Responses to Questions
Webinar: Improving Planning and Budgeting at the Sub-national Level to Advance UHC

This document provides answers to questions asked by audience members during a webinar presenting promising practices discussed in LHSS's Practice Spotlight Brief: **Advancing Universal Health Coverage through Better Planning and Budgeting at the Subnational Level**

Q&A

Are there particular recommendations about how to train health professionals versus financial management people (together? separately?). The silos tend to be a problem. Another problem is the tendency to do "management by workshop" where health officials only work on budget when invited to a specific meeting. Did you find this or have suggestions for how to get financial management to seem like more of an ongoing responsibility.

Promising practice #2 in the brief covers tailoring capacity building to meet the specific needs of sub-national actors which can address these two issues. Tailoring capacity building to actors' specific objectives, whether that is sub-national health officials or facility workers, is a way to align financial management objectives with the needs of these actors. Needs could be demonstrating efficiency to support advocacy for increased budgets (see brief for Bangladesh case) or implementing flexible financial management rules to re-allocate funds to address immediate facility issues like stock-outs. Enabling users to contribute to the design of subnational capacity strengthening helps make sure it meets their day-to-day needs and so encourages ongoing engagement.

Do the frontline health care workers have the capacity to manage the finances and simultaneously the service delivery?

You've put your finger on the challenge here. Frontline health care workers are being asked to take on new responsibilities for which they are often not well equipped. Even if they have time to carry out both roles, they need capacity strengthening to allow them to carry out both roles well.

The financial management systems (described in the brief's Tanzania case study) used at facility level are very simple to use and there are no complex/professional accounting skills needed. Reports such as cashbook, financial statements, etc. have been automated so that health care workers are required to enter limited information, mainly acknowledging receipt of funds and process payments. There are also accounts assistants who have been recruited across health centres who then support a network of dispensaries.

Is the funding being channeled through direct health facility funding (DHFF) - coming from the domestic source or pooled from partners and does PlanRep (Tanzanian planning tool) support tracking of individual program budgets and expenditure i.e. (HIV, TB, channeled by government etc.)?

On DHFF funds: We have health basket funds (pooled donor funds) through Treasury but also National Health Insurance Fund (NHIF) flowing directly to facility accounts. Facilities are also allowed to retain user fees into their bank accounts. Initially, reimbursements from NHIF and user fees were deposited into the council account. And yes, it is possible to track spending across programs. For example, we have a National Objective for HIV customized in PlanRep. All funds budgeted for HIV are aligned to this national objective. Also, PlanRep requires planning entities to specify priority and intervention areas (e.g. malaria, TB, etc.) in the system. Hence it is possible to track using these priority and intervention areas. However, the list is not comprehensive for all diseases.

How to engage subnational to contribute their resources put into the financial planning in order to strengthen their capacity, in practice at the community level?

LHSS: The brief outlines the three promising practices, each of which can play a rule in this engagement, especially the national-subnational collaboration (Tanzania case) and the collaboration with external stakeholders (Timor Leste case).

The discussion so far assumes that the Ministry of Finance is on board for decentralization. My experience is very different. How have you ensured that MOF will actually support the process in a timely manner.

As Helene mentioned, decentralization looks very different in each country. For the purpose of our brief, we decided to look at contexts where subnational level actors have an official mandate with increased responsibility for planning and budgeting.

In a country where planning and budgeting is still very centralized, and there is minimal involvement of the subnational levels, how does one kickstart the conversation?

In LHSS's experience there have been numerous starting points. In Lagos State, Nigeria, the starting point was increasing HIV budget execution but then the activity was broadened to cover the entire state ministry because the ministry leadership realized that the coordination issues identified were systemic, rather than HIV program specific. In Madagascar, the MOH analyzed the weak points in the planning and budgeting process and outlined the impact of highly centralized budgeting to act as an advocacy tool. In Bangladesh (promising practice #2 case study) the National Government mandated local

government to plan, budget, finance and implement primary health care – thus the need for tailored capacity building on planning and budgeting to achieve this new mandate.

Tailoring capacity strengthening at the sub national levels, does it means we are being more prescriptive in terms of PMS systems?

Perhaps not so much prescriptive as ensuring that actors are able to understand and use specific financial management skills and processes towards their objectives and day-to-day needs.

How enters out-of-pocket expenditure the PFM to increase UHC at SNL?

Tailored capacity strengthening (promising practice #2) can help address this by ensuring that actors can track the level of out-of-pocket expenditure, captured as facility fees, and where allowed, keep and use them at the facility or sub-national level through accurate planning and budgeting. In Tanzania they can do this in real time throughout the year, not only at the point of annual budgeting.

How is the subnational level being supported to utilize data to inform prioritization of interventions during the planning and budgeting amidst the limited resources that are often allocated by the central level?

The Comprehensive Council Health Planning guideline requires the use of situational analysis data to inform planning and budgeting across all levels including facilities. The facilities are using morbidity and mortality data from the DHIS2 to inform their plans and budgets in each year. The PlanRep systems has a space to enter situation analysis where facilities are supposed to upload health status data including major causes of disease and mortality.

The council health management team normally scrutinize health facility plans and budget to make sure that they align with needs based on the situation analysis data for each facility.

How to ensure all budget expenditure at subnational level is transparency and efficiency without dominance from central level?

The brief's promising practice #3 and the Timor Leste case describe one approach for ensuring transparency and efficiency – effective stakeholder engagement at the sub-national level of civil society. Other stakeholders such as community leaders, the private sector can also help hold local entities to account.

The experience from Kenya is the lack of a budget line to support Min of Finance and health and National to support the devolved units. Technical assistance to sub national is largely donor dependent.

This is a common problem. Promising practice #1 and our LHSS experience describes a situation where the championing was moved above health and finance to the President's office as it was tied to a broader decentralization initiative. Contextual analysis is required to identify what arguments are required (efficiency, new mandates, introduction of new budgeting approaches like program-based budgeting, etc.) to generate support for establishing these budget lines. In Tanzania, the national level has invested in strengthening the subnational level because the former understood that successful implementation of national policies relies on how well the subnational level can implement those policies.

Are there good examples of strengthening capacity in subnational actors and/or supporting subnational stakeholder engagement that has resulted in improved budget execution at the local level?

Yes. The brief describes the case in Tanzania budget execution rose from 58% to 82% at the health facility level. In Nigeria, discussed in the webinar, budget execution at the ministry level has increased from 16% for Y2023 to 34% in Y2024. At the HIV program level, mid-year budget execution of 45.7% for FY 24 has already surpassed the annual budget execution for FY 23, which stood at 40%.