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This policy brief is based on a research report "The Implementation and Effects of Direct Facility Funding in Kenya's Health Centres and Dispensaries" The report is available on the CREHS website, [www.crehs.lshtm.ac.uk](http://www.crehs.lshtm.ac.uk)

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## INTRODUCTION

Following evidence that user fees present a barrier to accessing health services, especially for poor and vulnerable people, there has been increasing pressure for user fees to be reduced or abolished.

In 2004, Kenya removed high and variable user fees for health facilities, replacing them with flat rate fees of KES 10 (approximately US\$ .15) at dispensaries, and KES 20 (approximately US\$ .30) at health centres.

However, there have been concerns that these lower fees limit the money available to health facilities for daily expenditures. To avoid shortfalls in funding, the Kenyan Government and the Danish International Development Agency (DANIDA) have piloted an innovative scheme of directly funding health facilities in Coast Province.

With direct facility funding (DFF), health facilities receive money directly into their bank account. The funds are managed by a health facility committee (HFC) consisting of community members and the health worker in charge of the facility. The items on which DFF can be used include: salaries, water and electricity supplies, communications, staff travel costs, office and general supplies and routine maintenance of vehicles, equipment and buildings.

## RESEARCH QUESTION

The research evaluates the DFF pilot scheme in the Kenyan Coast Province. It aims to explore the implementation and perceived impact of DFF at health centres and dispensaries.

The focus is on these types of facilities because they are most used by poor rural households, and direct funding mechanisms have not been used before at this level.

## METHODS USED

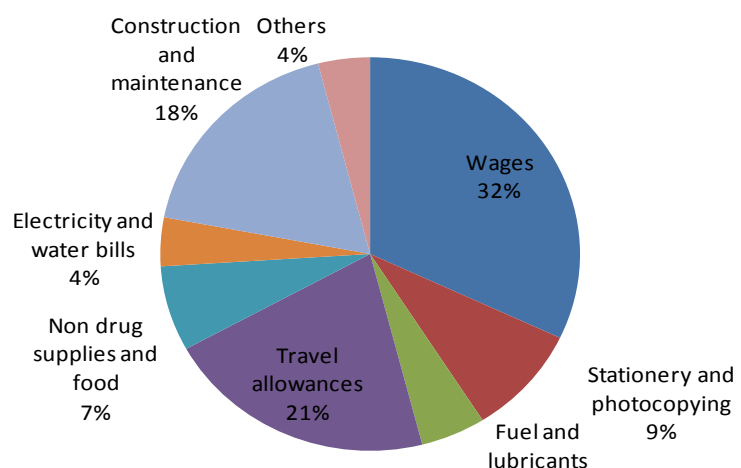
- Data collection in 2 districts within Coast Province - Kwale and Tana River
- Structured survey at 30 health centres and dispensaries including interviews with the facility in-charge, record reviews and exit interviews (total 292 exit interviews)
- In depth interviews in a sub-set of 12 facilities - Interviews with the facility in-charge and health facility committee members
- In depth interviews with managers and stakeholders

## KEY FINDINGS

### DFF INCOME AND EXPENDITURE

- The average annual income from DFF was US\$4,720 and US\$2,802 per health centre and dispensary, respectively. This accounted for an average of 56% of the facilities' annual income (the remainder being from user fees, insecticide treated nets, income generating activities and donations).
- However, DFF represented a small fraction of the total costs, being equivalent to only 2% and 13% of the recurrent costs at health centres and dispensaries, respectively.
- The main categories of DFF expenditure were wages, travel allowances and construction and maintenance.

DFF expenditure in health centres and dispensaries



## IMPACT OF DIRECT FACILITY FUNDING

### Achievements

- DFF procedures were well established, HFCs met regularly, and accounting procedures were broadly followed.
- DFF was perceived to have a highly positive impact through funding support staff; outreach activities for immunization and antenatal care; building renovations; patient referrals and increasing the activity of HFCs.
- Employment of extra support staff and payment of staff incentives in the form of allowances, has reportedly improved health worker motivation, the safety and cleanliness of facilities, and led to reduced waiting time.
- District managers, health facility staff and HFC members felt that DFF has had a positive impact on utilisation and quality of care.

### Challenges

- Problems with DFF implementation include: inadequate training for members of the HFC, especially in the area of financial management, and a lack of relevant guidelines at the facility level.
- The operation of the HFC has improved since the introduction of DFF. However, community members are largely not aware of DFF funds, the identity of their HFC representatives or official user fee policies.
- Despite the DFF funds, many facilities are not adhering to the user fee policy. They continue to levy charges above the prescribed fees and fail to exempt groups of patients such as children under 5 years old.



An example of DFF funded maintenance: fixing a gutter to collect rainwater

## POLICY RECOMMENDATIONS

### For the Kenyan Government

- The positive findings from this provincial-level pilot indicate that scaling up of the current DFF system is warranted. The amount of funds could be increased because facilities currently show good absorptive capacity and HFC and health workers have appropriate ideas about how additional resources could be used.
- To replicate successes in Coast province, other provinces may require additional support such as strengthened drug delivery systems, infrastructure and supervision for facility managers.
- DFF implementation and operations should be strengthened. This will require comprehensive training for HFC members and health workers, and a clear manual which covers the HFC roles, procedures for elections, and key elements of DFF operations including rules on how funds can be used.
- The policy on user fees should be clarified with a document from the Ministry of Health that lists all applicable fees, and this should be displayed at all health facilities. Adherence to the user fee policy should be made a key part of DFF training, and the receipt of DFF money should be conditional on user fees adherence.

### For policy makers in other countries and development partners involved in advising on health financing policy

- Direct funding offers an opportunity to compensate health facilities for loss of user fee revenue where these are removed or reduced. Although user fee removal can improve equity, it also removes an important source of discretionary funds which, though small in absolute amount, can have an important impact on facility performance.
- Direct funding can be implemented successfully at health centres and dispensaries, but requires an effective mechanism for transferring funds to the lower levels of the health system. In many contexts, this means circumventing the bureaucracy and corruption problems that have been identified in public expenditure tracking surveys.
- Performance based financing mechanisms are being increasingly discussed, but have potential disadvantages including administrative burden, fraud and perverse incentives. This study indicates that even without performance targets, an increase in funding at peripheral level may have a positive impact on utilization and quality.

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