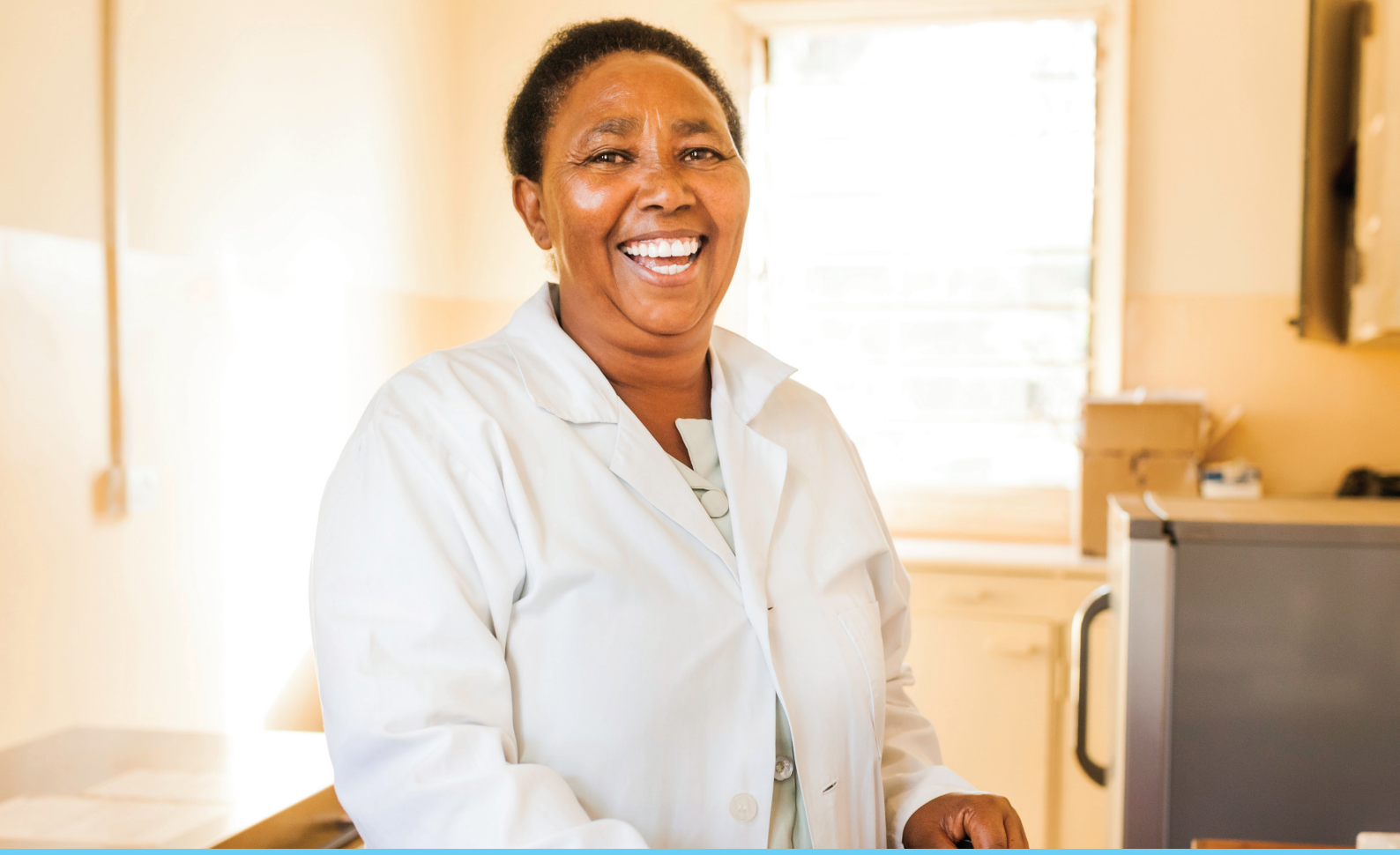

An assessment of cross border health facility's financial and institutional capacity: Kenya, Rwanda, Tanzania and Uganda

2017

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral treatment
CB-HIPP	Cross Border Health Integrated Partnerships Project
EAC	East African Community
FIF	Facility Improvement Fund
HCT	HIV Counselling and Treatment
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HSSF	Health Sector Services Fund
KEMSA	Kenya Medical Supplies Agency
MIP	Medical Insurance Provider
NHIF	National Hospital Insurance Fund
NMS	National Medical Stores
PEPFAR	President's Emergency Plan for AIDS Relief
SHOPS	Sustainable Health Outcomes for the Private Sector
SP	Strategic Plan
USAID	U.S. Agency for International Development

INTRODUCTION

The Cross-Border Health Integrated Partnership Project (CB-HIPP) is a regional project funded by the USAID Kenya and East Africa Mission and is implemented by a team of partners led by FHI 360. Project implementation dates are September 1, 2014 to August 31, 2019. It is designed to extend quality integrated health services in strategic land and wet cross-border areas and other transport corridor sites in East, Central and Southern Africa.

One of the key result areas for CB-HIPP is to identify alternative health financing models and implement and test the models to strengthen the long-term sustainability of networked health and HIV/AIDS service delivery. Abt Associates, a partner within the CB-HIPP consortium, is tasked with strengthening the sustainability of health facilities operating in cross-border areas and transport corridor hotspots.

To inform the development of a strategy for strengthening the health facilities, Abt conducted a study to evaluate the financial sustainability of the health facilities currently operating in the CB-HIPP priority cross border areas. The purpose of the study was to identify the institutional capacity and financial sustainability of the health facilities at cross border areas, including the financial management systems currently in place. The study was conducted at 45 facilities in cross border areas in Kenya, Rwanda, Tanzania and Uganda between 2015 and 2016.

The study used an adaptation of a tool developed by Abt called the ProCapacity Index (ProCap). For the purposes of this study, only the financial strength pillar in the index was employed. Abt used data collected from interviews with Facility In-Charges and Financial Managers to compute scores with the modified ProCap. These scores can be used to benchmark facilities and will provide a baseline to gauge progress of technical assistance provided to facilities.

This report summarizes the findings from the facility capacity assessment conducted in Kenya, Uganda, Rwanda and Tanzania. The report begins with a summary of the methodology used for the assessment followed by a section detailing the assessment findings and sustainability scores computed for the facilities, and concludes with recommendations for technical assistance.

