient. This concern was also raised in the FCI study.

Table 4: Proportion of health facilities with copies of the HSSF financial management documents

Document	KITUI	NAKURU
	N=15 n (%)	N=15 n (%)
1. Copy of gazette members notice or legal notice relevant to HFMC/HSSF	3 (20)	5 (33)
2. HSSF guidelines (2010)	13 (87)	12 (80)
3. Minutes of all the HFMC meetings	15 (100)	15 (100)
4. Annual operational plan (AOP)	14 (93)	13 (87)
5. Quarterly activity implementation plan and budget (QIP)	15 (100)	15 (100)
6. Quarterly financial report	7 (47)	12 (80)
7. Monthly expenditure return	7 (47)	15 (100)
8. Quotation form (S10)	8 (53)	5 (33)
9. Official receipt / Cash register	12 (80)	15 (100)
10. Receipt voucher (F017)	13 (87)	11 (73)
11. Payment voucher (F021)	14 (93)	15 (100)
12. Cash book	14 (93)	15 (100)
13. Imprest warrant	15 (100)	8 (53)
14. Imprest register	11 (75)	5 (33)
15. Local purchase order (LPO)	15 (100)	14 (93)
16. Local service order (LSO)	15 (100)	9 (60)
17. Counter receipt voucher (S13)	15 (100)	13 (87)
18. Counter requisition and issue voucher (S11)	14 (93)	13 (87)
19. Counterfoil receipt book register (CRB)	8 (53)	5 (33)
20. Memorandum vote book	15 (100)	14 (93)
21. Service delivery reporting tool (MOH 105)	14 (93)	12 (80)
22. Bank reconciliation	10 (67)	11 (73)
23. Stock control card / bin card (S3)	15 (100)	15 (100)
24. Annual facility stock taking report	1 (7)	6 (40)
25. Fixed asset register (Inventory)	15 (100)	15 (100)
26. Cheque book	15 (100)	14 (93)
27. Cheque register	3 (20)	11 (73)
28. AIE file	14 (93)	15 (100)
29. Bank statements file	15 (100)	15 (100)

Source: FCI report, pg 38

3.2.2.2 HFMC functioning, involvement and relations

The IIFRA report for the quarter ending September 2012 found that all health facilities visited had a properly constituted HFMC in line with the Kenya Gazette supplement No. 123 Legal Notice No. 401 and the amendments in the Legal Notice No. 79 of 5th June 2009. Most (92%) HFMCs met at least once during the quarter and discussed the operations and activities of the respective facilities (pxii; vi).

All the health centres included in the KEMRI and FCI studies had active committees, with most committees re-constituted within the last three years and according to guidelines. In addition to all committees meeting at least every quarter, most facilities visited by KEMRI also reported monthly meetings for executive committee members. In both studies, HFMCs were reportedly committed to

their duties, which they primarily described as linking the community to the health centre. In the FCI report it was noted that other than the Secretaries and Chairmen (bank signatories), members were not well engaged in the running of committees' affairs, with most members unable to remember for example how much money the committee received even though they do attend QIP meetings (p 28).

Aaaa----I think Ksh 23,000... [Laughter] (FCI study, HFMC Treasurer)...

I think she has forgotten, [Laughter]... it's important for members to learn, the GOK gives us Kshs 112,500 per quarter then we add our user fee and any other donor money like OBA (FCI study, HFMC Chair).

In both studies there was a reported need for more training in the modalities of HSSF and HFMC members' roles in HSSF, with KEMRI interviewees highlighting some confusion and resulting tension in relationships with in-charges:

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...this is in terms of financial management they act like auditors but not overseers of the implementation, ... that has been a big problem because now it brings a bad line between the facility in-charge and the committee (KEMRI Study, DHMT member).

A related concern raised by several CBAs was a hesitation among HFMC members to sign or check expenditures:

When you call the committee particularly the signatories to come on board to sign a cheque... some of them just ignore you or maybe we can say they sabotage the process. [They say they will not sign] unless they are paid (KEMRI Study, CBA).

In terms of allowances, HFMC members were reportedly only receiving 500/= per quarter, as standardised across the country, for attending quarterly meetings. In both the KEMRI and FCI studies, these payments were considered inadequate ('peanuts'), even for an essentially voluntary role, given the amount of time involved. For urban facilities, KSH 500 was a reduction from the KSH 750-2000 per meeting previously received, while in rural areas KSH 500 was usually an increase, but in both rural and urban setting meetings used to be held more often than once a quarter (KEMRI study).

3.2.2.3 Facility sources of income and spending

Detailed information on facility income, including user fees and HSSF funds, was collected by the KEMRI team. None of the 10 health centres they visited reported adhering to the user fee policy for free care for under 5's and KSH 20 for adults. However there were some categories of patient that facilities did not always charge for: for example 2 yr old children with malaria (free in most urban health centres), 2 yr old children with pneumonia (free in most rural health centres) and adults with TB (free in most rural health centres).

The total income from user fees for facilities as derived from facility records for one year (Jan to Dec 2011) ranged from KSH 76,450 to 2,138,216 (910 to 25,455 USD), while the equivalent figures for HSSF funds were KSH 325,000 and 549,600 (3,870 to 6,543 USD) (Table 6). Across the rural and urban health centres, user fees and HSSF funds each represented approximately half of total facility income. However of interest is that the proportions varied considerably for each facility (Table 7), with the proportion of all income coming from HSSF ranging from 17% to 85%, and the equivalent figures for user fees ranging from 6% to 83%.

Table 5: User fees charged at ten health centres visited during KEMRI study (KSH)

User fees charged for:	Rural health centres			Urban health centres			Total		
	Mean	Median	Range	Mean	Median	Range	Mean	Median	Range
2 yr old with Malaria	20	20	0-50	18	0	0-70	19	10	0-70
Adult with Malaria	122	140	40-200	68	70	20-140	95	80	20-200
2 yr old with Pneumonia	10	0	0-30	16	20	0-40	13	10	0-40
Adult with Pneumonia	82	90	40-120	38	20	20-90	60	50	20-120
Adult with TB	12	0	0-60	26	20	0-70	19	0	0-70
Adult with Gonorrhoea	170	100	90-290	108	70	20-290	139	100	20-290
Woman at first ANC visit	222	250	120-320	82	100	20-170	152	120	20-320
Mother delivering	480	500	300-600	104	20	0-300	292	300	0-600

Source: data from KEMRI study

Table 6: Income from user fees and HSSF funds in 2011 at ten health centres visited during KEMRI study (KSH/USD)

	Rural health centres		Urban health centres		Total	
	KSH	USD	KSH	USD	KSH	USD
User fee income						
Mean	593,443	7,065	543,956	6,476	568,699	6,770
Median	281,212	3,348	168,578	2,007	210,160	2,502
Range	76,450-124,7750	910-14,854	81,683-2,138,216	972-25,455	76,450-2,138,216	910-25,455
HSSF income						
Mean	408,600	4,864	462,420	5,505	435,510	5,185
Median	437,500	5,208	438,000	5,214	437,500	5,208
Range	325,000-437,500	3,869-5,208	437,000-549,600	5,202-6,542	325,000-549,600	3,869-6,542
Other income*						
Mean	0	0	156,440	1,862	78,220	931
Median	0	0	0	0	0	0
Range	0	0	0-782,200	0-9,312	0-782,200	0-9,312

*Income from other sources includes Output based aid (OBA) for specific services in MCH, and financial donations, both of which were only recorded in one facility

Source: data from KEMRI study

Table 7: Health centre sources of income by facility at ten health centres visited during KEMRI study

	User fee % of total	HSSF % of total	Other % of total
Facility 1	24.2	75.8	0
Facility 2	5.8	38.9	55.3
Facility 3	72.1	27.9	0
Facility 4	74.0	26.0	0
Facility 5	41.0	59.0	0
Facility 6	41.3	58.7	0
Facility 7	82.6	17.4	0
Facility 8	14.9	85.1	0
Facility 9	30.4	69.6	0
Facility 10	27.8	72.2	0
Total	52.5	40.2	7.2

Source: data from KEMRI study

In the FCI study, there was some suggestion that where HSSF funds represent only a small proportion of the total income, the reporting requirements for all funds introduced as a result of HSSF can be a source of irritation and tension:

...for example, there is a facility that collects between KSH 250 – 260,000 per month. They develop QIPs worth about KSH 700, 000. It doesn't make sense to them when we push them around because of about KSH 120,000. They feel it's a bureaucracy that has been added. They don't understand why they cannot spend because they have to wait for a piece of paper from Nairobi...this creates fights between the Chair and the facility in-charge (FCI study, DHMT member).

Figure 5 shows how facility funds across the country were spent between July 2011 and December 2012 (see Appendix C for definitions of expenditure categories). A quarter of funds were spent on contractual and temporary employee wages, including accounts clerks, watchmen/security staff, groundsmen and cleaners. In the KEMRI study, facilities also reported hiring cooks to serve maternal inpatient facilities. High proportions of funds were also allocated to medical supplies (14%), travelling accommodation and subsistence (13%) and other operational costs (11%), fuel lubricants and other costs (6%) and maintenance (6%). Only a small proportion of funds (2%) were reportedly spent on purchasing drugs. Similar expenditure patterns were recorded during record reviews conducted by KEMRI. In interviews, urban health centres 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. HFMC members also mentioned the importance of HSSF in paying their allowances for meetings.

In both the KEMRI and FCI studies, there appeared to be some lack of clarity in guidelines on using HSSF to buy drugs or hire accounting clerks. Some interviewees reported it was not possible to buy drugs, while many mentioned that some funds simply had to be spent on essential drugs, because drugs are crucial in attracting patients and KEMSA supplies are so often late.

