Strengthening Local Level Health Sector Planning and Budgeting to Deliver Basic Health Services

Lessons from Selected Local Levels

Local Governments (LGs) are the frontline units that provide public services in the federal structure, and they are responsible for addressing basic human rights including delivering health services. This is a fundamental departure from the highly centralized "unitary" governance system in the past. Federal and provincial legal and policy documents and guidelines provide the framework for LGs to prepare their Annual Work Plan and Budget (AWPB). Based on these Acts and Regulations, LGs develop their own laws, including Finance and Appropriation Acts. The major components governing planning and budgeting at the local level include constitutional provisions; policies, laws, and plans; medium term expenditure frameworks (MTEF); annual planning and programmes; framework for fiscal transfer; programme/project banks; municipal challenges and prospects; and finally, the programme implementation framework. This AWPB cycle begins in February and ends in July every year, and requires harmonisation and coordination across the three tiers of government. In addition to the AWPB cycle, some level of program planning is continuous throughout the year, especially to address issues arising during program implementation and during the monthly and quarterly reviews.

Seven steps to local level planning and budgeting:

- ☑ *Preparation phase*
- ☑ *Resource projections and determining the ceiling*
- ☑ *Settlement-level planning meeting*
- ☑ *Project selection and prioritisation at Ward level*
- ☑ *Municipal budget plan formulation*
- ☑ *Budget approval by Executive Committee*
- ☑ *Approval by Municipal Assembly*

The UK aid-funded Nepal Health Sector Support Programme (NHSSP) supports the Ministry of Health and Population (MoHP) in the implementation of the Learning Laboratory (LL) approach, with the primary objective of strengthening health systems at the local level[1]. The LL approach has evolved to strengthen local health systems, particularly basic health services, with a focus on capacity enhancement. This Technical Brief highlights key insights and lessons gleaned from the selected local levels.

Local level planning and budgeting: in practice

The realities of planning and budgeting were examined in the selected LL sites supported by NHSSP. The insights are grouped in four parts: (1) federal and provincial roles in local planning, (2) governance structure for planning at local level, (3) use of available evidence in the planning process, and (4) new initiatives addressing contextual needs. Key insights and lessons from these four areas include the following:

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[1] The seven LL sites are: Itahari Sub Metropolitan City (Province 1), Dhangadhimai Municipality (Province 2), Madhyapur Thimi Municipality (Bagmati Province), Pokhara Metropolitan City (Gandaki Province), Yasodhara Rural Municipality (Lumbini Province), Kharpunath Rural Municipality (Karnali Province) and Ajayameru Rural Municipality (Sudur Paschim Province).

Federal and Provincial roles in planning and budgeting	▪ Local levels do strive to align with federal and provincial level policies and programmes, but there are examples still of similar activities being funded by different levels ▪ Although decreased over years, there are still too many budget heads under the Federal conditional grants, reducing flexibility to address local needs ▪ Delays in sending the budget and the implementation guidelines from the federal and provincial level is (still) not uncommon ▪ "Policy and programme" documents usually precede the AWPB and therefore set the priorities for the AWPB
Governance structure for planning at local level	▪ There is increasing clarity on the local level role in health sector management including the endorsement of the package of basic health services ▪ The Budget Formulation Committee and Sectoral Committees are mainly responsible in the planning and budgeting process at the local level ▪ Local Level planning and budgeting includes sectoral planning at the municipal level and area-focused planning at the ward level ▪ Ward level budgets were found to be divided equally between wards in some local levels despite unequal needs ▪ Prioritisation of the program and activities proposed for AWPB varies across LGs and aims to address the contextual needs ▪ Different factors have contributed to gradually prioritising the health sector in the local level planning and budgeting ▪ Budget proposals from divisions and sectoral committees usually exceed the ceilings and are adjusted in the finalization process
Use of available evidence in the planning process	▪ Local levels are expected to develop a Master Plan, Periodic Plan, and Medium Term Expenditure Framework (MTEF) to feed into the planning process. Some LGs develop them, some do not ▪ The programme bank, Municipal profiles, case studies, and learning briefs were found to be instrumental in the planning process particularly to prioritise resources ▪ There are multiple tools to support evidence-based decision making and planning at the local level, including: information system reports; assessment checklists; sector profiles, review meeting and committee minutes; cross-sectoral and cross-municipality sharing meetings; public statements from political leaders; and capacity enhancement tools (such as Minimum Service Standards [MSS], Routine Data Quality Assessment [RDQA], and Organisational Capacity Assessment [OCA]). See select lessons in box below.
New initiatives addressing local level needs	Examples for the LL sites include the following: ▪ Focus on both supply and demand: performance-based incentives (see example in box below) ▪ Nutrition allowances targeting marginalised communities ▪ Workload-based readjustment of the health workers

Lessons from implementing the MSS and OCA

1. *The MSS assessment helped to identify the health facility-related gaps in health services. The MSS score and relative gaps were presented in municipal-level discussions and those gaps were advocated for addressing in review meetings, Health Facility Operational and Management Committees (HFOMC) meetings, key stakeholder discussions, and key decision-making forums in AWPB preparation. And it worked: LGs allocated budget to address the gaps in the next AWPB; in some cases, within same fiscal year to address critical gaps. For example, in Kharpunath significant budget was allocated to address the MSS gaps identified through the MSS assessment.*
2. *OCA helped to identify key capacity gaps at LGs. OCA has seven domains (building blocks of the health system) that provide the platform to identify gaps, and those gaps were addressed through the AWPB planning process. After addressing the gaps, the OCA scores improved.*

