Maternal and Newborn Improvement (MANI) project

CASE STUDY

GET WITH THE PLAN

Learning from Bungoma County on the annual performance review and work planning

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Introduction

The Maternal and New-born Improvement (MANI) project has been supporting Bungoma County since 2015 to strengthen health service provision, with specific attention to maternal and new-born health services. This support addresses all six WHO health system building blocks, including health financing and health governance and leadership[1]. Interventions under these building blocks have included the development of Bungoma County's first Public Expenditure Review as well as technical assistance with annual performance reviews (APRs) and annual workplans (AWPs). This is the fourth consecutive year that technical support has been availed to the county for the APR and AWP.

The overall objective of this case study is to assess the development and implementation of APRs and AWPs in Bungoma county and identify lessons for improving planning and budgeting within Bungoma County and other counties. Specific objectives include:

- Identify what has worked and what has not worked with the development and implementation of AWPs
- Identify opportunities, challenges and emerging issues in the development and implementation of AWPs at county and sub-county levels
- Identify lessons for improving planning and budgeting performance
- Apply lessons to planning and budgeting processes

This is one of two case studies looking at the APR and AWP in Bungoma County, the first one having been prepared in July 2017. The current case study has been undertaken to verify if lessons have been applied and improvements made to the planning and budgeting processes in Bungoma County as identified through the initial case study.

Methodology

A qualitative case study approach was employed, drawing on primary and secondary data sources. Secondary data included relevant contextual and background documentation. The case study focused on the APR for 2016/17 and the AWP for 2018/19. Primary data was collected from key information interviews, these included:

- The Senior Leadership of the Department of Health - one member (Chief Officer, Health)
- The County Health Management Team (CHMT) - eight members
- Three Sub-County Health Management Teams (SCHMTs) - 14 members
- MANI - three technical advisors
- Partners - four representatives

Key informants from SCHMTs were selected from three (Kanduyi, Kabuchai and Kimilili) of the ten sub-counties of Bungoma. Interviews were conducted in July 2018 and included a total of eight interviews comprising 29 respondents.

Findings

There was concerted effort to de-link the APR from the AWP. As per the Government of Kenya planning and budgeting cycle, the APR is supposed to take place from August to October of every year, in advance of the budget outlook which occurs in November. This is followed by sectoral resource bidding in December. From February of every year the planning cycle is supposed to begin and includes public participation. In the case of Bungoma County, the APR for fiscal year (FY) 2016/17 took place in November 2017 while the AWP for 2018/19 started in April and continued through to the end of May 2018. While AWPs are typically uploaded into the District Health Information System by June 30th of every year, this was brought forward to May 31st, 2018 to accommodate the requirements of the *Transforming Health Systems for Universal Care* (THS-UC) programme. This was communicated through the Council of Governors.

Worked well

Despite the shortened period for the AWP, the County Department of Health (CDoH) reported that there was good technical input and financial support. There was reported to have been greater technical representation from county programme managers, whereas in the previous year, some critical programmes, such as immunisation and laboratory, were missing[2]. Programmes were more able to articulate priorities, whereas in the past, this was reported to be directed by the CDoH finance staff. Partner participation was also higher than previous years, with cost sharing taking place between partners to fund:

- A 'kick off' sensitisation meeting at county level
- Sensitisation and planning meetings at the ten sub-counties with health facilities and community units
- A week-long consolidation meeting, which took place in a neighbouring county

1 World Health Organisation, 2007. Everybody's Business: strengthening health systems to improve health outcomes (WHO's Framework for Action), WHO, Geneva.
2 Other departments considered 'missing' (e.g. they were not present at the off-site consolidation meeting were nutrition, community health, human resources, TB and the AIDS Coordinator.

"Every technical aspect was properly on board." (CHMT member)

At sub-county level, the process was described as 'bottom up', with effort made to include health workers and community representatives. SCHMT members indicated that health workers liked being included, that they *"own the activities"*. Concerted effort was made in sub-counties to include Community Units, and, where this was not possible, Community Health Extension Workers (CHEWs). Consolidation of health facility workplans was done by the SCHMTs, principally the sub-county Health Information Records Officer (HIRO).

The content of the AWP was also reported to be much stronger than in previous iterations. This was expressed by the CDoH, MANI technical advisors and some partners. Respondents indicated that the content *"built on the previous AWP and focused on gaps"*, that *"activities were clearer, more relevant and reflected best practices".* There is evidence that MANI and other partner activities were transferred to the THS-UC. These included maternal and peri-natal death surveillance and response (MPDSR), mentorship, Community Health Volunteer (CHV) stipends, traditional birth attendants (TBAs) as birth companions, and defaulter tracing. This has facilitated sustainability of interventions that were previously wholly reliant on partners.