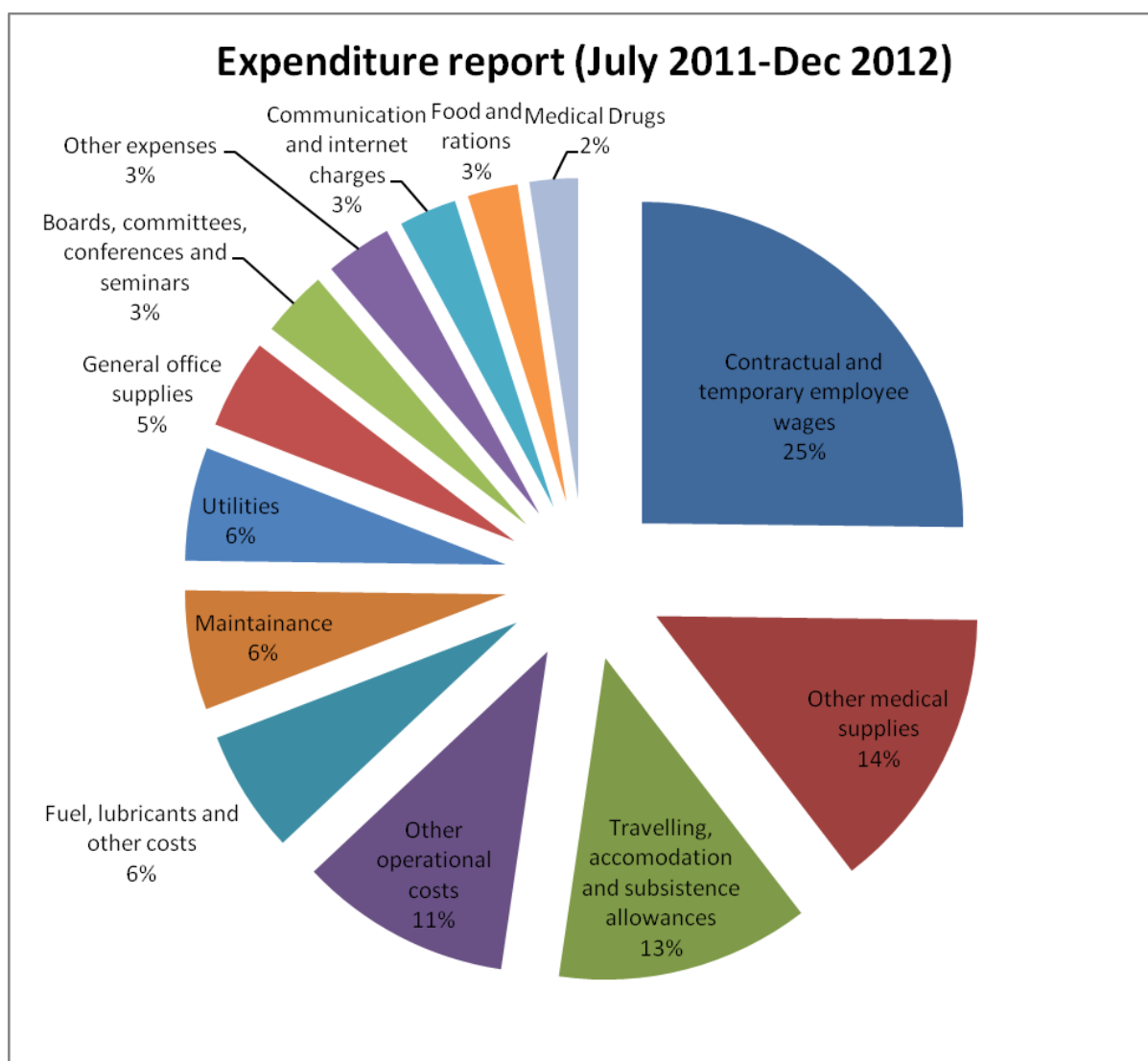
Before we started receiving HSSF, we used to spend the money collected at the facility to buy drugs so we never used to run out of stock. But the moment we started receiving this money, it has pressed us. For example when you run out of a drug, you don't have funds to purchase that drug (FCI study, HFMC Secretary, Pg30).

There are the essential drugs or tracer drugs that a facility should never go without and KEMSA at times doesn't supply. If we were allowed, we would use that [HSSF money to buy the required drugs], but our hands are tied (KEMRI Study, In Charge).

In the KEMRI study, several in charges reported buying drugs with the guidance of district pharmacists. Some expenses that were rejected by the DHMT, CBA or national secretariat included newspapers, paying for transport other than designated ambulances to refer patients, major renovations, locum health workers, and furniture. These became known as ineligible expenses during initial tranches, and will reportedly now be increasingly heavily sanctioned where noted,. Responsibility for ineligible expenditure ultimately rests with the civil servants (government employees) and therefore the in-charge at the facility level and the DMOH at the district level. Potential consequences include demotion, suspension, transfer, sacking, and salary deductions to payback, with these consequences described as contributing to some major anxiety and inaction among some staff, as described more below (section 3.2.2.4).

Beyond ineligible expenditure, there were some cases of misuse. Examples reported to KEMRI included user fee money being pocketed rather than recorded and banked by a lab technician (he was suspended without pay), and an HFMC member taking a cash advance and then claiming to have been robbed (the case was still under investigation). One in-charge reportedly tried to forge signatures of HFMCs and transfer money to a personal account, but was caught and the in-charge demoted and transferred. A reported 10 or so people throughout the country (primarily DMOHs) were reported to have had salaries deducted for ineligible expenses that could not be explained. One DHMT reported that a few facility in-charges were taking too long to use the funds out of a fear of the consequences of misuse that they had been told about in training.

Figure 5: Use of HSSF funds between July 2011 and December 2012



Source: HSSF secretariat, May 2013

3.2.2.4 Impact of HSSF funds on facilities' quality of care and utilisation

In the IIFRA reports, programme funds were reported as generally being well used, with facilities able to improve their upkeep, buy consumables to improve quality of care, and overall ensure visible improvements in service delivery [World Bank, 2013]. The KEMRI and FCI studies in health centres both highlight overall very positive impacts of HSSF, with the benefits described by the FCI HFMC interviewees summarised in Figure 6 (source: Family Care International, 2012). Improvements have reportedly been even more visible and impressive in dispensaries, where HSSF has been described as a 'huge success' (KEMRI national interviews, 2013).

Figure 6: Benefits of HSSF funds

Quality of care and staff motivation

The majority of KEMRI and FCI interviewees reported a marked improvement of the general conditions of facilities as a result of HSSF, reportedly achieved through hiring casuals such as security guards, cleaners and groundsmen to keep the facility clean and presentable. Most facilities also reported making minor repairs and renovations like painting their facilities, and repairing toilets. The FCI report noted that these interventions led to very observable changes. Together with improved access to supplies, and more motivated staff, KEMRI interviewees reported HSSF as having had a positive impact on quality of care offered to patients:

Of course it has improved; initially if you didn't have gloves you would tell a client "we are sorry, we can't help you" (KEMRI Study, In Charge).

If you are providing services in a clean environment you are improving the quality... [with] drugs now there is no folding of envelopes as if you are selling groundnuts (KEMRI Study, In Charge).

Increased motivation among health workers was attributed to improved working conditions, and better availability of basic resources:

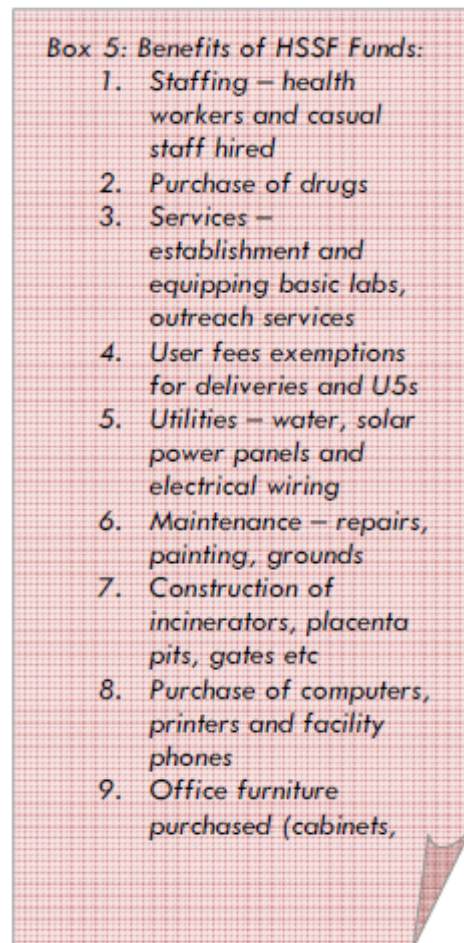
paying bills we are able to, before we used to get a backlog of bills but now we are able to pay our bills in time ... we are able to even to collect drugs if for example we are out of stock; we can fuel a vehicle to go to the rural facilities and transport whatever excess drugs they have to our facility and make use of them. So it has made many things possible (KEMRI Study, In Charge).

Within this overall positive picture, challenges have included the amount of paper work needed, and complaints about inadequate levels of funds in facilities. Also, slightly less than half of the in-charges were described to KEMRI staff as uncomfortable with the constant 'interrogation' from HFMCs, and one mentioned that there was a quarter where the facility had undergone so many external audits that health workers had felt 'harassed'. DHMTs and national level interviewees were sympathetic to in-charges' difficulties in taking on their double burden of clinical and accounting work, highlighting inadequacies in training:

[People] who have never been allowed to manage are sent funds to manage. And training focuses on how to manage the funds while missing out on the real issues of how to prioritise and make decisions about how to use the money for the benefit of the facility (KEMRI Study, National level interviewee).

There were reports of several in-charges who were "kwamad [blocked] by terror" at the thought of having to lose their salary through accounting errors, preferring not to use or report on funds. As an interviewee noted:

Supervisors had to sit down with them and explain the procedures and situations that could get you in trouble (KEMRI Study, National level interviewee).

- 
- Box 5: Benefits of HSSF Funds:**
1. Staffing – health workers and casual staff hired
 2. Purchase of drugs
 3. Services – establishment and equipping basic labs, outreach services
 4. User fees exemptions for deliveries and USs
 5. Utilities – water, solar power panels and electrical wiring
 6. Maintenance – repairs, painting, grounds
 7. Construction of incinerators, placenta pits, gates etc
 8. Purchase of computers, printers and facility phones
 9. Office furniture purchased (cabinets,

Patient views and satisfaction

More than three quarters (79.6%) of the 99 KEMRI exit interviewees reported an improvement in overall service delivery at the facility over last year, and slightly more than two thirds improvements in facility cleanliness (62.1%), waiting time (61.6%) and treatment given (60.9%). Just over half (51.1%) reported improvements in the availability of medicine, and just under half in the number (44.5%) and courtesy (47.6%) of staff. Patient views were even more positive in the FCI study, where the majority of 599 exit interviewees reported that the overall quality of service, waiting time, cleanliness and the state of the health centres had improved over the last year, although there had been no reported change in the staff attitudes, state of furniture, and the duration of time that the health centres are open to attend to clients. 93% of FCI exit interviewees reported being satisfied with the overall service in health centres in their county, with high proportions for each of a range of aspects of health care including for example waiting time, health worker attention, child immunisation and health worker attitude.

While patients in general reported satisfaction, in the FCI study, negative health worker attitudes towards patients as well as lack of drugs were the major complaints raised by community members. A high proportion of community members – over 50% - reported having had to purchase drugs in private facilities after discharge, mainly because of stock outs. This was reported as a major source of discontent among facility users.

Outreach and services provided

Most in charges and HFMCs interviewed by KEMRI felt that HSSF had contributed to the introduction of new services, or the strengthening of existing services, including for example deliveries, in-patient care, and outreach activities. Two facilities reported that the availability of funds for transport and allowances enabled outreach activities to be carried out in their districts for the first time. DHMTs felt such outreach activities were important not only for care, but also to ‘sell’ services available at facilities. Although better referral processes were also mentioned, ambulances remained rarely available in two districts.

Utilisation

In the 2013 World Bank report, it was noted that a significant number of people are visiting health centres, and that the “administrative data” of the Ministries of Health found an increase in utilization rates of public health facilities. During the last nine months of fiscal year 2011/12, nearly 27.9 million individuals used primary health services compared to 25.8 million in 2010/11, with over half of these users (16.3 million) female. In addition, nearly 0.8 million eligible children were reportedly fully immunized, with marginal improvements in coverage levels in North Eastern Province (World Bank, 2013, pg 14).