METHODOLOGY

Location and Target Facilities

The study was conducted at public and private health facilities in land and water cross-border locations in East Africa, including Kenya, Uganda, Rwanda and Tanzania. The cross border study areas included in this report are: Busia, Kenya/Uganda; Malaba, Kenya/Uganda; Port Victoria/Sio Port, Kenya; and Majanji, Uganda; Taveta, Kenya /Holili, Tanzania; Katuna, Uganda /Gatuna, Rwanda; and Kasensero, Uganda; . The target sites were public and private health facilities in cross-border locations (defined as within five kilometers of a border crossing post or ten kilometers along the major highway) in East Africa that can provide priority services[1] to key and vulnerable populations. Table 1 below shows the distribution of the facilities by level and ownership. A list of all facilities visited is included in Annex 1.

Table 1. Distribution of facilities by level and ownership

Country	Cross Border Site	Public Facilities			Private Facilities		
		Hospital	Health Centre	Dispensary	Hospital	Health Centre	Clinic
Kenya	Busia	2	1	1	1	1	3
	Malaba	1	0	1	0	2	0
	Port Victoria/ Sio Port	2	1	3	0	0	0
	Taveta	1	1	1	0	0	4
	Cross Border Site	Public Facilities			Private Facilities		
		Hospital	Health Centre III	Health Centre II	Hospital	Health Centre	Clinic
Uganda	Busia	0	0	1	1	3	0
	Malaba	0	1	0	1	1	0
	Majanji	0	1	2	0	0	0
	Kasensero	0	0	1	0	0	0
	Katuna	0	1	0	0	1	1
	Cross Border Site	Public Facilities			Private Facilities		
		Hospital	Health Centre	Dispensary	Hospital	Health Centre	Clinic/ Dispensary
Tanzania	Holili	0	0	1	0	1	1
	Cross Border Site	Public Facilities			Private Facilities		
		Hospital	Health Centre	Health Post/ Dispensary	Hospital	Health Centre	Clinic
Rwanda	Gatuna	0	2	0	0	0	0

The sample frame was defined from a mapping study of health facilities along transport corridors in the East African Community (EAC) conducted under the ROADS II project in the EAC partner states. The study included most of the public and private facilities at these cross- border locations. As much as was feasible, the study aimed to ensure representation of Hospitals, Health Centers, Clinics and Dispensaries within the defined radius of the border crossing site in the above mentioned locations. However in Uganda, all public facilities in the selected cross-border locations were Health Centers II and III and therefore higher level public facilities are excluded. Similarly, in Tanzania and Rwanda, both public and private facilities within the defined radius were health centres or dispensaries, and therefore hospitals were excluded. In Rwanda, there were no private facilities within the defined radius.

1 The CB-HIPP priority services are adopted from the East African Community (EAC) Guidance document for minimum package for HIV and AIDS and other health services along the EAC Transport Corridors 2015

Study Tools

The study used an adaptation of a tool developed by Abt Associates called the Pro-Cap Index. Pro-Cap was developed under the USAID-funded Sustainable Health Outcomes for the Private Sector (SHOPS) project, and measures the long-term capacity and sustainability of a non-governmental organization or health facility. Using predefined indicators across three pillars of sustainability, the tool assesses the organization's capacity to grow and endure. For the purposes of this project, only the financial strength pillar in the index was employed. The modified tool used interviews with Facility In-Charges and Financial Managers to ask questions pertaining to the strategy for the health facility, facility's financial and service delivery systems.

Data Collection

Data was collected by research assistants from Kenya and Uganda, while a firm was contracted for data collection in Rwanda and Tanzania. The research assistants and the contracted firm were experienced with financial data collection at health facilities, and were trained in the tool by Abt Associates staff prior to the commencement of data collection. Data collectors in each location were overseen by an experienced team lead, and reported daily to Abt Associates staff.

Data was collected through facility assessments and in-person interviews with key personnel at the facilities using the interview guides developed by Abt Associates. The researchers also collected financial data from the health facilities' manual and automated systems using paper-based tools.

Data Analysis

The research assistants entered data into excel spreadsheets. The results were aggregated using both qualitative and quantitative summary statistics to identify the overarching themes and issues impacting the sustainability of the health facilities. A score sheet was developed based on the Pro-Cap Index in order to systematically score the financial sustainability of the facilities.

FACILITY FINANCIAL AND INSTITUTIONAL CAPACITY FINDINGS

The study team visited 25 facilities in Kenya, 2 in Rwanda, 3 in Tanzania and 15 in Uganda. , . However due to the poor quality of data available from two sites in Busia, Kenya, the data from these two sites were not included in the analysis and the findings presented below.

The findings are presented by country, facility level and ownership in three main sections:

- Institutional capacity
- Financial sustainability
- Service delivery

Institutional Capacity

Under this section, findings on strategic planning; knowledge of competition; presence of finance manuals, financial controls, and audits; and coordination and flow of financial information are presented.

Strategic Planning

Overall, few facilities had strategic plans as shown in Table 2 below. Higher level facilities were more likely to have a strategic plan than lower level facilities, and more private than public facilities had a strategic plan in Uganda.

Table 2. Challenges and best practices encountered in implementation of strategic plans (SP)

Facility Type	Total Facilities	Facilities with SP	Challenges encountered	Best practices encountered
Kenya	23	4		
Public	14	2	Lack of funds to implement the SP SP and implementation teams not aligned	
Private	9	2	Staff not sensitized on SP	Department heads meet regularly to track progress
Uganda	15	5		
Public	7	1	Lack of funds to implement the SP	
Private	8	4	Overspending budgets Poor staff retention	Ensuring strategic plans are well resourced
Tanzania	3			
Public	1	1	Strategic plan sent to Central MOH and not received back	
Private	2	1	Competing priorities	
Rwanda	2			
Public	2	1	Lack of funding	Realign plan to changing context

Knowledge of Competition

In Kenya, Uganda and Tanzania, public facilities identified the private sector as their primary competitors. Uganda public facilities also listed drug shops as competitors while two public and three public facilities in Kenya and Uganda respectively, located in remote areas, had no competition. One facility in Rwanda had no competitor. The public facilities in Kenya, Uganda and Tanzania identified the competitors' strengths as offering a wide range of services perceived as good quality, few commodity stock outs, shorter waiting times, more services and accreditation to NHIF and other insurers. The primary weakness of the competitors in Uganda and Kenya was the user fees they charged. In Rwanda, the competitors for the public facilities were facilities across the border in Uganda that did not charge user fees, and facilities that had sufficient donors, enabling a waiver of maternity user fees. In Rwanda other public facilities were also competitors if they had more modern infrastructure.