There was effort to capture other resources beyond the Exchequer. In addition to the THS-UC, this included 18 partner/programme[3] contributions as indicated in the foreword. However, only five partners are reflected in the budget, not including the THS-UC. This was reported to be an administrative error. Some SCHMTs indicated that they had included their user fee revenue, but this is not reflected in the AWP. While revenue targets for Linda Mama were not included, some SCHMTs reported that they budgeted for claims processing equipment. In sum, this suggests that CDoH stakeholders are starting to engage with a broader notion of budgeting, one that includes multiple resource streams. This is to be encouraged as it improves transparency and reduces duplication.

Technical assistance, provided through MANI, was less visible than in previous years. The same consultant was contracted by the MANI project to work with the teams, however, for the FY 2018/19 AWP this was done remotely. As some CDoH stakeholders noted, the County HIRO is very capable.

"We used to do [AWP] ourselves before devolution…the problem we are having is confidence in ourselves." (SCHMT member)

Did not work well

While the APR was done in advance of the AWP there were some structural and quality issues with it. The APR did not align to the newly introduced AWP template. Respondents also indicated that there was *"missing data and data quality issues".* As a result, the APR had to be redone at the time of the AWP. The original APR presents as a *"laundry list"* of challenges with no explanation provided on why some activities *"stalled"*[4]. Procurement of 60% of non-pharmaceuticals is viewed as an achievement while the APR notes that *"all health facilities offered maternal and child health services at 50% as planned with the support of county government & our partners"*[5]. It is unclear why these benchmarks have been set, or why gaps in pharmaceuticals and services are viewed positively.

While there was some content improvement in the AWP, some evidence-based activities were excluded. For example, Kangaroo Mother Care (KMC), which was successfully tested in Bungoma County, was not included in the AWP as there is reportedly *"no data capture for this".* This was also the reason given for some nutrition interventions being left off[6]. While the THS-UC did include new activities, an improvement on the previous AWP, where training was the main activity, the programme itself is viewed as the purview of one person on the CHMT. None of the SCHMT and the majority of CHMT respondents were able to articulate plans for THS-UC activities or why some activities were prioritised over others. Furthermore, partners also indicated that, as the AWP was only 50% completed during the consolidation meeting, it was difficult to contribute due to data gaps.

"In a 50% document, it is difficult to give input." (Partner)

There was a disconnect between respondents in relation to improvements in the AWP process and plan. Some partners expressed frustration and disappointment, with a view that the previous AWP was managed better. As noted by partners and SCHMT respondents, information on the AWP came late, and there was confusion with the template which was changed midway through. This affected quality and completeness at a sub-county level. Partners also indicated that their financial contribution to the process was not considered adequate, *"what partners could support was not well received by the county".* The final version of the AWP did not include some partner activities and resources despite these same partners having contributed financially and technically to the AWP. Partners indicated that *"it's important to be included"* but as they did not see the AWP before its submission, they could not rectify the omissions. As a result, it is unclear if these partners will continue to fund the APR and AWP as this has created challenges with justification internally with partner organisations as well as with donors.

3 Bungoma County Department of Health Nov 2017; Annual Programme Review for the Fiscal Year 2016-17
4 Bungoma County Department of Health Nov 2017; Annual Programme Review for the Fiscal Year 2016-17
5 Bungoma County Department of Health Nov 2017; Annual Programme Review for the Fiscal Year 2016-17
6 Bungoma County Department of Health Nov 2017; Annual Programme Review for the Fiscal Year 2016-17

As with previous AWPs, many respondents indicated that only partner activities are funded and implemented. In this regard, the CDoH respondents noted that not all partners are flexible or responsive to county priorities and service gaps. Overall, the AWP included only activities that were funded (through partners, the THS-UC and the Bungoma County Government), while those that were not funded were included in an annex (of note, the AWP for the following year remains unfunded). SCHMT respondents noted that *"key activities did not attract resources"*, including performance reviews at sub-county level. As a result, some SCHMTs have used their limited facility Improvement Fund (FIF)[7] to support non-funded activities. It was noted that, *"AWP implementation is done at programme level, but no one is stewarding this"*; as a result, it remains *"more of a wish list".* This suggests that greater prioritisation of limited resources is needed so that AWP implementation is not reliant on partners alone.

"Plan well for the plan"

A CDoH stakeholder indicated that the inclusion of the AWP in the list of unfunded activities was an improvement on previous AWPs which did not mention it at all, showing "an element of ownership by the county."

Conversely a partner indicated that "It is telling that the AWP is in the plan but not budgeted for, this shows that it is not a priority."

AWP implementation

Respondents indicated that the previous AWP was only used partly to guide service delivery. This was attributed to a lack of resources. Encouragingly, some SCHMTs had taken matters into their own hands and had initiated regular meetings to review their data and update plans. In some instances, this has required facility in-charges to use their personal funds to attend meetings, which are held at the sub-county hospitals.