Utilisation was also perceived to be positively affected in the KEMRI study. In-charges said there were more patients coming to the facility because of the availability of drugs and lab re-agents for testing, the improved general condition of the facility, increased outreach programs, and affordable prices relative to private clinics. In one case, HFMC members attributed the increased utilisation to reduced user fees, which they introduced as a result of HSSF funds. This reduction in user fees was only reported in one facility however, with most facility retaining user fees well above official levels (see section 5.2.3).

3.2.2.5 Community information sharing and understanding

One of the stated specific objectives of HSSF is to support and empower rural communities to take charge of improving their own health. A key approach is through establishing and strengthening HFMCs (section 3.2.2.2). In-charges felt that ensuring all final decisions involved the HFMC reduced potential suspicion between the HFMC and in-charge, and that this strengthened transparency and relationships between the facility and the community. Other approaches include increasing

awareness among community members about the HFMC, HSSF, and the facility (for example through public meetings and posters), and allowing communities to voice their views through these meetings and other mechanisms such as complaints boxes and client charters.

Regarding awareness of HFMCs and HSSF, all KEMRI and FCI interviewees felt that community members needed to know about HSSF, with key information needs including: what the fund is and why it is important; that user fees are part of the fund; that the funds are not adequate without user fees and therefore user fees are still needed; their rights as patients; and the benefits of having the fund. In-charges interviewed by KEMRI differed on whether exact figures on income should be shared, with those against it concerned it would lead to security risks and raise expectations that could not be met. However, exit interviews in both studies found low awareness of HFMCs' existence and low understanding of HSSF among facility users. In the FCI study, nearly 90% of interviewees did not know an HFMC existed (Table 8); the equivalent figure in the KEMRI study was 72%.

Although 63% of interviewees had heard of the direct facility financing reform in the FCI study, only 37.4% of KEMRI exit interviewees had heard of HSSF; with the latter hearing most often from the radio (25.6%) or health facility (23.3%) (figure 6). Only 16.2% of those who had heard of HSSF in the KEMRI study described it correctly however. In the Social Accountability Pilot report, it was noted that there are still significant misunderstandings about HSSF, and that it is often confused with NHIF (SAC site visit).

In the IIFRA report for the quarter ending 30th September 2012, half of audited health facilities had not put in place complaints boxes and complaints handling and resolution procedures (pxii;viii). In the FCI study, although many exit interviewees had complaints, few reportedly ever formally lodged a complaint. Reasons for not doing so included not knowing how to, not believing it would make a difference, and being concerned not to upset relations with health providers.

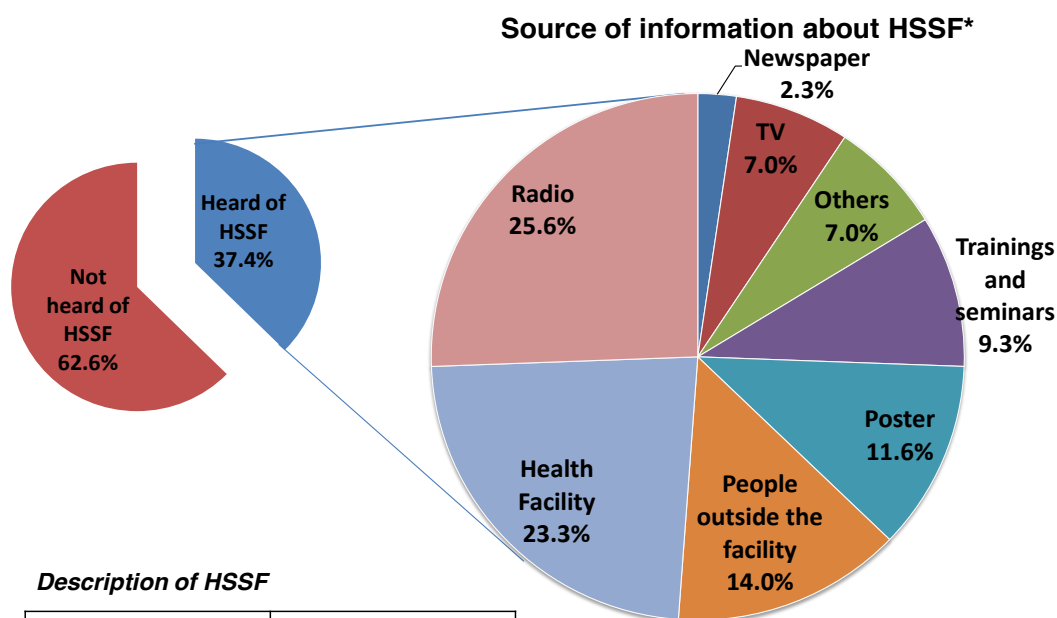
More recent documents [World Bank 2013; Aide Memoire 2013] have noted that more attention is now being paid to compliance with guidelines for community participation. In addition to an increase in facilities displaying client charters and information on services offered free of charge, information on total funds available and how they were being used were disclosed more often. However concerns remain that complaint redress mechanisms aimed at giving voice to citizens remained weak, inefficient and non-transparent.

Table 8: Community members' knowledge of the HFMC and financial matters

		Kitui n=308 (%)	Nakuru n=291 (%)
Know who manages the health facility and its finances	Yes	38 (12.3)	32 (11)
	No	270 (87.7)	259 (89)
Know how the facility raises funds	Yes	82 (26)	73 (25.1)
	No	226 (74)	218 (74.9)
Aware of government DFF reform	Yes	195 (63.3)	88 (30.2)
	No	113 (36.7)	203 (69.8)
Know how money was spent last year	Yes	21 (6.8)	11 (3.8)
	No	287 (93.2)	280 (96.2)
Know how money in the facility will be spent next year	Yes	4 (1.3)	1 (0.3)
	No	304 (98.7)	290 (99.7)
Ever enquired about funds in the health facility	Yes	2 (0.6)	3 (1.0)
	No	306 (99.4)	288 (99)
Ever voiced priority need in the health facility	Yes	25 (8.1)	23 (8)
	No		268 (92)
Would like to be engaged in decision making in the health facility	Yes	140 (45.4)	116 (39.9)
	No	159 (51.6)	166 (57)
	Maybe	9 (3.0)	9 (3.1)

Source: FCI study, p 23

Figure 7: Exit interviewee knowledge of HSSF*



Source: KEMRI study exit interviews
 * NB: the description of HSSF is of those who had heard of it

3.2.3 District level experience

3.2.3.1 Access to, financial planning and management of HSSF funds

IIFRA noted that all the DHMTs reviewed during the 1st quarter of 2012/13 had opened bank accounts specifically for the HSSF programme funds, and that 56% of DHMTs had received their KSH 131,500 disbursement for the quarter in time. In addition, almost all (92%) received the AIEs for the quarter on time. This was an improvement on previous quarters, where the proportion receiving funds late in the quarters up to June 2012 was 54% (Q1), 88% (Q2), 70% (Q3) and 63% (Q4). All the DHMTs reviewed during 1st quarter of 2012/13 were reported to have put in place appropriate systems of internal controls, including a strong control environment, reasonably adequate accounting system, and control procedures in line with GOK financial regulations. On the basis of selected key performance indicators, 73% of DHMTs were rated “Green”, 27% “Amber”, and none ‘Red’. The proportion coded green had increased substantially in each quarter of the year up to June 2012 (8%; 18%; 50%; 53%).

In the KEMRI and FCI studies, similar challenges with regards to accessing HSSF funds by DHMTs were identified to those at facility level, including problems with submitting QIPs in time, and delays in receipt of AIEs. Additional challenges raised included the difficulty of following the required consultative procedures for developing an AWP, and complex finance procedures to be followed by staff with many other commitments:

You know the annual operational plan is really a demanding exercise and it is normally very difficult to find the funding... no [funders want to] take that responsibility [because of that feeling that] aah the HSSF is funding all that (KEMRI Study, National level interviewee).

DHMTs reported relying heavily on the CBA to do the financial accounting and documentation for them, with CBAs in 4/5 of the districts visited by KEMRI co-opted into the DHMTs. One CBA confirmed that they waited so long for reports they eventually just had to go and do the accounting for them:

They give me their expenditure records and I do it for them... but then I warn them not to complain (KEMRI Study, National level interviewee).

3.2.3.2 Spending and levels of funds received

In the IIFRA report for the year 2011/12, it was reported that sampled DHMTs generally utilized the programme funds well. The few anomalies and poor usage of the programme funds identified were reported to MOPHS in a rapid response letter. In recent national interviews (May 2013), HSSF funds were reportedly initially spent on a wide range of ineligible items such as utility bills until they were corrected by IIFRA, and informed that they can only spend funds on activities directly related to supervision (for example fuel, per diems, and vehicle maintenance). In national level interviews, DHMTs were described as having faced the worst problems in terms of accounting, possibly linked to the number of bank accounts they have to manage, with HSSF bank accounts being treated separately.

In the KEMRI and FCI studies, HSSF money at district level was reportedly spent primarily on supportive supervision, utilities, transport, stationery, maintenance of vehicles, and district casual staff. In the KEMRI study, DHMT members expressed concerns about losing the 25% of user fee collections they used to receive from district hospitals, although this was counterbalanced to some extent by not feeling responsible for bailing out facilities with financing difficulties. With the 2008 split of the MOH into two, administration costs also increased.

Overall, DHMTs reported feeling underfunded and that HSSF is still very ‘top down’ and centralised, undermining local ownership:

The requests from departments are just overwhelming and the amount is so small. You don't know who/how to allocate that money to; it is so little (KEMRI Study, DHMT member).

Decentralization can make disbursements easier. It may be easier if the disbursements were done at county level (FCI study, DHMT member)

HSSF has come in the format of old polices “You have been told to do ABCD...Sometimes we have to arm-twist the in-charges. Ownership may take time (FCI Study, DHMT member).

DHMTs in the FCI study complained that all Districts received inadequate funds, and that levels were the same amount regardless of the size, number and distribution of health facilities under their supervision.

The money is not sufficient. For DHMTs with vehicles, we cannot cope. For example, one tyre of a Land cruiser is KSH 20,000, if you change the tyres in a quarter, the money is finished...you have not fuelled or serviced it (FCI study, DHMT member).

They were also unhappy with the lack of a clear line of communication and response to their queries and complaints at national level. None knew of a contact person or office that handled queries and none of their complaints had reportedly ever been addressed.

Aaaa...those numbers are just PR, when we call to ask about AIEs we are told that the AIE is almost ready and we are not given options even when staff are threatening to go on strike for lack of salaries (FCI study, DHMT member).

We write to the Secretariat but we never get feedback. For me feedback is very important...sometimes I don't know if it's the mood, we get feedback after very few minutes, sometimes we never get feedback (FCI study, DHMT member).

3.2.3.3 Supportive supervision by DHMTs and CBAs

In the IIFRA for the period ending Sept 2012, it was noted from supervision checklists left at facilities by the DHMTs that 77% of DHMTs carried out supportive supervision of the health facilities within their jurisdictions, in line with GOK regulations and procedures. In addition, from DHMT records it was noted that 44% of sampled DHMTs supervised **all** the health facilities planned for the quarter.