Private facilities in Kenya and Uganda listed public facilities, other private facilities and unlicensed practitioners or 'quacks' as their competitors. One private facility in Tanzania had no competitors. The strength of public facilities in Kenya, Uganda and Tanzania was stated as lack of user fees, but they were considered crowded and impersonal. Unlicensed practitioners had low fees but were viewed as unsanitary and dangerous. Strengths of other private facilities included their accreditation to insurers which diversified their revenue, and in Uganda, some private facilities receive subsidies from government through grants, free commodities and seconded staff. One private facility in Tanzania noted that it had no competitors because other private proprietors were too impatient to make a profit, and as a result went under quickly.

Finance Manuals

Public facilities in both Kenya and Uganda have public accounting and finance manuals developed at national level; however, none of the Ugandan facilities had any present at the facility. In Kenya, four public facilities had manuals present either from HSSF or Facility Improvement Fund (FIF) guidelines. However there were concerns that these manuals had not been recently updated and compliance was weak. In Rwanda, manuals were issued from the District Health Management office, but the manuals in use were outdated (from 2009 and 2011). The public facility in Tanzania did not have manuals.

In Kenya and Tanzania, none of the private facilities had finance manuals, while in Uganda half of the facilities had finance manuals and compliance was enforced.

Best practices identified from existing finance manuals included the following:

- Instituting a finance committee to provide oversight of the finance department and compliance.
- Penalties for non-compliance.
- Recording all cash received for services and reconciling cash books daily.
- Banking all cash received.
- Ensuring no expenditure is incurred from cash received before banking.
- Multiple levels of authorization for payments to avoid embezzlement.

Auditing and Financial Controls

In Kenya and Uganda, public facilities had internal audits by district or county finance teams. In Kenya, six of the facilities reported audits while in Uganda three reported audits and regular supportive supervision by the district accountant.
Public facilities in Rwanda and Tanzania did not have audits. Among the private facilities, three facilities in Kenya and four in Uganda had annual external audits. Neither of the Tanzanian private facilities had audits.

"From the districts, funds are sent or wired to the facility account, the health unit management committee acknowledges its receipts and accountability which is then sent to the district finance auditor for approval or otherwise."

Facility Manager Health Centre II, Uganda

For financial controls, most facilities relied on physical controls such as locked rooms, guards, and burglar bars as theft deterrents. Public facilities in Kenya minimized exposure to cash as per their cash management guidelines with daily banking, controlled access rights to finances, and automated revenue collection to reduce incidences of fraud and embezzlement. Public facilities in Uganda did not collect user fees and only had access to limited operational funds. Expenditure was approved by the health unit management committee and the district accountant. Public facilities in Rwanda had written procedures manuals, while in Tanzania the facilities followed unwritten District procedures.

Private facilities in Kenya, Uganda and Tanzania relied on locking assets, minimizing the number of people handling cash and regular banking.

Across both public and private facilities inventory management was poor. Only seven facilities had a record of their inventory and only one of these facilities had updated their inventories in the current financial year.

Fraud

Table 3 below gives details of facilities that experienced fraud, the type of fraud and the action taken by management. None of the Ugandan or Tanzanian public facilities reported cases of fraud. Kenyan facilities, particularly private facilities, reported the highest incidences of fraud. One Rwandan facility had a major incidence of fraud, with the funds to pay the District for drugs embezzled. As a result, the District has placed strict restrictions on the facility, requiring a payment of RWF 100,000 monthly plus upfront payment for drugs before commodities are released.

The four private facilities in Kenya, one facility in Uganda and one facility in Tanzania that reported incidences of fraud lacked finance manuals and controls.

Table 3. Types of fraud experienced by facilities and action taken by management

Country/ Facility Type	Total Facilities	Facilities reporting fraud	Types of fraud	Action taken
Kenya	**23**	**7**		
Public	14	3	Extorting money from patients for services Spending before banking Revenue diversion Pilfering of drugs from pharmacy to sell to patients	Disciplinary action taken against culprits Automation of registration of clients and cash collection
Private	9	4	Stealing by staff Under-recording cash received	Culprits were dismissed Banking of all cash received
Uganda	**15**	**2**		
Public	7	0		
Private	8	2	Under-recording cash received	Daily banking Audits Recruiting new staff Senior staff approving all payments
Tanzania	**3**			
Public	1	0		
Private	2	1	Minor fraud	Ensure all sensitive matters pass through owner
Rwanda	**2**			
Public	2	1	Embezzlement of funds for drugs	Facility is paying District Hospital Pharmacy back on monthly basis; has to pay for drugs up front

Coordination and Information Flow

Ugandan public facilities reported that coordination and financial information flow was efficient. Rwandan public facilities likewise reported efficient procedures, with templates provided for reporting through the District. Reporting procedures for Tanzanian public facilities were light, with only patient numbers and revenue collected required to be reported.

In Kenya, public dispensaries and health centers do not charge user fees and rely on central disbursements through the Health Sector Services Fund (HSSF). The HSSF was reported to be well organized and financial flows and reporting efficient. However Kenyan public hospitals in Busia, Malaba and Port Victoria/Sio Port sites expressed dissatisfaction with current fiscal management post-devolution. Prior to devolution in 2013, public hospitals had financial autonomy and decision making. Currently they encountered challenges with bureaucracy, shortages of funds, and inability to maintain a bank account hampering their ability to manage the facility. The facilities reported that they provided timely information on their monthly expenditures, but the county delayed monetary allocations.

> *"The coordination is efficient since there are clear channels of coordination between the county and the health facilities."*
>
> **Public Dispensary Facility Manager, Kenya**

Most private facilities in Uganda, Kenya and Tanzania were owned by sole proprietors and did not report on their finances to external agencies. Three facilities reported financial information to regional offices and they stated that the processes were well documented and efficient.

Summary

Strategic plans are important because they set organizational priorities and align all staff to focus on achievement of identified priorities. Planning and tracking progress of performance should be encouraged for all healthcare organizations. This study found that facilities are aware of their competitors' strengths and weaknesses and how they compare with their own organizations. There are concerns of a level playing field among private facilities and ensuring that private facilities are treated equitably. The public sector can benefit from extending subsidies to more private facilities to expand access to priority services through the private sector.

