2016 CLA CASE COMPETITION

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Case Story

This Case Story was submitted to the 2016 CLA Case Competition. The competition was open to individuals and organizations affiliated with USAID and gave participants an opportunity to promote their work and contribute to good practice that advances our understanding of collaborating, learning, and adapting in action.

Strengthening County Human Resources for Health Budgeting through Collaborative Learning and Adapting

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Executive Committee Member for Health Department Presents at a Forum on financing for Human Resources for Health in Homa Bay County. *Credit: IntraHealth International.*

What is the general context in which the story takes place?

Kenya devolved its health care services in 2013 as a step toward the implementation of the its Constitution 2010. The management of resources—including human resources—was delegated to the county-level governments. The national government disburses funds to county governments to meet the demands of hiring and managing the health workforce. The counties embarked on work planning and budgeting processes, but soon realized challenges in articulating the detailed budget for human resources for health (HRH) related to expenses beyond personnel emoluments (e.g., staff promotions, HRH supervision, and recruitments). Additionally, the health department budgets were consistently reduced by the Members of County Assembly (MCAs) during the approval process with no contextual understanding or explanation. The budget implications affected health workforce recruitment and promotions, and led to unrest, including health worker strikes. The project engaged with the national Ministry of Health to undertake a trend analysis on county budget allocation. The analysis informed the development of a HRH budget checklist to guide counties on how to budget for HRH, an activity that brought together the county health management teams (CHMTs); MCAs

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for Health, Department of Finance and Planning; and implementing partners, including IntraHealth International and the Health Policy Plus project, to develop and agree upon the checklist. The CLA approach has led to program-based budgeting, sensitization of CHMTs on the HRH budgeting checklist, and utilization of the checklist to develop justifiable annual HRH budgets.

What was the main challenge or opportunity you were addressing with this CLA approach or activity?

County governments were not adequately budgeting for the true costs of hiring and retaining health workers, and the already inadequate budgets submitted were being reduced without explanation, leaving county health departments unable to hire and retain the health workers needed to serve their populations.

The HRH budgeting challenge led the county health departments to put in place structures and mechanisms for developing annual work plans that informed budgeting. One challenge that the counties faced was how to develop HRH budgets that included the necessary costs beyond personnel emoluments. This led the Ministry of Health to commission a study with support from the USAID-funded HRH Capacity Bridge project to review trends of HRH budget allocation at the county level, and to collate and synthesize information on the current situation of budget allocations. If the budget is not sufficient to cover the full cost of hiring and supporting a health worker, the county will fail to attract and retain the workers it needs and health will services suffer. Specifically, the trend analysis sought to determine the adequacy or inadequacy of the budgets since the onset of devolution and to establish the pattern of the allocation; establish the involvement of the county health departments in the budgeting process, the effectiveness of the flow of information on the budgeting cycle, the budgeting process followed, and the adequacy of the timelines provided; and establish the stages followed to ensure the county health departments' budget inputs are approved at the County Assembly.

The trend analysis employed a desk review and qualitative methods, such as key informant interviews, in the data collection. Sampling for key informant interviews was purposive. Study units were sampled from a frame developed from a list of USAID focus counties across Kenya. Stratification was done through county clusters to eliminate bias.

Data collected from secondary sources such as financial reports were analyzed using Microsoft Excel and tables for trend analysis; data gathered from the key informant interviews were analyzed and cross-tabulated, also with Excel. The resulting notes were typed into Microsoft Word and analyzed by the study team for emerging themes to enrich, and to fill gaps of data from the desk review to prepare possible options and solutions.

Describe the CLA approach or activity, explaining how the activity integrated collaborating, learning, adapting culture, processes, and/or resources as applicable.

Collaborating: County engagements for strengthening HRH budgeting

Strengthening the county HRH budgeting process integrated collaborating through a county engagement process that involved holding meetings with the county health department leaders to plan for dissemination of the results of the budgeting trend analysis. The meetings created a shared understanding of the objectives of the dissemination workshop and informed the identification of required participants so the county health departments could invite them. At the meetings, the stakeholders also identified and agreed on three levels of dissemination of the budget analysis report and sensitization for HRH budgeting process. The first level included the CHMTs—the direct beneficiary of the results of the trend analysis—and the MCAs, who were sensitized on the importance of HRH budgets. The next level of engagement involved mobilizing the MCAs for Health who have the responsibility of approving the budgets prepared by the departments of health. The county executive committee member for health who is the head of the county health department engaged the MCAs. The third level of engagement was mobilizing other relevant departments, such as finance and planning, to be part of the sensitization workshop with the MCAs. These levels of engagement yielded the desired results in attendance and discussions.