Most facilities visited by KEMRI had supervisory visits from the DHMT within the last quarter, which in-charges reported as useful in correcting minor mistakes but inadequate. CBAs therefore had to offer informal training and supervision to in-charges and facility accounts clerks, which was reportedly greatly appreciated by facility staff:

I didn't know anything because I'm just a clinical officer; I didn't know anything about finance so at least with the accountant coming I have all this knowledge on how to handle this (KEMRI Study, In charge).

In case I am having a problem, they usually feel free for me to maybe contact them, or consult the accountant. It's like we are working with together- so for myself, I normally find it very useful (KEMRI Study, In charge)

KEMRI national-level interviewees were concerned with ‘very weak’ supervision by the DHMT, and low coverage and high turnover of CBAs, explaining the latter as related to poor pay, lack of funding, and inadequate integration into district system from the outset (discussed further in section 6.1). One national level interviewee recently expressed concerns about how CBAs were introduced, as

supervisors rather than mentors and facilitators, and that in some facilities in-charges had to leave and sometimes even close facilities to go and seek assistance from CBAs, who were perceived to be 'ineffective'. The FCI study interviewees supported that CBAs are overwhelmed and need extra support. In May 2012, an additional 60 accountants were employed and so by May 2013 there were just over 100 in total; around 2 per county. It was also hoped that an additional 173 accountants would be funded for 2 years by the Danish Embassy to ensure one accountant per district but this has not yet taken place, as discussed more below.

3.2.4 National level experience

In recent interviews, it was noted that the secretariat has a small budget for transport and office expenses but that a larger cost has been announcing quarterly disbursements in newspapers. There are also funds available for training as noted above, and IIFRAs are funded out of national HSSF resources. Other initiatives, such as PBF and SAc are separate line items under KHSSP. IIFRA reviews noted that the HSSF and SWAp secretariat had generally maintained proper books of accounts and prepared interim financial reports on a timely basis [Aide Memoire, 2013], although there was a concern that overall accountability of the funds disbursed to the DHMTs and health facilities was compromised by a lack of reconciliation of disbursement records with consolidated expenditure reports, due to the latter being prepared in Navision (page ix) [IIFRA, 2012].

4. Performance based financing pilot

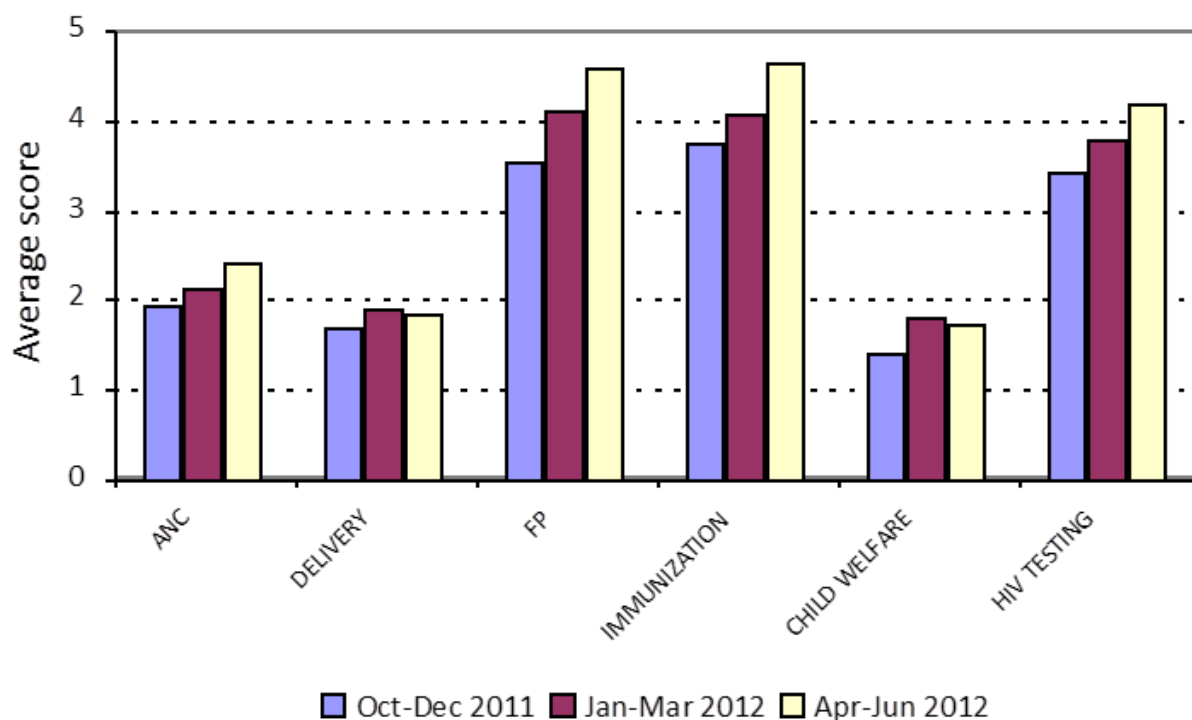
A Performance-Based Financing (PBF) pilot programme has been implemented in Samburu County by the Government of Kenya in collaboration with the Population Council since October 2011, with funding from the World Bank. The programme aims to: (1) improve coverage and quality in access to the services by incentivizing facilities for improved performance on key output and quality indicators; and (2) strengthen supportive supervision provided by the District Health Management Teams (DHMTs). The pilot is exploring the operational feasibility of PBF under the HSSF with technical input from the Health Results Innovations Trust Fund. Evaluations compare facilities with and without PBF with regards to: changes in maternal and child health (MCH) and reproductive health services utilization and quality of care; and facility management. Six key reproductive and child health services shown to be critical for reduction of child and maternal mortality are linked to performance payments. These comprise family planning counselling, antenatal care consultations, safe deliveries, full vaccination of children below one year of age, growth monitoring for children below 5 years of age, and HIV testing and counselling services. The routine reporting of the PBF indicators is based on the existing national Health Management Information System (HMIS) of the Ministry of Health, with verification performed by DHMTs.

Two rounds of facility-based verification of the PBF pilot programme in Samburu County were conducted covering three quarters: October-December 2011, January-March 2012, and April-June 2012. The verification activities compared output and quality indicators in the 26 PBF facilities (24 dispensaries and 2 health centres) in Samburu Central District with 11 control dispensaries in Samburu North. At the facility, records and HMIS reports during the quarters under review were gathered using a standard checklist (appendix D); clinical and cross-cutting quality indicators and the financial management and record-keeping at the facilities during the quarters under review were also recorded using checklists (appendix D). On the basis of each facility's output and quality data based on six services, the basic payment for each facility for the quarter was calculated. For each service, the payment reflects the unit price and number of units delivered, with an adjustment to reflect the relevant clinical quality criteria. The payments are added to the standard HSSF amounts received by the facilities (and never exceed HSSF amounts). 60% of the payment was given as individual incentive payments to health workers.

Facilities were reported as receiving on average KSH 21,580 per quarter through PBF between October 2011 and June 2012), although there was significant variance between facilities (standard deviation of KSH 33,645 in Oct-Dec 2011 and KSH 27,186 in Jan-March 2012). The major findings of this pilot were:

- There was increased utilization of family planning, deliveries and immunization during the first two quarters at PBF sites, while the number of people tested and counselled for HIV declined.
- The average utilization of antenatal care and child welfare services consistently increased in PBF sites during the three quarters while non-PBF sites experienced declining trends in these indicators during the first two quarters before slightly increasing during the third quarter.
- There were consistent improvements in the average clinical quality scores for family planning, antenatal care, child welfare services, and HIV counselling and testing during the three quarters (Figure 7). In addition, the average cross-cutting quality score consistently improved during the same period. While government facilities and community owned facilities registered consistent improvements ($p < 0.01$ for both categories), faith-based facilities did not.
- There were notable discrepancies found between the data reported in the District HMIS and what was found in the facility registers in each quarter. In reports, verification data, confirmed by DHMTs at time of their visit, are assumed as the gold standard.
- There were significant administrative challenges that delayed the implementation of the programme and management and supervision costs were higher than average, but were expected given the distance of the selected facilities from provincial and national HQs.
- Verification costs were initially budgeted at 50% of the value of the total PBF disbursement for that quarter. Careful review of the budget reduced that cost to 22% of the first PBF disbursement.

Figure 8: Trends in average clinical quality scores for the key PBF indicators during the three quarters



Source: Mutai et al., presentation, September 2012.

Several recommendations were made regarding the way forward for PBF:

- Qualitative research to understand which indicators are most likely to be affected by PBF incentives, and optimum levels or workloads beyond which incentives will not significantly affect motivation (pg21).
- A need to improve infrastructure and supplies at facilities, potentially through greater investment using HSSF and PBF funds (pg20).
- Reasons for discrepancies between DHIS and facility level data are identified in order to improve the quality of data and support future programming (pg 6).
- DHMTs encourage community health workers and HFMCs to better mobilize communities (i.e. generate additional demand) (pg 6)
- Involve community based organisations, other non-governmental organisations on the ground and community in verification exercise, although this will pose a challenge in raising costs (pg 22, last bullet)

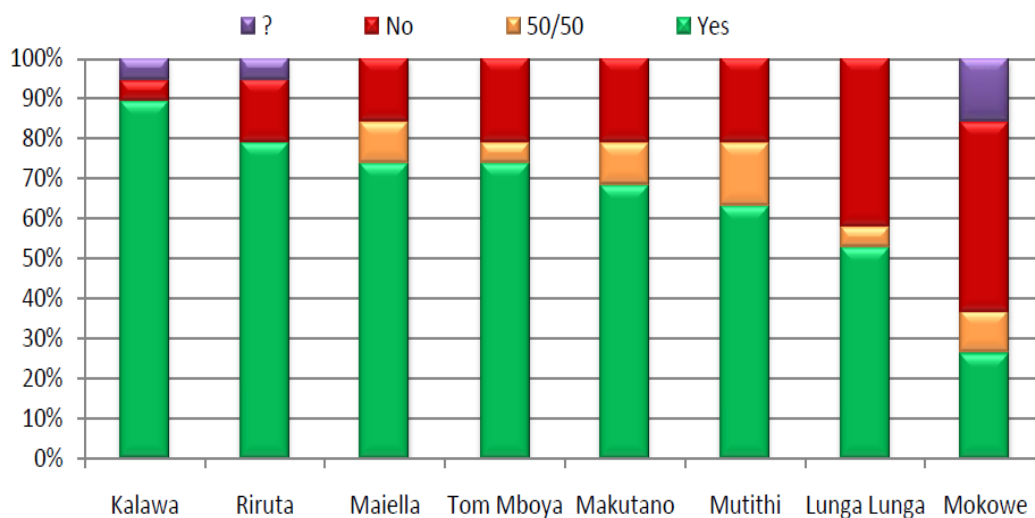
An experience sharing work shop was held in November 2012 where the lessons from the PBF pilot were discussed and a strategy for scale-up proposed. It was decided to scale up PBF gradually, beginning with the rest of Samburu, Lamu and West Pokot Counties by mid-2013 to obtain more experience with this intervention over the next 1-2 years.