Public facilities had finance manuals and audit procedures that were largely adhered to. Lack of compliance led to incidences of fraud, particularly among public hospitals in Kenya that collect user fees. Most private facilities lacked finance manuals and controls which exposed their organizations to increased risk of fraud, as evidenced by the high incidences reported. Inventory management was a consistent gap across all facilities. As health facilities have expensive infrastructure and equipment, inventory management is an area that requires strengthening to ensure better management and control of facilities' assets.

There was dissatisfaction reported by public hospitals in Kenya post-devolution with the reduced autonomy of finances and decision making, while lower level facilities in Kenya, Rwanda and Uganda were content with current coordination structures.

Financial Sustainability

This section presents findings on self-reported sustainability, sources of revenue, provision of credit and accreditation for insurance, presence of financial statements, income and expenditure statements and balance sheets.

Sustainability

These findings are based on self-reported financial sustainability. Table 4 below gives a sample of the responses given on self-reported sustainability, and best practices encountered to improve facility sustainability.

Public facilities in Kenya, Uganda, Rwanda and Tanzania provide subsidized services and do not aim to attain cost recovery. The public facilities surveyed in Uganda were all Health Centre II and III and do not charge user fees. In Kenya, user fees were abolished at public dispensaries and health centers in 2013. Kenyan hospitals charge user fees but these are highly subsidized and do not reflect the actual cost of service delivery. Revenue generation from user fees was only 5-12 percent of operational costs in Kenyan hospitals but the Rwanda facilities reported a small surplus in the most recent financial year. During the assessment, all the Kenyan public facilities reported that they were not financially sustainable, while in Uganda, four of seven stated they were not sustainable. Devolution was cited as the main reason Kenyan public facilities were not sustainable. In Rwanda public facilities relied upon internally generated funds from user fees and government support, but reported that they were unable to cover their costs. Likewise, in Tanzania user fees provided a significant income source, but not enough to cover regular operating costs or facility upgrades.

Among private facilities half of the Ugandan private facilities stated they were financially sustainable while in Kenya seven of the nine were financially sustainable. In Tanzania both private facilities reported that they were financially sustainable, but were not able to invest in expanding their facilities to provide more services. Delays in patient and insurance payments contributed to lower revenue than expected. In total, 68% of all private facilities recorded a profit/surplus in the 2014/15 financial year.

Table 4. Reasons for self-reported sustainability and best practices encountered to improve sustainability

Country/ Facility Type	Total Facilities	Financially sustainable?		Reasons they are not sustainable	Best practices encountered
		Yes	No		
Kenya	**23**	**7**	**16**		
Public	14	0	14	County government budget allocations insufficient Budget allocations received late, making planning difficult Unpaid suppliers Budgets are based on the official catchment area and do not take into consideration volume of services provided	Farming to earn revenue and reduce expenditure on food supplies Outsourcing non-core functions such as security and cleaning, reducing management time for these functions and the cost of their delivery Expanding services to attract more clients Non-medical sources of revenue such as leasing space, selling water, selling food waste and incinerator services External funding from donors to subsidize services
Private	9	7	2	Low number of clients Clients unable to pay user fees resulting in waivers	Purchasing the property the clinic stands on to eliminate rental costs Professional staff to attract clients to the facility Accreditation with insurance to reduce reliance on out-of-pocket financing and diversify revenue sources External funding from donors to subsidize services Partnerships with the public sector for supply of free medical commodities Accreditation to a franchise for training and access to low cost commodities
Uganda	**15**	**8**	**7**		
Public	7	4	3	Budgetary allocations insufficient for service delivery	Sufficient budgetary allocations that cover all the costs External funding from donors to subsidize services[2]

2 Though donor reliance can make a facility unsustainable, donors can be a short-term strategy to receive subsidized commodities to expand services offered and increase utilization for other non-subsidized services.

Private	8	4	4	Rely on expensive credit such as overdrafts from banks to meet running costs[3] Cannot meet financial obligations such as rent and salaries Reliance on donors	Surpluses used to expand infrastructure for service delivery Diversifying medical services to expand revenue streams Partnerships with the public sector for grants, supply of free medical commodities and seconded staff Operating nursing schools that supply staff to the facility and earn revenue from fees Non-medical sources of revenue such as leasing space Outsourcing non-core functions Accreditation with insurance to reduce reliance on out-of-pocket financing and diversify revenue sources External funding from donors to subsidize services
Tanzania	**3**				
Public	1	0	1		Request funds from government to cover capital investments
Private	2	2	0	Sustainable, but issues with insurance delays and patients not paying	
Rwanda	**2**				
Public	2	0	2	Most patients are unable to pay user fees and access on credit	Uses revenue generated from user fees to support facility Advocating with MOH for specific resource gaps (such as ambulance services)

Revenue

Salaries, drugs and medical commodities constitute 89-99 percent of public facilities' operational costs, which are met through county or district budgetary allocations from county and/or national tax revenue. Salaries are paid centrally by the county government in Kenya or national government in Rwanda, Tanzania and Uganda. Drugs and medical commodities are supplied by the central medical stores with hospitals assigned drawing rights while lower level dispensaries and health centers operate on a push system in Kenya, Tanzania and Uganda. In Rwanda, the facilities procure their medical commodities from their internally generated revenue. As most operational costs are provided for, public facilities in all countries have restrictions on user fees charged. Uganda health centers II and III and Kenya dispensaries and health centers do not charge user fees. The Kenyan public hospitals, Rwanda and Tanzania public facilities charge subsidized user fees and collect payments from public and private insurance. In Kenya, collections are submitted to county governments who decide on the allocation of resources across different county priorities. This means that revenue collected by hospitals was not necessarily reallocated back to the hospitals, causing discontent among managers. As such, user fee revenue had significantly declined between 2012/13 and 2014/15 by as much as 50 percent in some facilities. Other sources of revenue were donor funding, primarily for HIV and AIDS services, and operating revolving drug funds.

3 Though credit from financial institutions can be beneficial for the organization, particularly for further investment, credit within the EAC can be very expensive with few products available for health businesses. In addition borrowing to meet running expenses on a regular basis is unadvisable.