Flow of funds and budgetary patterns

There are three major categories of revenue for the local level: (1) distribution of revenue and royalty, (2) federal and provincial grants, and (3) revenue internally generated by respective local levels. Grants are the most significant source and include conditional grants, equalisation grants, complementary grants, and special grants. The MoHP prepares implementation guidelines for health sector conditional grants setting the terms and conditions for how activities should be operationalised, and there is little flexibility to adapt locally. Funds provisioned through grants do not necessarily cover all the local level functions outlined in the Local Government Operations Act 2017 and hence local levels complement through internal budget allocation. Evidence was varied in terms of the Leave No One Behind (LNOB) and gender responsiveness of local budgets: 77% was directly or indirectly gender responsive but only 49% was directly or indirectly LNOB responsive.

New initiative: performance-based incentives

Since its establishment, Ajayameru Rural Municipality has prioritized both supply and demand sides to ensure access to basic health services. As a community-based approach tailored to the local context, from the fiscal year 2017/18 onwards, budget was allocated from internal resources of the municipality to strengthen the Female Community Health Volunteer (FCHV) program through the provision of performance-based incentives. To increase the utilisation of health services, FCHVs were assigned to promote health services at the community level. FCHVs could accumulate their points by ensuring the utilisation of targeted services from the nearby health facilities. Points ranging from 1 to 4 were assigned for different services. From the incentive side, each point is equivalent to NPR 50, meaning that FCHVs can claim that amount for each point gained, of which respective health facilities keep records. They then coordinate with the municipal office for the payment, which takes place on a monthly basis.

Lessons and Recommendations

Planning alignment

1. **There are examples of similar local level activities being funded from multiple levels indicating potential duplication in activities and resources.** While making Federal conditional grant provisions, areas of additional financing from provinces or local levels should be indicated to avoid duplication and enhance alignment across all three levels.
2. **Conditional grants specify budget heads for multiple activities. Though the number of budget heads is decreasing over years, the grants remain fairly restrictive.** Either the activities in Conditional Grants should be further merged, with specific guidelines on what they should be spent for, or more flexibility should be provided to partially switch budget from one activity head to another.
3. **The targets set in the Health Management Information System (HMIS) do not always match with the local level reality particularly in relation to maternal and child health services.** Local level performance should be also be analysed at district level for strategic planning. Monthly review meetings at the district level are found to be effective for cross sharing and learning.
4. **Drug stock outs still remain a periodic problem in the majority of LL sites. In contrast, the occasional oversupply of certain medicines, often near expiry, has also been reported.** Support more effective procurement coordination to ensure continuous availability of medicines at the health facility level.
5. **There are still delays in sending the budget and implementation guidelines from the federal and provincial levels.** Priority should be given for ensuring timely release of budget and implementation guidelines from the federal and provincial levels.

Generating evidence through management tools

6. **The roll out of OCA, MSS, and RDQA created the opportunity for participation by elected representatives, senior officials, and health staff in a single platform to understand the complex health system functions and challenges. These tools sensitized decision makers to specific needs, and**

motivated them to make evidence-based plans and allocate budget accordingly. Introduce and maintain the OCA, MSS, and RDQA tools in each LG. Develop a separate MSS tool for those Primary Health Care Centres which are not to be upgraded to primary hospital but need to function at higher capacity than a Health Post.

7. **Currently, MSS is not available for health facilities below the Health Post level. But there are facilities functioning under different names such as Community Health Units, Urban Health Centres, Urban Health Promotion Centres and, more recently, Basic Health Service Centres.** Work with MoHP to standardize health facility nomenclature. After this standardization, ensure appropriate MSS tools exist for all levels.
8. **Development of the local level MTEF is an important component of the planning process, but many local levels are yet to do this.** Ensure that local levels develop MTEF during the planning process.
9. **A programme bank consists of priority projects to be considered during AWPB. A programme bank can help to speed up the planning process at the local level. However, only a few of the local levels were found to have initiated it.** Establish a programme bank at each LG site.
10. **Municipal profiles and fact sheets highlight major progress and challenges, feeding evidence into the planning process. Some municipalities produce comprehensive profiles, even conducting municipal level surveys, while others have done little**. Support LGs to prepare municipal profiles and fact sheets and institutionalize in the sites where this has been started.
11. **In some LL sites, the health facility "functionality status" was not up-to-date in the health facility registry and hence in the Health Management Information System (HMIS). Issues like listing of non-functional health facilities and appearance of same health facilities more than once were identified.** Update the health facility registry so that the database in the HMIS can also be corrected and maintained.

Coordination and meetings

12. **The practice of organising health sector monthly meetings ensured timely reporting from health facilities, enabled discussion on existing issues, and provided opportunities to engage senior municipal officials in progress monitoring**. Organise monthly health sector review meetings, perhaps rotating between different health facilities to ensure field observation;
13. **Continuous coordination with the MoHP and Provincial Health Directorate, where feasible, has helped to harmonise support at the local level. Sharing lessons through case studies, process documentation, and comparative analyses can promote cross learning and strengthening of the system.** Ensure regular monitoring and documentation of progress at the local level and feed results into the decision-making process at the higher level;

Human resources

14. **Roles and responsibilities of individual staff in the local health sector were not clearly defined, causing confusion and even conflicts in programme implementation.** Support the practice of assigning focal persons for thematic areas at local level.

Options

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