5. Social accountability pilot

The SWAp Secretariat contracted the African Development and Emergency Organisation (ADEO) to implement a 16-month 'social accountability pilot' (November 2011 to February 2013) in nine locations reflecting different socio-economic settings in Kenya. One health centre was selected in each of the following nine districts: Kirinyaga South, Lamu, Naivasha, Garissa, Turkana South, Mbooni, Suba, Msambweni and Nairobi West [Aide memoire, 2013 pg 8, pt 30]. The pilot tested the operational feasibility of improving transparency in sharing information about health services, enhancing participation of communities in health service delivery planning and introducing effective complaint redress mechanisms, targeting the user communities [Aide memoire, 2013, pg 8]. The main element of community participation was the Community Score Card (CSC) designed to encourage dialogue between service providers and the community to improve health services in the pilot health centres. For complaints redress, both written and telephone text messages were used. All compliments and complaints received were logged in a detailed complaint register which also includes complaints received through the text messages that were linked to the ADEO website.

Between September and December 2012, visits were made to all but one site (Garissa site was excluded due to security concerns) to review the progress of the social accountability (SAC) pilot, understand the operational challenges, document whether complaints redress mechanisms were working, and assess the feasibility of scaling up the proposed model. Group interviews were held with the in-charge, other available health facility staff, and the CSO representative in the facility. Findings from the interview were corroborated by observation of measures at the health facility and informal discussions with randomly selected clients who were present at the health facility. A standardised checklist (Appendix E) was used to track implementation of the three key SAC measures against 19 indicators. Overall site performance was illustrated graphically (Figure 9), with 'green' showing that all indicator requirements had been met, amber that some had or '50/50', and red that none had.

Figure 9: Performance of sites in the implementation of three key SAc measures



Source: Piloting Integration of Social Accountability Approaches in the Health Sector Services Fund [MOPHS, 2012].

The key findings from the pilot were reported as: (a) improvement in information sharing and disclosing behaviour from the health service providers with corresponding information seeking from users; (b) creation of an enabling environment for users and providers to build trust and develop positive attitudes towards each other; (c) an improvement in the selected and prioritized performance indicators as measured by community score cards; and (d) greater opportunity for the community and health centre staff to dialogue and plan together in community forums (2013 Aide memoire pg 8). Uptake of health facility services was reported to have improved, and communities were described as less sceptical on spending as information on income and expenditure was displayed (although the display of a facility's financial information had raised security concerns especially in Lunga lunga).

Identified as critical to success were the involvement of DHMTs and HFMCs, the community's relationship with the in-charge, and buy-in of all health facility staff to facilitate integration of SAc into all services. Ownership challenges identified included poor linkage of the SAc pilot with the HSSF communication strategy (leading to duplication of efforts) and implementation of the pilot by an NGO. Important supply side challenges for most facilities were delayed AIEs, undersupply and delayed delivery of drugs, and understaffing of facilities.

Several recommendations were made regarding the way forward for SAc:

- MOPHS is in the process of mainstreaming SAc activities and the SWAp Secretariat with support from the Bank and DANIDA consultants are to finalize a manual and road map
- The reception for the score card had been better at district than facility level, HFMC members should be excluded from the scoring process, and score cards should be translated to the local language. In some settings, linking the scoring to other community events may improve turnout.
- For complaints, verbal communication is preferred to written by all, and most popular channels are Opinion Leaders, HFMC members, Chiefs, and DHMT members
- Literacy levels are a concern given that is important in understanding complaint handling mechanisms and SAc, and particularly when using channels such as text messaging.

- A tactful complaints management strategy to be instituted to deal with cases of demoralisation among health facility staff

6. Key issues for consideration in future HSSF planning

Overall, there appear to have been impressive achievements to date with HSSF in terms of ensuring that funds reach facilities, and in ensuring that funds are being overseen and used in a way that strengthens community involvement (i.e. through HMFCs) and quality of care. The latter has not yet been measured, but interviews suggest that spending on casual staff, basic improvements of facilities and simple day to day facility needs can have an important impact on the condition of facilities, health workers' motivation, patient satisfaction and ultimately quality of care. There is less experience in dispensaries than in health centres, but national level interviews suggest that positive impacts have been particularly impressive in these smaller facilities.

Our review suggests that there are some important areas that require attention moving forwards, including financial management, the design of HSSF under devolution, and if, when and how to incorporate PBF, additional social accountability mechanisms and FBOs. The impact of user fee removal on HSSF implementation and impact will also be important to consider.

6.1 Financial management

One of the key arguments for introducing HSSF was a need to reduce the complexity and delays in access to funds for facilities, and in turn facilitate the strengthening of quality of care. Experience with HSSF to date suggests that unanticipated problems and complications have been introduced by the way in which HSSF has been implemented with negative implications for both HSSF funds and use of user fees. There are several key financial management issues that need consideration and monitoring and evaluation in continued implementation, regardless of design under a devolved system:

Access to both HSSF and user fee funds: Concerns include delays in receiving funds in bank accounts, and especially in receipt of AIEs, AIEs not reflecting QIPs, and if and how to use money allocated in AIEs to items that are non-essential to the facility. The impact of the July 2012 initiative of introducing annual rather than quarterly IPs (and AIEs), with an option for additional AIEs mid-year, is a positive move which needs evaluating. One national level interviewee suggested that an additional initiative might be to pilot the use of a non-itemised AIE with only broad guidelines on what funds should be used for by facilities. Facilities would then develop itemised budgets within these broad guidelines based on local priorities. This would strengthen flexibility and responsiveness to local priorities and needs as they arose.

Time spent by in-charges on financial management forms: In-charges are responsible for filling numerous financial management forms at facility level. Not all forms are available or filled, and health workers find it difficult to balance accounting and documentation requirements for which they feel inadequately trained, with clinical care. In-charges spend an estimated 20% of their time fulfilling their management/accounting roles. The new longer reporting schedule introduced in July 2012 should have eased challenges, but this needs to be monitored, and high financial management burdens are likely to remain for in charges. Interviewees highlighted a range of options moving forwards:

- Ensure that the proportion of in-charges' time spent on their management/accounting roles – approximately one day per week - is recognised in their job descriptions, the expectation of the time they spend offering clinical care, and their induction and training systems. Especially for smaller facilities with only one clinical staff member, this might require employment of additional clinical staff to ensure that quality of care is not compromised.

- Recognise that there is a tension between current financial management requirements and clinical care, and that governmental requirements should be simplified for peripheral facilities, even if this requires departure from standard government systems.

The election and functioning of HFMCs: HFMCs are potentially critical to community participation, and to strengthening facility accountability. There is a need for more training for HFMCs in the modalities of HSSF and on their roles in it, to alleviate confusion and some indications of tension with in-charges. Such training would also support wider community information sharing. An issue needing resolution moving forwards is the election of new committees, given that many committees are coming to the end of their term in June 2013. National level interviews highlighted some concerns about up-coming HFMC elections, and especially if and how new committees will be gazetted. National level gazettement of HFMCs who are elected locally in communities, and who inevitably change over the course of a three year term, was not supported. Why gazettement is needed at all for committees that are not finally held to account for facility funds was not clear to all interviewees. However it was recommended that any gazettement or approval considered necessary should be conducted at county level or below.

Role of CBAs, and their integration in DHMTs/CHMTs. Mentoring and support for in-charges in financial management and accounting is crucial, and often given by CBAs as opposed to DHMTs. Challenges include CBAs being overstretched (especially since the inclusion of dispensaries in HSSF), and some lack of clarity in who is formally responsible for conducting and funding the day to day training and support for in-charges. With regards to CBAs' relationship with DHMTs, some DHMTs said that the role of the DHMT in management of HSSF funds was not clear from the guidelines, now that there are CBAs to handle both HSSF and user fees for facilities. That CBAs report directly to the HSSF secretariat accountant, although not the initial intention in HSSF, was described as contributing to the verticalisation and centralization of the HSSF process. The importance of embedding CBAs within DHMTs was regularly noted, something that has reportedly happened with some of the new CBAs recruited in May 2012. However, given that there are far fewer CBAs than DHMTs it is not possible to have a one-to-one relationship. Although more CBAs were employed in 2012, there is still need for more to support hand-holding of facilities.

A specific area of concern is the lack of involvement of the district treasury in HSSF. It was noted in the 2013 Aide Memoire that: *'accountants were yet to comply with GOK fiduciary procedures because they have not been integrated within the district treasury, they lacked supervision budget to far flung facilities, and were not incorporated in DHMT and were not always included during supervision visits to facilities'* (pg 5, pt 16c). One national level interviewee described the lack of involvement of the district treasury as having been 'the Achilles heel' of HSSF, while another argued that the parallel system had been necessary because of the failings of the district treasury.

A consultancy conducted to review the present HSSF financial management information system used by the health facilities, DHMTs and the HSSF Secretariat, made a series of recommendations at all levels for ensuring full integration in the GOK system (MOPHS 2013). Recommendations included: the elimination of the role of the HSSF Secretariat (with the Directorate for Primary Health Care at the MOH to take over responsibility for administering the fund and reporting to the Cabinet Secretary responsible for health); a shift to preparation of AIEs through standard GOK procedures; the discouragement of IIFRAs; and the closure of district HSSF accounts. The consultancy proposed that facilities use the District Vote Book Management System which would automatically record expenditures in IFMIS, the GOK financial management system, with the discontinuation of use of Navision software. It was argued that this would ensure that all HSSF expenditures appear in the government records and that it is possible to reconcile disbursement and expenditure records. It was suggested that the current DHMTs are maintained until the county restructuring is implemented, and that HSSF accountants are redesignated as Internal Auditors based in the Office of the County

Director of Health Services to exercise oversight over the HSSF activities. The consultants argued that the value added of CBAs was “minimal and unsustainable” and that it was not cost effective to deploy additional accounting resources specific only to the health ministry. Overall, there was a recommendation for a deliberate shift towards entrenching social accountability, social auditing and social monitoring (e.g. through HFMCs) as opposed to greater emphasis on traditional fiduciary controls.

In national level interviews in May 2013, several of these consultancy recommendations were not supported by some stakeholders, including integration with the district treasury, discouragement of IIFRAs, and transition from Navision to IFMIS:

- It was commented that the *creation of a parallel funding system* had been necessary because of the failings of the district treasury, and that integration with Treasury would essentially lead to a collapse of HSSF. It was also noted that this verticalisation and lack of integration was a general problem at the MOH, and not specific to HSSF. A counter argument was that HSSF was only ever meant to be an interim measure, and that now that health centres and dispensaries are established as accounting entities that can receive funds, concerns at the outset of HSSF are no longer relevant. This person was concerned that HSSF funds should not be seen as a separate programme, but rather ‘a pipe of money to facilities’.
- *Regarding IIFRAs*, one interviewee stressed the importance of these audits to highlight and address inappropriate uses of funds, to improve outcomes in facilities, and to ensure credibility. Mentioned instead was the importance of HSSF links to and communication with for example HMIS and accounting systems. This interviewee mentioned that at least one major donor’s continued funding of HSSF would depend on IIFRAs continuing to be conducted.
- *Regarding ensuring that HSSF is captured under IFMIS*, the joint World Bank and DANIDA support mission tasked MOPHS to come up with a time bound action plan to be prepared for transition from Navision to IFMIS. Some people interviewed were concerned that facilitating the implementation of IFMIS nationally would be an extremely costly exercise, while others felt that this was in fact unknown. One factor contributing to debates is a lack of clarity on how funds at district level are currently accounted for, and therefore how complex any shift would be. One interviewee was concerned that lack of interest in IFMIS might be related to the transparency in the system, and that at least one major HSSF donor would withdraw funds if HSSF funds are not accounted for by the government by 1st July 2013. We recommend that there is a clear exposition of the steps required to transition from Navision to IFMIS, including the activities and costs involved, and realistic timeframes for each step. Such information should facilitate decision-making moving forwards.