In Rwanda and Tanzania, public facilities are allowed to collect user fees and apply them directly to their facilities' expenditures. The facilities also accepted insurance, but reported difficulties with delayed payments from the companies. Donor funding was used for discrete services, such as HIV service delivery, but were also used more broadly. In Rwanda public facilities were not allowed to engage directly with donors, but had to wait for the government to channel the donors to them. Rwandan facilities also received a proportion of their funding through performance-based funding.

Non-medical resource generating strategies used by public facilities included:

- Renting incinerators to other hospitals,
- Selling waste food to vendors,
- Farming activities such as chicken and cattle rearing and crop farming,
- Tapping the Constituency Development Fund in Kenya by lobbying a Member of Parliament,
- Waiving the ultrasound fee to attract more patients to their maternity services and thereby increase their maternity reimbursement from the government free maternity program in Kenya,
- Writing to partners requesting support.

Private facilities in Kenya, Tanzania and Uganda charge user fees and received payments from public and private insurance. Some faith based facilities received additional funding for large capital investments from the church, and in Uganda faith based facilities also received grants from government. Similarly, they pursued the public sector and donors for funding of free drugs and commodities, and joined franchises where they accessed subsidized commodities and medical supplies which they sold to generate additional revenue.

Non-medical resource generating strategies by private facilities included:

- Farming
- Expanding services to attract customers
- Training nurses
- Lobbying the president and politicians for additional funds
- Partnering with local churches

Provision of Credit and Accreditation to Insurance

Ugandan public facilities and Kenyan public dispensaries and health centers surveyed did not provide credit, nor were they accredited to insurance companies. Five of the six Kenyan public hospitals surveyed provided credit to individuals and schools, and were accredited to the public insurer, the National Hospital Insurance Fund (NHIF). Only one of the six hospitals was accredited to a private insurance company. Public facilities in Rwanda and Tanzania provided credit to private patients and worked with insurance agencies.

Private facilities in Kenya and Uganda offered credit to individuals, schools and development centers, private companies such as banks clearing and forwarding companies, women's groups, non-government organizations, fisheries and orphanages. They were accredited to multiple health insurance companies, medical insurance providers (MIP), health maintenance organizations (HMO) and the NHIF for Kenyan facilities as shown in Table 3 below. Both private facilities in Tanzania took insurance, and one also provided credit to nearby schools.

Table 5. List of companies where private facilities were accredited

Kenya	Uganda
Co-operative Insurance Company Ltd. APA Insurance Company Jubilee Insurance Company Britam General Insurance Company Gateway Insurance Company National Hospital Insurance Fund AON Health Insurance Brokers Ltd (MIP) Xplico Insurance Company Madison Insurance Company AAR Insurance Kenya Alexander Forbes Risk and Insurance Brokers Ltd. (MIP) Mercantile Insurance Company	IAA Healthcare (HMO) UAP Insurance Uganda Ltd. Sanlam General Insurance (U) Ltd International Health Network (HMO) International Air Ambulance Case MedCare (HMO) Liberty Blue St Catherine Clinic Ltd. (HMO) Kadic Health Foundation Ltd. (HMO) Jubilee Insurance Company
Tanzania	**Rwanda**
NHIF- National Health Insurance Fund ICHF- Integrated Community Health Fund AAR Insurance Tanzania Strategis Insurance Tanzania Ltd. Kilimanjaro National Park parastatal Tanzania Electricity Supply Commission PharmAccess	Mutuelle de Sante Rwanda Health Insurance Fund (RAMA) Military Medical Insurance (MMI) Société Rwandaise d'Assurances (SORAS) MEDIPLAN SAHAM Insurance Company

Financial Statements, Income Statements and Balance Sheets

At the majority of public and private facilities, the survey team used a considerable amount of time reviewing multiple documents and books including receipts, cash books, invoices, and payment vouchers to develop and reconcile income and expenditure reports. Records were generally inconsistent and incomplete, and information was often stored in different locations.

All public facilities produced financial statements but varied widely in the type of financial statements they produced. The most commonly used were annual budgets, monthly or quarterly income and expenditure reports, and cash books. Balance sheets were not available in Kenya, Uganda or Tanzania. In Rwanda standardized reporting templates and requirements meant that public facilities completed monthly income statements, balance sheets, and budgets. Ten public facilities in Kenya had the information required for data collectors to develop income statements for the past three years. In Uganda, the information for the past three years was not readily available. One public facility in Tanzania and one in Rwanda had sufficient information available to develop income statements for the past three years.

Among private facilities, two in Kenya, one in Uganda and one in Tanzania had no financial statements. The other facilities had varied types of statements and only three in Kenya and three in Uganda had audited financial accounts with monthly or quarterly income and expenditure statements, cash books, and budgets available at the time of review. Three facilities in Kenya and one in Uganda had balance sheets. Seven private facilities in Kenya, one Ugandan, and one in Tanzania had income and expenditure data for the past three years available.

Summary

Financial management varied across level and type of facilities. Finance manuals were largely absent and financial statements were developed haphazardly. These areas require strengthening to improve management and planning for these cross-border facilities.

Lack of financial autonomy at public hospitals has affected service delivery. A major issue raised was under-budgeting due to budgeting based on the catchment area, rather than services provided. This predominantly affects facilities serving mobile populations and other nationals. Other issues included delays in receiving allocations and delayed payments to suppliers leading to stock-outs.

Service Delivery

This section reviews the tracking of facility performance, delivery of HIV services, and membership in franchises.

Tracking of Performance

All facilities track service delivery or workload indicators, most commonly through government registers at public facilities and at all private facilities receiving free drugs, commodities or government grants. Submitting reports is generally a requirement to accessing subsidies, and services associated with this incentive, such as vaccination, HIV testing and treatment, family planning, and tuberculosis treatment, had better reporting. Private facilities that did not use government registers used their own registers, mostly linked to cash received, to track services offered. In almost all facilities, service delivery indicators were not complete and had months missing. Due to lack of data, it was not possible to compare growth of client visits over a period of three years. In Rwanda, facilities underwent a more thorough performance review on a quarterly basis as a requirement for performance-based funding. Issues such as hygiene, equipment maintenance, staff timeliness, report submission timeliness and completeness of records are assessed by the District Hospitals.

Other performance indicators tracked by a few public facilities include patient exit interviews, internal quality reviews, and performance appraisals, while private facilities tracked income received.