Learning: Dissemination and sensitization of CHMTs and MCAs

The process of disseminating the results of the trends of the county HRH budgeting process provided a learning opportunity to the CHMTs. The HRH Capacity Bridge project made presentations on the background of the trend analysis, its objectives and methodology, its results and recommendations, and guided the discussions. The result was the HRH budgeting checklist to guide counties on the specific items to include in the HRH budget. The CHMTs then led discussions on the proposed checklist and involved other counties in the cluster for further input. During the dissemination forum, the CHMT was tasked to make a presentation on its current budget, highlighting the HRH elements that were included. This showed the CHMT members just how much they had not considered budgeting for its health workers beyond personnel emoluments. The end result was a plan on how to sensitize the MCAs and other relevant departments on the importance of budgeting for HRH beyond personnel emoluments.

The first step in sensitizing the MCAs and other relevant departments involved sharing the key objectives of the departments of health with targets set in the county health annual work plans, articulating what meeting those targets meant in terms of HRH from the dispensary level to county referral hospital. Insufficient budget to support the health workforce has the implication on attraction and retention of health workers and, by extension, poor health services at the county level. This was even a better knowledge exchange opportunity, with the MCAs appreciating the need of investing in HRH and its importance. It became clear to the MCAs that if they did not support the county's request for an increased HRH budget, the county would fail to attract and retain the number of health workers required to serve the population.

Adapting: Utilization of budget checklist

The CHMTs resolved to use the proposed HRH budgeting checklist to inform their budgets rather than using their conventional practice. This was a display of the adapting process in CLA. While the budget cycle remains constant, the timing of our dissemination and sensitization exercises was important. We made sure that all these processes were done between February and April 2016 in order to have the CHMTs use the checklist in the development of the next departmental budget in June 2016. The HRH budgeting checklist has since been adopted by the counties as a tool to inform the HRH budgeting process.

Were there any special considerations during implementation (e.g., necessary resources, implementation challenges or obstacles, and enabling factors)?

A main challenge was mobilizing the MCAs for the sensitization forum, as they cited busy schedules. The counties embraced a cost-share approach to meeting some administrative costs of the forum because they understood its significance. The MCAs appreciated the unique features of the department of health that make it necessary for it to receive additional and sustained budget provision, instead of the usual trend of reducing health sector financial allocation. In other counties, the HRH Capacity Bridge project partnered with the Health Policy Plus project to bring together the MCAs to appreciate implications of health financing.

With your initial challenge/opportunity in mind, what have been the most significant outcomes, results, or impacts of the activity or approach to date?

The most significant outcome was getting the MCAs to understand the effects their habitual reduction of health department budgets has on health service delivery. Consequently, the MCAs have approved the recent budget reading without any reductions. Budgets for HRH increased to include promotions, human resources supervision, performance management, and recruitments.

If your project or activity is in the development phase or just recently underway (less than 1 year into implementation), how do you intend to track results and impact? What outcomes do you anticipate?

The project will track results and impact at various levels. First, it will track the numbers of staff promoted against the budget allocated for promotions. It will track the number of staff recruited to support service delivery at the facility level and compare with the previous year, tracking performance at all levels, from CHMTs to service delivery points, using markers such as maternal indicators, neonatal, infant, and child indicators, and HIV indicators. Going beyond salaries and remuneration, the project will track what percentage of the budget is allocated for HRH items other than salaries and remuneration.

What were the most important lessons learned?

Health has consistently suffered from under-financing largely because of the lack of political will. However, we learned and showed that politicians can be made to understand the implications of their support to the health sector. Much can be achieved when information is well-packaged, clearly written (e.g., simple language, not technical language), and targeted to suit the context of discussion. We also confirm that health financing deserves multi-stakeholder involvement based on value addition. When politicians understand and know, they provide support.

Any other critical information you'd like to share?

Developing shared tools for developing and advocating for sufficient health workforce budgets may seem removed from day-to-day health service delivery. However, in the end, how much politicians agree to invest in the health sector and the health workforce makes the difference between a functioning health system and one that fails to meet the needs of Kenya's citizens. It is easy to glance at a budget sheet and move numbers around without realizing the impact, but through persistent and targeted CLA efforts, we have been able to work with county officials to better budget and advocate for the funding counties need to support their health workers and provide their communities with the best health care possible.

The CLA Case Competition is managed by USAID LEARN, a Bureau for Policy, Planning and Learning (PPL) mechanism implemented by Dexis Consulting Group and its partner, Engility Corporation.