6.2 HSSF in a devolved system

It was noted that the devolved health care system in Kenya provides a huge opportunity for offering more responsive and accountable health services, addressing some of the equity and efficiency concerns about the centralized system [World Bank, 2013]. A key priority for HSSF moving forwards is how to align the HSSF legal framework and institutional and management procedures with the devolved system of governance (p13). At present, there are so many unknowns in how the wider devolution process will unfold, that the alignment of HSSF within this wider context is challenging.

The potential benefits of devolution according to the literature include improved efficiency through greater cost consciousness and control at the local level, and better quality, transparency, accountability and legitimacy [Bossert and Beauvais, 2002]. However evidence on the performance of devolution is relatively weak, partial and inconsistent, with available evidence suggesting that

expected benefits have often been undermined by insufficient transfer of decision-making power to local levels, lack of clarity in responsibilities, and broader factors such as the prevailing political context, and inadequate finances [Mills et al., 2002; Bossert and Beauvais, 2002; Conyers, 2007]. At sub-national and facility levels, practice is often influenced by 'decision space' or the degree of autonomy that key actors have in relation to key functional areas including finance, human resource, access rules, service organisation and governance rules [Bossert, 1998].

In Kenya, a Transitional Authority Commission was established as an arbiter in the process of deciding how decision space and flow of funds would be organized in the run up to, and in the three years post, the new government. Many of the details are still under intense discussion and debate. However in the constitution it states that at least 15% of the total federal government budget goes into a block grant for counties, allocated based on resource allocation criteria (RAC), with the 27 poorest counties receiving a further 3%. These funds are intended to be non-conditional, although the national government is negotiating for counties to account for them using IFMIS. There is a pledge to increase the size of the block grant up to 40% over 3 years, as more counties become functional, and there is currently a budget before parliament that is not yet approved for the block grant to be 31%. Given that the minimum 15% block grant is relatively small in real terms for counties, this will be supplemented by a series of conditional grants. Conditional grants will involve an agreement between national and county governments, whereby the central level sets conditions on use of grants. The national government will continue to set national policies and guidelines and provide technical support to counties.

National level interviewees highlighted 3 main options for HSSF funding under devolution:

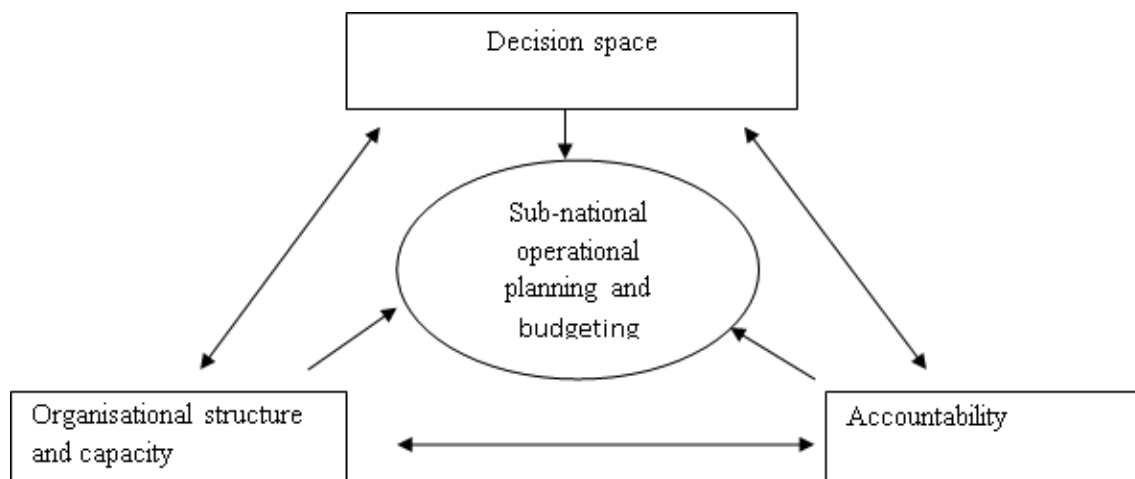
- (i) HSSF funds are **rolled into the block grant** received by counties which they have complete discretion over. However, this option was not favoured by any national level interviewees as it was felt important to maintain some control over the programme to ensure that resources were directed to the agreed priorities within health centres and dispensaries.
- (ii) HSSF funds continue to be **managed at a national level**, with funds flowing directly from national level to facility accounts, using existing reporting and monitoring systems. The MOH has written a petition to the Transitional Authority requesting that HSSF be kept at a national level, but has not yet heard the outcome of this request. Proponents of this view felt that this approach was essential to ensure continuity in the benefits of HSSF, avoid the challenges experienced prior to HSSF with flow of funds through district treasuries, and ensure appropriate fiduciary oversight.
- (iii) HSSF is considered a **conditional grant** to counties (some interviewees preferred the term "earmarked funds"). HSSF funds would be considered as county resources, but counties would only be able to access them if they agreed to spend them according to HSSF guidelines. Proponents felt that this approach was essential to develop capacity and ownership of HSSF at the county level, and to ensure full integration of HSSF into mainstream GOK procedures.

In reality, there are some important overlaps between these options. Under options (ii) and (iii) the national level would continue to lay down the terms and conditions under which HSSF funds are allocated and spent; it is possible for funds to flow directly from the national level to facilities even under the conditional grant; and there would likely be some involvement of counties in oversight of HSSF funds with both a national or conditional grant approach. Moreover, there were different views on the degree to which conditions should be specified under conditional grants, with some interviewees open to the idea that counties would decide within-county allocations across their facilities, while other interviewees felt this should continue to be specified from a national level. One interviewee argued that HSSF funds should be conditional on counties continuing to allocate health centres and dispensaries the same level of GOK resources that they had prior to devolution, and on

counties not building additional facilities – thus implying that the conditions would encompass expenditure by counties on funds from both HSSF and non-HSSF sources. It was also recognized that even where changes are implemented it may be necessary to have a transitional period.

Options for HSSF may therefore be better thought of as a continuum of choices, rather than distinct rival options. It is helpful to consider devolution in terms of three key spheres (Figure 10): (i) how much decision space there is at facility, county and national level in relation to different aspects of the intervention; (ii) how accountability is ensured at facility and county level; and (iii) the degree to which there are appropriate organizational structures and capacities in place to implement the programme at each level.

Figure 10: Conceptual framework of managerial decision space under devolution



Source: Adapted from Bossert and Mitchell, 2011

In developing the idea of a continuum of choices, and application of the above three key spheres, we suggest that the following steps are followed:

1) Agreement on decision-space for all key HSSF decisions

We have developed on the basis of our review and interviews, a list of potential key HSSF decisions moving forwards (Figure 11). We suggest that this list is reviewed, amended and agreed. There should then be, for each decision, a discussion on the ideal decision-making space at national and county level, and – where relevant - the facility level. We recommend that in each case, in line with the spirit of devolution, there is attention given to the potential of decreasing decision-space at the national level, and increasing decision-space at the county and – where relevant – facility levels. The latter should ultimately be aimed at ensuring a more responsive and accountable health system, and addressing some of the equity and efficiency concerns about the centralized system.

2) Incorporating accountability plans into HSSF

Once decision-making space for key decisions is agreed, more detailed accountability plans are needed. Accountability mechanisms typically require individuals or agencies to provide information about, and/or justification for, their action to other actors, along with the imposition of sanctions for failure to comply and/or engage in an appropriate action. Accountability mechanisms can be categorized as either external mechanisms (out to the public, communities or to other institutions or bodies), or as ‘internal’ or bureaucratic mechanisms, which are the institutional oversights, checks and balances internal to the public sector. In Figure 12 we suggest a series of accountability questions to ask in relation to key finance, human resource and service organization responsibilities

and actions. Once accountability is considered for each separate decision-space domain, it is essential to consider the total accounting responsibilities for each key actor. Specifically the interest is whether this total responsibility in terms of time is feasible amongst that actors' other responsibilities, whether he/she has appropriate training and support (discussed more below), and whether different forms of accountability potentially undermine each other (for example a large time requirement for internal reporting might undermine the potential for discussions with community representatives).

Figure 11: Key HSSF decisions

<p>Finances</p> <ul style="list-style-type: none"> - How much per county? - How much per facility? - What can money be spent on? - Is PBF included? What is the design? <p>Human Resource</p> <ul style="list-style-type: none"> - Are accountants employed? - How do they support facilities? <p>Access rules</p> <ul style="list-style-type: none"> - Can FBOs be included? - Which levels of facilities can be included? <p>Service organization</p> <ul style="list-style-type: none"> - Who decides how facility resources are spent? <p>Governance rules/accountability</p> <ul style="list-style-type: none"> - How should facilities account for resources and to whom? - What role and mechanisms for community participation? - If and how integrated in county and national treasury
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Figure 12: Accountability questions for all decisions

<p>Internal accountability</p> <ul style="list-style-type: none"> - What financial management and activity forms and other reporting are essential at each level, and who is responsible? Can forms be simplified? - Who receives and reviews those forms? By when? Can processes be simplified? - How are problems acted upon? What training, what support, what sanctions, and for whom? - How are external accountability mechanisms checked and supported in the system? <p>External accountability</p> <ul style="list-style-type: none"> - How are communities informed about HSSF? At facility, county and national level? What information is essential? How can information be kept clear and simple? - How can community members make suggestions and complaints? To whom? How do they get feedback? <p>Considering accountability requirements together:</p> <ul style="list-style-type: none"> - What are the total accounting responsibilities for each key actor? - How might different forms of accountability undermine each other? And undermine other actor responsibilities?
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3) Organisational structure, capacity and political realities

Once decision-making space and accountability lines are agreed, there is a need to consider whether the appropriate structures, training, and capacities are in place for key actors to be able to implement their responsibilities effectively. Where systems are not currently in place or adequate, realistic assessments of what steps are needed, and when these can be achieved, would assist in developing a roll-out plan for the wider HSSF plan.

In so doing, political realities should also be considered. The potential responses of County Governors to devolution options are not known, and in particular whether they will be willing to accept strict conditions of HSSF funds that pass through their hands. It was also noted that continuing funding on a "per facility" basis could contravene the RAC as it would channel relatively

more funds to counties with high numbers of facilities. An alternative would be to distribute funds on the basis of the RAC, but still earmarked for HSSF, which would mean that facilities in counties with a high facility density would receive fewer funds per facility.