Management Information System

Most facilities in all countries relied on paper based systems for both service delivery/workload reporting and financial reporting. Three public and two private facilities in Kenya had automated systems while five private facilities in Uganda had automated systems. Rwanda and Tanzania did not have any automated systems.

HIV Services

The facilities offered services to various vulnerable and key populations including fisher folk, vulnerable young women, transport workers, people living with HIV, men having sex with men, sex workers, and people who inject drugs.

All Kenyan public and private facilities offer HIV Counselling and Testing (HCT) and receive their test kits from Kenya Medical Supplies Agency (KEMSA) directly or through sub-county officers. All public facilities provided Antiretroviral Treatment (ART) and received ART drugs from KEMSA. Only three private facilities in Kenya offered ART and they received the ART drugs from KEMSA through sub-county officers.

In Uganda, only one public facility did not offer HCT while all the other public and private facilities did. Public facilities and two private facilities sourced their test kits from the National Medical Stores (NMS), while the others sourced from private alternatives and therefore charged for HCT services. Four public and three private facilities offered ART and all but one sourced the drugs from NMS while one was sourced through a USAID funded project. It should be noted that Health Centre II facilities in Uganda are not expected to offer ART and therefore refer positive cases to the nearest facility.

In Rwanda, medication, equipment and supplies are provided by the MOH for HIV services. Other donors, working through the MOH, provide funding for specific initiatives, such as services for sex workers.

In Tanzania, government hospitals receive funds from the MOH for HIV services. In one private facility the government provided support for PMTCT, and the facility was working with Elizabeth Glazer Foundation for sustainability of the initiative. The other private facility did not provide HIV services.

Private facilities in all countries expressed their interest in partnerships to offer ART services.

Membership in Franchises

Public facilities in all four countries were not members of social franchises, but expressed their interest in joining a franchise.

Five private facilities in Kenya and six in Uganda were members of a franchise or network. Only one

private facility in Tanzania was a member of a referral network. Non-members were interested in joining a franchise. Franchises listed in Kenya were Amua, Tunza, Child Family Wellness, and Goldstar while those in Uganda were Marie Stopes, Pace, Malaria Consortium, and Star E. The faith-based facilities were members of their faith-based networks in their respective countries.

The benefits noted from membership in a franchise were access to commodities, staff training, community outreach support, bulk procurement, and association with a quality brand.

Summary

Facilities tracked their performance mostly through paper-based systems and submitted their service delivery indicators to the public system as a requirement to accessing free commodities. However this was better managed for certain services such as vaccination, HIV testing and treatment, family planning, and tuberculosis treatment, for which incentives were associated. There is room for improvement in tracking progress at facility level and institutionalizing reporting to the county or district health management to ensure all facilities are captured in planning and reporting.

For HIV services, Kenya has worked to ensure supply of HCT test kits in the private sector and can do more to expand ART services through providing training, drugs and commodities at private sector providers interested in providing services. This will increase reach of ART services. In Tanzania and Uganda more can be done to expand public supply of HCT test kits and ART to ensure more affordable access to these services within the private sector.

FACILITY SUSTAINABILITY SCORE

Facilities were assigned qualitative scores to assist with assessing the overall strength of the facilities' financial and institutional capacity. The scoring system was based upon the criteria presented in Table 7, with a total possible score of 78.

Table 8 summarizes the scores for each country by ownership. In Uganda, government facilities had an average score of 27.4, with a range of 24 to 35. Private facilities in Uganda had an average score of 39.9, with a range of 21 to 60. In Kenya, government facilities had an average score of 35.9 (range 22-60) while private facilities had a score of 39.4 (range 22-54). Rwanda facilities scored highest with an average score of 58.5 (range 56-61). Tanzania facilities had an average score of 36 (range 34-38).

Table 9 displays the individual scores for each criterion, for all surveyed facilities. Facility names have been coded in the results presented. Table 6 below provides the facility codes and abbreviations used in this report.

Table 6. Facility codes and abbreviations used in the report

Country	Ownership	Level	Facility code
Kenya	Public	Dispensary (Disp)	PuD1, PuD2, PuD3, PuD4, PuD5
		Health Centre (HC)	PuHC1, PuHC2, PuHC3
		Hospital (Hosp)	PuH1, PuH2, PuH3, PuH4, PuH5, PuH6
	Private	Dispensary (Disp)	PrD1, PrD2, PrD3, PrD4, PrD5, PrD6, PrD7
		Health Centre (HC)	PrHC1
		Hospital (Hosp)	PrH1
Rwanda	Public	Health Centre (HC)	PuHC1, PuHC2
Tanzania	Public	Dispensary (Disp)	PuD
	Private	Dispensary (Disp)	PrD
		Health Centre (HC)	PrHC
Uganda	Public	Health Centre II (HCII)	PuHCII1, PuHCII2, PuHCII3, PuHCII4
		Health Centre III (HC III)	PuHCIII1, PuHCIII2, PuHCIII3
	Private	Dispensary (Disp)	PrD1, PrD2, PrD3
		Health Centre (HC)	PrHC1, PrHC2, PrHC3
		Hospital (Hosp)	PrH1, PrH2

Table 7. Facility scoring criteria

Performance Area	None-0	Low-1	Mid-2	High-3	Relative Importance (Scale of 1 to 3)
Institutional Sustainability					
Strategic Planning	No strategic plan	Have a strategic plan-not implementing	Have a strategic plan-having trouble implementing	Have strategic plan-implementing	1*
Finance manuals	No finance manual	Unwritten system or outdated manual (in view of finance manager)	Accounting manual	Updated finance manual for all financial transactions	3
External Audits	No internal or external audit	Internal audit	External Audit from a finance manager outside facility (or auditor unnamed)	External Audit from a company	1
Controls	No controls	Physical controls--locking, guards, burglar bars	Cash management/ banking controls, inventory books, receipt books, supervisory visits	Procedure manuals, automated systems, inventory tracking systems	1
Financial Sustainability					
Financial Sustainability	Don't know whether sustainable	Not sustainable	Sustainable-able to meet expenses	Sustainable-able to make profit/ investments back in company	1*
Profit/Loss (from income statements)	Not enough information	Making a loss in most recent year	Breaking even or trending towards sustainability (Private facilities)	Making a profit in most recent year (Private facilities) or breaking even (Public facilities)	3
Revenue		Single source	Single Source but trying for others	Multiple sources	2
Credit and Insurance	No credit or insurance	Provide credit to individuals or businesses	Provide credit to individuals or businesses. Accredited with one insurance company	Provide credit to individuals or businesses. Accredited with more than one insurance company	3