6.3 Performance Based Financing

There is a growing interest in PBF approaches as a means to align the incentives of health workers and health providers with public health goals, although rigorous evidence on the effectiveness of PBF in improving health care and health, particularly in low- and middle-income countries, is limited. PBF is thought to be a powerful tool for increasing key targeted outputs. However, potential challenges include the validity of quality indicators; targets skewing activities and performance in a way that is detrimental to more complex services; increased administrative and monitoring burdens and costs; and gaming [Witter 2012; Eldridge and Palmer, 2009]. There are also risks that facilities are heavily incentivised to go with central as opposed to facility priorities. Furthermore, there may be increased inequity in access and quality through the best resourced facilities and individuals being better able to meet targets and better able to manoeuvre themselves in a complex intervention.

In KEMRI interviews there were mixed views on PBF in HSSF. Some expressed strong views that PBF is essential to ensure that quality and quantity in services are incentivised and maintained - “you can’t dole out money on averages”. Others expressed concerns that performance is impacted upon by many factors that cannot be adequately measured, and that poorly functioning facilities or facilities in more deprived areas would be disadvantaged and unable to improve under PBF. Some also objected to the receipt of personal incentive payments by individual health workers, and argued that the burden on DHMTs of verification was excessive. There was a general concern that more fundamental challenges with HSSF already being experienced (see section 6.1) needed to be resolved before adding on an additional complication of PBF, and that any PBF initiative would need to consider contextual differences, and ensure populations do not suffer as a result of individual under-performance.

Rewards should be in extra funding or other forms and funds should never be cut from a facility because it is the people who suffer (KEMRI Study, DHMT member).

Several interviewees in favour of scaling up PBF reported that the Samburu pilot findings are rather mixed and difficult to interpret, and one highlighted that there are significant challenges with the limited, low quality data available. The nationwide scale-up of PBF would therefore benefit from lessons from the current expansion of the pilot to three counties, with evaluations tracking the range of potential challenges with PBF from both the literature and local key stakeholders, as described above. Also of potential interest would be results from an endline survey of facilities involved in the Samburu pilot and a qualitative exploration of the intervention from the perspective of health workers and DHMTs. A problem is that donor and government requirements might need faster consideration of what is currently an internationally favoured approach. Should this be the case, it will be important to ensure that careful and in-depth monitoring and evaluation mechanisms document both positive and especially perverse outcomes, and that there is a rapid response process in place to amend the design and implementation of HSSF as necessary.

6.4 Social Accountability

Regarding the Social Accountability pilot, it was clear in KEMRI interviews that the future of SAc in HSSF is undecided, with manuals and training plans on hold as broader HSSF and health system plans unfold under devolution. Whilst some successes were acknowledged, concerns were raised in national level interviews about the pilot, including necessity and scale-ability:

- One interviewee felt that social accountability mechanisms were already adequately incorporated into HSSF through the HFMCs, and that creating new systems would be counter-

productive; and that additional initiatives should focus on strengthening the social services department which already has a remit to strengthen community awareness of health issues.

- Another national level interviewee felt that although some transparency elements of the pilot (for example showing basic data on income and expenditure) should be possible to implement on a large scale, others (such as complaints redress and community participation through community score cards) require greater interaction and facilitation and are therefore more challenging. This interviewee felt that decisions regarding SAc need to be pragmatic and focused on elements that do not need significant external support.

6.5 Incorporating Faith Based Organisations

The programme has reportedly been exploring specific modalities for contracting FBOs under HSSF for some time, including considering the option of using performance-based financing. National interviews suggested that the most recent discussions were in October 2012, but that the memorandum of understanding that was being developed was not supported by everybody, leading to an impasse. One interviewee felt that this issue could 'break the basket' (ie stop donors from pooling their funds), because opinions vary so strongly on this; not least the PBF elements discussed in the previous section.

6.6 User fee removal

Removal of user fees and free maternal care is a key contextual factor influencing HSSF implementation and impact going forwards. Experience from many countries shows, however, that user fee removal is far from a simple 'stroke of the pen' exercise [Gilson & McIntyre, 2005]. Without due attention to the process of fee removal, the expected utilization and affordability benefits may not be achieved, and existing problems may even be exacerbated. User fees restrict utilisation of health services and create a large pool of unmet need, and so removal of fees often leads to substantial increases in utilisation. Without increased funding for health care, these increases can compromise quality of care through drug shortages and difficulties for staff in managing increased workloads [Gilson & McIntyre, 2005]. This experience suggests the need to ensure there are resources allocated to facilities to compensate for loss of user fees in advance. Failure to do so risks one or more of the following: 1) user fee removal not being implemented in facilities; 2) user fee removal being implemented with negative implications for quality and utilisation, and for HSSF funds achieving their goals. All interviewees agreed that HSSF was potentially a good platform to channel those additional funds, with one arguing that it was a particularly appropriate channel given the community involvement it entailed in decision making. It was also highlighted that in the context of user fee removal it was particularly important to ensure that HSSF funds were not disrupted during the transitions of devolution as otherwise facilities could be left without both user fee revenue and HSSF funds at the same time – with critical implications for their operations. Determining the level of compensation for facilities is likely to be challenging, as compensating facilities according to current revenues will favour facilities with richer catchment areas and further compromise adherence to the RAC.

7. Conclusion

Overall, there appear to have been impressive achievements with HSSF in terms of ensuring that funds reach facilities, are spent appropriately, and are overseen and used in a way that strengthens community involvement (HMFCs). There are also indications that this has strengthened service delivery and quality of care. Although there is less experience in dispensaries than in health centres, national level interviews suggest that positive impacts have been particularly impressive in these smaller facilities. The introduction of a devolved health care system in Kenya over the next few months and years provides a huge opportunity for offering more responsive and accountable health

services, but also presents some concerns and dilemmas for the design and implementation of HSSF in future. Our review and interviews highlight some areas that require particular attention, including some aspects of financial management (such as delays in receiving funds and AIEs, complexity of documentation for in-charges, and the importance of practical and facility-based support and supervision for in-charges and HFMCs), the design of HSSF under devolution, and if, when and how to incorporate PBF, additional social accountability mechanisms and FBOs. Also critical to consider is the potential impact of user fee removal on HSSF. Finally, it is recognized that HSSF alone will not be able to ensure high quality service delivery. Other crucial influences on facilities and HSSF include drug supplies, and availability of qualified clinical staff.

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Appendix A Terms of Reference for the KEMRI Study

Review of HSSF Implementation and Experience

Background

The Health Sector Services Fund (HSSF) is an innovative financing mechanism within the Ministry of Public Health and Sanitation (MOPHS) that channels financial resources directly to public sector health centres and dispensaries. Under HSSF, the Government and development partners (DANIDA and the World Bank) contribute to a central fund, which is used to credit funds directly into an approved facility's bank account.

The overall goal of the fund is to generate sufficient resources for providing adequate curative, as well as preventive and promotive services at level 1, 2, and 3 of the current health sector pyramid as it is defined in the Kenya Essential Package for Health, and according to the respective Annual Operational Plans, and to account for the resources in an efficient and transparent manner.

The specific objectives of the HSSF are to: Support and empower rural communities to take charge of improving their own health; Support capacity building in management of Health Facilities in the country; Provide financial resources for medical supplies, rehabilitation and equipment of health facilities; Provide grants for strengthening of the faith-based health facilities through their respective secretariats; and improve the quality of service delivery at the health facilities.

HSSF was initially piloted in Coast Province starting in 2005, and has now been rolled out nationally in phases. From October 2010, funds were credited to public health centres, with further roll out to dispensaries from October 2011. HSSF funds are to cover the facility's operational expenses, according to financial guidelines set out by the Ministry for Public Health and Sanitation (MOPHS). At the facility level, HSSF funds are managed by a Health Facility Committee (HFC) that includes community members from the facility catchment area. District Health Management Teams also receive funds to cover supervisory expenses in relation to HSSF, and County Based Accountants provide support and oversight of facility financial management. Other key aspects of HSSF implementation have included training of MOPHS and HFC personnel, and a communications campaign.

The DANIDA Kenya office will be undertaking a Sector Review in May 2013, when HSSF will be considered. It is therefore timely to review the process of HSSF rollout and experiences with HSSF implementation, in order to assist with planning for future support to HSSF and the health sector more generally.

Objectives

- 1) To describe the process of HSSF implementation to date, including facilities covered, funds disbursed, and activities undertaken.
- 2) To review evidence on the experience with HSSF implementation
- 3) To identify key issues including deveolution for consideration in future planning around HSSF

Scope of work

The following activities will be undertaken:

1. Document review of policy documents, administrative reports, and studies related to HSSF. This is expected to include:
 - Disbursement records from HSSF Secretariat
 - Description of HSSF process prepared by the World Bank
 - HSSF communications materials
 - Integrated Fiduciary Risk Assessment reports
 - Consultancy study on potential strategies for integrating HSSF with Government of Kenya financial systems
 - Aide Memoires from Joint Assessment of Kenya Health Sector Support Programme
 - Reports on implementation and evaluation of performance based financing pilot in Samburu
2. Extraction and review of data collected at health centres, district and national level under the “HSSF Process Tracking in Health Centres” study conducted by KEMRI-Wellcome Trust in 2012
3. Interviews with key stakeholders in MOPHS, DANIDA and World Bank, to obtain updates on HSSF implementation and experience.
4. Consider impact of devolution on HSSF and provide recommendations for re-designing HSSF implementation at county level.

Outputs

Outputs will comprise:

1. Full Report
2. Executive Summary
3. Power point slide deck of key findings

The suggested structure for the full report is as follows:

1. Executive Summary
2. Background to HSSF
3. Description of the process of HSSF implementation
4. Experiences of HSSF implementation, summarizing findings from:
 - 4.1. HSSF Process Tracking in Health Centres study
 - 4.2. Integrated Fiduciary Risk Assessment reports
 - 4.3. Consultancy study on potential strategies for integrating HSSF with Government of Kenya financial systems
 - 4.4. Aide Memoires from Joint Assessment of Kenya Health Sector Support Programme

4.5. Evaluation of performance based financing pilot in Samburu

5. Discussion and identification of key issues for consideration in future HSSF planning

Team composition

The review will be conducted by a team from the KEMRI-Wellcome Trust Research Programme, which has considerable experience in studying the delivery of health care services and community accountability in general, and specifically the implementation of HSSF. The team has conducted an evaluation of the HSSF pilot in Coast Province in 2007-8; a nationally representative survey of health facilities to serve as a baseline for nationwide HSSF rollout in 2010; and a qualitative process tracking study of experiences of HSSF implementation in Health Centres in 2012. Relevant publications from the team are listed below.

The team will comprise:

Sassy Molyneux, PhD (Team lead) – Dr Molyneux has been based at the KEMRI-Wellcome Trust Research Programme since 1995. She is a senior social scientist, with her current key research interests including community accountability in health delivery and health research, research ethics, and household access to and use of health facilities. She has an extensive publication record and considerable experience engaging in dialogue with local and national policy makers.

Catherine Goodman, PhD – Dr. Goodman is a Senior Lecturer in Health Economics and Policy at the London School of Hygiene and Tropical Medicine, and is affiliated to the KEMRI-Wellcome Trust Research Programme. Her key research interests include access and delivery of primary health care and the financing and management of health care facilities, and she has published widely in these fields.

Benjamin Tsofa, MPH – Dr. Tsofa has considerable experience in both the operational and research fields within Kenya. He worked as both a medical superintendent and a District Medical Officer of Health, before joining KEMRI-Wellcome Trust as their MoH/Policy Liaison Officer. Dr. Tsofa has particular expertise in the study of the planning and management of health services, including decentralisation.

Evelyn Waweru, BSc Nursing – Ms Waweru participated in the 2010 baseline health facility survey for HSSF and led the data collection for the process tracking study in 2012. She has experience in quantitative and qualitative data collection, analysis and report writing.

Mary Nyikuri, MA – Ms Nyikuri is a social scientist with experience in both research and programme implementation. She has worked on community engagement, and monitoring and evaluation of projects using both quantitative and qualitative methods of inquiry.

Timeline

First draft of full report and executive summary to be submitted by Monday 15th April 2013

Final draft of full report, executive summary and slide deck to be submitted by 30th April 2013

Contact Staff at DANIDA

Rhodah Njuguna, Programme Officer/Team Leader Health Programme, rhonju@um.dk

Appendix B Summary of documents reviewed

Document, author and year	<u>Type of document/ methodological approach</u> -Reports reviewed	No of districts and facilities included in interview/observation based studies	Formal interviews conducted
Aide Memoire for Joint DANIDA and World Bank Implementation Support Mission to the Kenya Health Sector Support Program 1-9 December, 2011	<u>Summary of mission</u> - Administrative data from MoH - In depth fiduciary review report by the internal audit of MoH - Facility records	<u>2 districts (Dec 2011)</u> Kisumu West: DHMT, 1 health centre, 1 dispensary Kiambu West: 1 dispensary, 2 health centres	None mentioned
Aide Memoire (as above) for 12-20 February, 2013	<u>Summary of mission</u> - Administrative data of Ministries of health - IIFRA reports - PBF and Social Accountability pilot reports - Information from HSSF secretariat	<u>3 districts (no dates)</u> Kakamega central: 1 dispensary, 3 health centres, KEMSA regional depot Kajiado South: 1 dispensary, 3 health centres Borabu: DHMT, 1 dispensary, 2 health centres	None mentioned
Bellows, B., et al. Performance-Based Financing (PBF) Pilot in Samburu County, Kenya. (Nov 2012)	<u>Presentation of monitoring data</u> - DHIS outputs - Facility records	<u>2 districts (April to August 2012)</u> Samburu Central: 26 facilities Samburu North: 11 facilities	None mentioned
Family Care International. Direct Facility Funding and quality of care (2012)	<u>Report of empirical research findings</u> - Interviews	2 districts: Kitui and Nakuru (June 2012) 599 exit interviews were conducted in 30 randomly selected health centres receiving direct facility funding 6 health centres (three from each county)	Exit interviews Focus group discussions with HFMC members in 6 health centres Two FGDs with DHMTs

Document, author and year	<u>Type of document/ methodological approach</u> -Reports reviewed	No of districts and facilities included in interview/observation based studies	Formal interviews conducted
IFFRA reports	<u>Audits conducted quarterly</u>		
KEMRI –WT HSSF interim process tracking report (April, 2013)	<u>Draft report of empirical research findings</u> - Interviews - Income & expenditure records at facilities and districts - Document checklist	<u>10 health centres in 5 districts (April-May 2012)</u> Nairobi central: DHMT, 2 health centres Murang’a South: DHMT, 2 health centres Kajiado: DHMT, 2 health centres Kisumu East: DHMT, 2 health centres Hamisi: DHMT, 2 health centres	139 Interviews with National, district, facility managers, HFC members and users of services at facilities
MOPHS Integration of HSSF FMIS into GOK country systems (March 2013)	<u>Review of current financial systems and proposal for future</u>	<u>3 Sites:</u> - Embu - Kilifi - Nairobi (details of dates and facilities not provided)	Interviewees from MOPHS Headquarters, selected departments at the Treasury, HSSF and SWAp Secretariats, Provincial Director of Public Health and Sanitation, DHMTs, District Treasury, HFMCs, and Ministry of Education
World Bank – Case study of HSSF Gandham, NV Ramana et al., (January 2013)	<u>Review</u> - Administrative data from MOH - Pilot report on Performance based financing - KEMRI-WT HSSF interim process tracking report	None	None mentioned

Appendix C Breakdown of major categories of facility expenditure:

Contractual & Temporary Employees Wages: Contractual employees, Casual labor/wages

Maintenance: Maintenance of equipment, offices and furniture and vehicles

Other medical supplies (excluding drugs): Dressings and non-pharmaceuticals; Chemicals & Industrial Gases; Lab Materials, Supplies & Small Equipment; staff and patients Uniforms and Clothing; Bedding & Linen

Other operating costs: Publishing & Printing Services; Subscriptions to Newspapers, Awareness and Publicity Campaigns; Catering Services, Conferences & Seminars; Supplies & Accessories for Computers & Printers; Sanitary & Cleaning Materials, bank charges.

Food and rations: for patients

Travelling, Accommodation & Subsistence Allowances: Travel costs, Accommodation, Daily Subsistence Allowance, Sundry Items (airport tax and taxis, etc), Shipment of Personal & Household Effects

General office supplies: stationery,

Utilities includes: Water & Sewerage Charges; Electricity;

Fuel and lubricants: Refined Fuels & Lubricants for Transport; Refined Fuels & Lubricants for Production; Transport Costs & Charges (freight, loading/unloading, clearing & shipping charges);

Boards and committees: HFC meeting allowances

Other expenses: Construction and civil works; Purchase of Vehicles, Furniture and equipment; training and workshops; Consultants' Services and Audits.

Medical drugs: essential drugs

Communication and internet charges: airtime, purchase of sim card

Appendix D The calculation of performance adjustments under performance based financing

On the basis of each facility's output and quality data, the basic payment for each facility for the quarter was calculated. The PBF payments made to each facility depend directly on:

- Delivery of six key services recognized as critical for achievement of reproductive and child health MDGs, measured by output indicators
- Measuring clinical quality factors related to best practice for services under each output indicator.
- Achievement of cross-cutting quality indicators to ensure quality of all services delivered at the facility and to minimize any distortionary effects of the non-comprehensive output-based PBF design.

The output-based component of the performance payment was based on the six key services. Each indicator was assigned a unit price (Table 1). For each service, the payment reflects the unit price and number of units delivered, with an adjustment to reflect the relevant clinical quality criteria.

Service	Detailed Definition of Output Indicator	Unit Price (KSH)	Data Source
Pregnant women receiving at least 4 ANC visits	Number of antenatal clients who have visited the antenatal clinic at least four (4) times for the current pregnancy.	200	Daily Activity (ANC) Register MOH 512 for levels 2– 6
Deliveries conducted by skilled health attendants in health facilities	Number of deliveries conducted by skilled health staff in a health facility.	900	Register MOH 333 for levels 2 – 6
Women of reproductive age receiving family planning commodities	Number of women of reproductive age 15 -49 years who have received family planning commodities	200	Daily Activity (FP) Register MOH 512 for levels 2– 6
Children <1year fully immunized	Number of children under 1 year (<1 year) who have received all the national antigens or completed the immunisation schedule against preventable diseases.	50	Immunisation Register MOH 510 for levels 2 – 6
Children <5years attending CWC for growth monitoring services	Number of children under five years (<5 years) who are attending Child Welfare Clinic (CWC) for the first time (New visit) for growth monitoring	50	Child Welfare Clinic (CWC Register) MOH 511 for levels 2 – 6
Population counselled and tested for HIV (VCT, PITC,DTC, HBCT,	Number of people who are tested and counselled for HIV in currently available counselling and testing services	50	Register MOH 711 for levels 2-6

PMTCT)			
<i>Notes:</i> ANC: Antenatal care; MOH: Ministry of Health; FP: Family planning; CWC: Child welfare clinic; VCT: Voluntary counselling and testing; PITC: Provider-initiated testing and counselling; DTC: Diagnostic testing and counselling; HBCT: Home-based counselling and testing; PMTCT: Prevention of mother-to-child transmission (of HIV).			

The formula for the output-based payment, for each service was adjusted to the clinical quality as follows:

$$[\text{Output numbers}] \times [\text{Clinical quality score}] \times [\text{Unit cost}] = \text{PBF payment for each service}$$

The overall output formula is summed from Table 2 and multiplied by the cross cutting quality score (calculated as a percentage) in Table 3:

Table 2: Parameters for calculating performance adjustment payments				
Service	Monthly Output (N)	Clinical Quality Factor, Q (%)	Price, P (KSH)	Monthly total for service
Antenatal care	N1	Q1	P1	$N1 * Q1 * P1$
Delivery	N2	Q2	P2	$N2 * Q2 * P2$
Family planning	N3	Q3	P3	$N3 * Q3 * P3$
Under 1 immunization	N4	Q4	P4	$N4 * Q4 * P4$
Under 5 CWC	N5	Q5	P5	$N5 * Q5 * P5$
HTC	N6	Q6	P6	$N6 * Q6 * P6$
Monthly Total Output-Based Payment: (OBP1)				Sum of above figures
<i>Notes:</i> CWC: Child welfare clinic; HTC: HIV testing and counselling; KSH: Kenya shilling.				

The total payment for each quarter is the sum of the quality-adjusted output-based payment for each month, subtracting any penalties arising.

Table 3: Final payment calculated from cross cutting quality (CCQ)			
Quarter	Output-Based Payment per Quarter	CCQ	Quality-Adjusted Payment
1	OBP1	CCQ1	$OBP1 * CCQ1$
Quarterly Total Quality-Adjusted Payment:			

Appendix E Social accountability indicators

Increasing Transparency and Interactive Information Sharing

- 1.1 Are main elements of Service Charter prominently and publicly displayed in Kiswahili & relevant vernacular language?
- 1.2 Information on funds received & expenditure posted on the board
- 1.3 Information on working hours, services provided and outreach activities planned posted on the board
- 1.4 Information on services provided & outreach services provided shared in the Health Baraza
- 1.5 Does the Facility display approved GoK user fee charges?
- 1.6 List of HFMC members displayed
- 1.7 Information on last supplies received from KEMSA is displayed & updated

Complaints Handling Mechanism

- 2.1 Complaint box (es) available
- 2.2 Toll free mobile phone number for complaints displayed
- 2.3 Toll-free number used (data supported)
- 2.4 Names of persons assigned to receive grievances at community level posted on notice board
- 2.5 Complaint register maintained and actions logged and reports checked by DHMT?
- 2.6 Evidence of action taken against confirmed complaint

Increasing Community Participation

- 3.1 1 Health baraza held?
- 3.2 AOP includes key priorities identified by health baraza
- 3.3 First scorecard completed and results made public?
- 3.4 Community feedback is reflected in the planning of health outreach activities
- 3.5 Does the Facility Management Committee hold regular (Quarterly) meetings?
- 3.6 Are minutes of such meetings available at facility level and availed to the DHMTs?