Financial Statements	No financial statements produced	Cash flow, budget (or only one of income or expenditure statement) or bank reconciliation	Income and expenditure statements, budget	Cash flow, income statement, balance sheet, budget	3
Timing of Financial Statements	Never	Too frequent (daily) or too infrequent (annually)	Quarterly	Monthly	2
Income Statements and Balance Sheets	No records	Data available to identify one year income	Data available to develop two to three years of income and expense statements	Data available to develop three year revenue and expense statements, balance sheet	3
Service Delivery					
Tracking Performance	Not tracking performance	Workload or patient tracking, revenue	Performance indicators, performance appraisals, internal quality review	Workload targets, performance appraisals, internal quality review, performance appraisals, patient exit interviews	2
Management Information System	No system		Unnamed system	Using an electronic system	1

**Low relative score due to subjective nature of assessment*

Table 8. Aggregated Facility Scores

Type of Facility	Strategic Plan	Finance Manual	Audits	Controls	Financial Sustain-ability	Profit/ Loss	Revenue	Credit or Insurance	Financial Statements	Timing of Financial Statements	Income Statement and Balance Sheet	Performance Tracking	Management Information Sys	TOTAL SCORE	PERCENT
Uganda															
Government	0.4	0.0	1.0	2.0	1.3	1.3	1.6	0.1	1.7	2.0	1.0	1.1	0.9	27.4	31%
Private	1.1	1.4	1.1	1.5	1.8	2.1	2.1	1.4	1.5	1.8	1.1	1.1	1.9	39.9	59%
Kenya															
Government	0.3	0.6	0.9	1.6	0.9	1.0	2.3	1.0	1.7	2.8	1.8	1.6	0.6	35.9	46%
Private	0.6	0.0	0.6	2.1	2.0	2.4	2.2	2.0	1.2	2.0	2.0	1.1	0.6	39.4	51%
Tanzania															
Government	0	1	0	3	1	1	3	3	1	3	0	1	0	36	46%
Private	1	0	0	2	2	2.5	3	3	0.5	1.5	0	2	0	36	46%
Rwanda															
Government	1.5	2	0	3	1	3	3	3	3	3	1	2	1	58.5	75%

Table 9. Detailed Facility Scores

Facility Name	Type of Facility	Strategic Plan	Finance Manual	Audits	Controls	Financial Sustainability	Profit/ Loss	Revenue	Credit or Insurance	Financial Statements	Timing of Financial Statements	Income Statement and Balance Sheet	Perform-ance Tracking	Management Information Sys	TOTAL SCORE	PERCENT
Uganda																
PuHCIII1	Government	3	0	2	2	1	1	2	1	2	2	1	2	0	**35**	**45%**
PuHCII3	Government	0	0	1	2	1	1	2	0	1	2	1	1	3	**26**	**33%**
PuHCII2	Government	0	0	0	2	2	1	1	0	1	2	1	1	3	**24**	**31%**
PuHCIII2	Government	0	0	0	2	2	1	1	0	2	2	1	2	0	**26**	**33%**
PuHCII1	Government	0	0	2	2	1	3	1	0	2	2	1	1	0	**31**	**40%**
PuHCIII3	Government	0	0	2	2	1	1	1	0	2	2	1	1	0	**25**	**32%**
PuHCII4	Government	0	0	0	2	1	1	3	0	2	2	1	0	0	**25**	**32%**
PrHC2	Private	2	3	3	2	3	3	3	3	1	3	1	1	3	**60**	**77%**
PrH1	Private	0	2	2	2	2	2	3	1	3	2	2	1	3	**51**	**65%**
PrH2	Private	0	3	2	2	1	3	3	3	1	1	1	2	3	**53**	**68%**
PrD2	Private	2	2	2	3	1	1	2	0	3	3	1	1	3	**44**	**56%**
PrHC3	Private	3	0	0	1	3	3	2	1	0	0	1	1	0	**28**	**36%**
PrD3	Private	0	1	0	1	2	1	2	1	2	3	1	1	0	**33**	**42%**
PrD1	Private	0	0	0	1	1	3	1	1	1	1	1	1	3	**29**	**37%**
PrHC1	Private	2	0	0	0	1	1	1	1	1	1	1	1	0	**21**	**27%**
Kenya																
PuH6	Government	0	3	3	3	0	1	3	2	3	3	2	3	3	**60**	**77%**
PuH2	Government	0	1	0	3	1	1	3	3	2	3	1	1	3	**45**	**58%**
PuH4	Government	2	0	0	2	1	1	2	2	1	3	2	3	0	**39**	**50%**
PuH1	Government	0	0	1	3	1	1	3	2	3	3	1	1	0	**40**	**51%**
PuH3	Government	0	0	0	1	1	1	2	3	2	3	2	1	0	**38**	**49%**
PuH5	Government	2	1	0	1	1	1	2	0	1	3	2	1	0	**31**	**40%**
PuD1	Government	0	0	0	1	1	1	2	2	2	3	2	1	0	**35**	**45%**

PuHC1	Government	0	2	2	3	1	1	1	0	1	2	2	2	0	**34**	**44%**
PuHC2	Government	0	0	3	1	1	1	2	0	3	3	1	2	0	**34**	**44%**
PuD4	Government	0	0	2	1	1	1	3	0	2	3	2	1	0	**33**	**42%**
PuHC3	Government	0	0	0	1	1	1	3	0	1	3	2	3	0	**32**	**41%**
PuD2	Government	0	1	0	1	1	1	3	0	1	3	2	1	0	**31**	**40%**
PuD5	Government	0	0	0	1	1	1	2	0	1	3	2	1	2	**28**	**36%**
PuD3	Government	0	0	2	1	1	1	1	0	1	1	2	1	0	**22**	**28%**
PrH1	Private	3	0	2	2	2	2	3	3	2	3	2	2	2	**54**	**69%**
PrHC1	Private	0	0	1	3	3	1	3	3	1	2	3	1	3	**46**	**59%**
PrD2	Private	0	0	0	2	2	3	3	1	1	3	3	1	0	**42**	**54%**
PrD1	Private	0	0	0	3	3	3	3	3	1	0	2	1	0	**41**	**53%**
PrD6	Private	0	0	0	2	2	3	2	1	2	3	2	1	0	**40**	**51%**
PrD3	Private	2	0	0	2	1	3	2	2	1	3	1	1	0	**38**	**49%**
PrD7	Private	0	0	2	2	2	3	1	3	1	1	2	1	0	**39**	**50%**
PrD4	Private	0	0	0	2	1	1	2	1	2	3	2	1	0	**33**	**42%**
PrD5	Private	0	0	0	1	2	3	1	1	0	0	1	1	0	**22**	**28%**
Tanzania																
PuD	Government	0	1	0	3	1	1	3	3	1	3	0	1	0	**36**	**46%**
PrD	Private	0	0	0	2	2	2	3	3	1	3	0	2	0	**38**	**49%**
PrHC	Private	2	0	0	2	2	3	3	3	0	0	0	2	0	**34**	**44%**
Rwanda																
PuHC2	Government	0	2	0	3	1	3	3	3	3	3	1	2	0	**56**	**72%**
PuHC1	Government	3	2	0	3	1	3	3	3	3	3	1	2	2	**61**	**78%**

DISCUSSION AND RECOMMENDATIONS

This study found that the majority of both public and private health facilities in the cross-border regions of Uganda, Kenya, Tanzania and Rwanda have room for considerable improvement in financial management and institutional capacity for increasing sustainability of the facilities.

The assessment found that private facilities in all countries are dependent upon user fees. The revenue from insurance and credit are marginal, and the majority do not have additional funding streams. Small public facilities in Uganda and Kenya are not authorized to collect user fees and instead rely upon budgetary allocations and reimbursements from the government. Kenyan public hospitals are allowed to collect user fees although they are highly subsidized. Rwanda and Tanzania's public facilities are allowed to collect revenue at all levels. Revenue generated in public facilities surveyed in Kenya and Tanzania was insufficient to meet the expenses.

Most public facilities in all four countries had financial systems in place. The systems are largely working, although only six public facilities had documented manuals in place. The private facilities had a wide range of financial systems—a few facilities had excellent systems, but for most, the systems were severely lacking. Likewise, financial and inventory controls were extremely weak in the majority of facilities, leaving the facilities vulnerable to theft and fraud.

In addition, most facilities engaged in limited strategic planning, performance tracking, and revenue diversification. Facilities cited the lack of funding to pursue strategic plans, and most chose to track their workload as their only performance metric.

These results show that there are a number of interventions which may be beneficial to improving the sustainability of these facilities. Capacity building opportunities for the facilities fall into three main areas:

1. Strengthening Financial Management Capacity:
    a. Regular financial statements, including cash flow, income statement, balance sheet and budget. Train facility-in-charges/owners on how to use the data for decision-making and improving performance
    b. Financial and inventory control systems, including procedure manuals, automated systems, and inventory tracking systems as appropriate.
    c. Finance manual development and updating for private facilities, and documenting procedures for public facilities.
    d. Internal and external audit functions
2. Funding Diversification:
    a. Establishing a system for credit for individuals or companies
    b. Accreditation as providers for insurance schemes
    c. Proposal writing and business development
    d. Alternative non-clinical revenue generation, such as small enterprises (Note that Uganda public facilities must obtain permission from the government prior to launching alternative funding generation strategies)
3. Strategic Planning and Performance Tracking:
    a. Realistic strategic plan development, including risk mitigation
    b. Performance monitoring metrics that goes beyond workload to provide opportunities to address quality and increase demand for services.

In addition to the above capacity-building opportunities, the vast majority of facilities expressed interest in joining franchises and linking to opportunities for HIV support. The facilities' desire to join such systems presents an opportunity for CB-HIPP to systematically strengthen the capacity of these facilities to deliver services for key and vulnerable populations.

CONCLUSION

This assessment shows that there are a number of opportunities to strengthen the sustainability of health facilities providing services in the cross-border regions of Kenya, Uganda, Tanzania and Rwanda. As the gaps identified are significant and wide-reaching, CB-HIPP may consider developing standardized training packages for some of the most common weaknesses, such as financial management and diversifying resource generation. In addition, the score sheet presented in Table 8 may be used to identify the individual needs of health facilities for targeted capacity-building. A franchise model for key and vulnerable populations service delivery and linking facilities to funding opportunities for HIV service delivery may be an efficient and effective method to increase the facilities' capacity to deliver services for priority populations.

Although many of the challenges facing the facilities, particularly government facilities, are beyond the scope of this project, this study has shown that there are a number of opportunities for health facilities to strengthen their sustainability within the larger policy context.

ANNEX 1: LIST OF FACILITIES SURVEYED

Facility Name	Type of Facility
Kenya	
Taveta Sub-County Hospital (SCH)	Public
Busia County Referral Hospital	Public
Port Victoria SCH	Public
Alupe SCH	Public
Kocholya SCH	Public
Sio Port SCH	Public
Ageng'a Dispensary	Public
Busia Trailer Park	Public
Matayos HC	Public
Ndilidau Dispensary	Public
Kitobo Dispensary	Public
Rukala HC	Public
Budalangi Dispensary	Public
Malaba Dispensary	Public
Busembe Dispensary	Public
Tanaka Nursing Home	Private
Pesi Medical Centre	Private
Divine Mercy Eldoro Dispensary	Private
Apex Medical Centre	Private
Equator Medical Clinic	Private
Your Family CFW Clinic	Private
FAO Hope Medical Centre	Private
Meditech Clinic	Private
Mubwekas Clinic	Private
Ndongo Purple Clinic	Private
Rwanda	
Mulindi Health Centre	Public
Rubaya Health Centre	Public
Tanzania	
Holili Dispensary	Public
AMEC Medical Centre	Private
Faraja Medical Centre	Private

Uganda	
Busitema Health Centre (HC) III	Public
Mundindi HC II	Public
Majanji HC II	Public
Kamuganguzi HC III	Public
Kasensero HC II	Public
Malaba Town Council HC III	Public
Sikuda HC II	Public
Nabululo Medical Centre	Private
Dabani Hospital	Private
St. Anthony's Hospital	Private
Katuna North Star Clinic	Private
Veana Medical Center And Lab	Private
Trust Medical Center	Private
Besesuda Medical Centre	Private
Africure International Medical Center	Private