As with the previous AWP, executive stewardship and accountability are viewed as critically missing from the process and its execution. In addition to the AWP being referred to as a wish list, others indicated that it was more of a *"rolling plan"* which lacks ownership by the Executive leadership and is a *"document more for the other officers".* This was seen to emanate from a lack of clarity in relation to roles and responsibilities, which has plagued the CDoH for some time. It was suggested that the County Executive Committee Member for Health was responsible for overall strategy and its realisation; that the Director is responsible for technical execution; and, the Chief Officer is responsible for operational execution. It was further suggested that this be reflected in appointment letters at executive level and cascaded to managerial levels. This would reduce ambiguity in roles, encourage more active ownership of the AWP and ultimately its reflection as key document for decision making within the county.

"Who is accountable when something is not done?" (Partner)

For many respondents, there remains a disconnect between the CHMT and the SCHMTs in relation to AWP implementation. This comes down to resources and who has authority to spend these. As one partner indicated, *"at present it looks like a parallel system. It's an autonomy issue, the finance department dominates decisions on resources".* It was recommended that there needs to be greater clarity on the SCHMT resource envelop, which should be based on identified priorities within sub-counties (recognising that each sub-county has differential performance and needs). This has been recognised by the Bungoma Acting Chief Officer, Health who has authorised a supplementary budget for SCHMTs and has worked with the CHMT to better define their roles, particularly as pertains to sub-county support.

"One step forward is to activate the CHMT." (County Executive member)

There is further recognition that the AWP needs to be better integrated with other guiding documents. The AWP should operationalise Bungoma County's overall vision for health, as defined in the County Integrated Development Plan and articulated in the Health Strategic Plan. To do this, the AWP should be operationally connected to cash flow and procurement projections, both in terms of source and timing. For this to occur, the CHMT and SCHMTs need to *"pull on resources"*, which may not be happening due to managerial and attitudinal factors as well as a perception that *"treasury is fighting health"*. There is also need to better embrace partners as well as link AWP performance with that of the county and sub-county teams, through the appraisal process.

"We need to create an entry point for partners, this is not linked well with how the county operates." County Executive member)

"When all connected, we get motivated." (CHMT member)

7 The FIF has been in place since 2002 as defined in CIRCULAR NO. DHCF/VOL. 1 (138).

Conclusion

Within Kenya, decentralisation has been promoted to improve health sector performance through, inter alia, greater responsiveness and local accountability of health services. However, this case study shows mixed views of decentralisation in the context of Bungoma County as pertains to the APR and AWP. These processes have a critical function in the performance of service delivery and ultimately population health, as well as the morale of those at the service delivery front line.

While some improvements were seen in this iteration of the APR and AWP, there remains more than can be done. The APR and AWP should be viewed as means to an end - better service delivery that is responsive to the health needs of Bungoma's population. There is genuine concern that a more responsive county health sector is needed, *"people feel that health is neglected"*, that there is *"no top leadership for health"*. It is hoped that insights from this case study can be used to improve health leadership and the planning and budgeting processes in Bungoma County.

Recommendations

Given resource constraints, there should be greater data capture of other revenue streams[8]. This includes revenue generated from the Linda Mama programme and the National Hospital Insurance Fund (NHIF). For example, as targets are available for deliveries in most health facilities, estimating revenue against targets should be feasible and would act as a prompt for pro-active management of the Linda Mama programme. Similarly, given that the NHIF is included as an activity (in terms of subsidisation of cover for indigents or 'needy' individuals), revenue target setting should also be reflected.

Empower SCHMTs and facilities to utilise resources in line with priorities identified in the AWP. To do this, SCHMTs and health facility in-charges need to have the authority to incur expenditure (AIE). One respondent commented that AIE remains a *"work-in-progress"* even though the Public Financial Management Act allows for AIE at present. As noted, *"funds need to be acknowledged, it does not state that they need to be taken up by the centre…people want to use the law to control others, not to be more efficient".*

Use population-based estimates to inform the "reasonability" of financial allocation within the AWP. As the APR review indicated, maternal and child health (MCH) services were planned at 50%. This suggests that the existing resource envelope is inadequate and/or that efficiency measures are not optimised. It further reinforces the need to ensure that all partners and revenue streams, such as the NHIF and Linda Mama, are on plan and on budget so that services are planned to a more reasonable level of delivery, in response to population requirements and not budget enveloped restrictions.

Use the AWP as a living document, one that guides service delivery. Build on some existing good practice of monthly and quarterly reviews as highlighted by SCHMTs. Engage partners in this process, and seek to more effectively incorporate them into plans, and not just as funders of activities (including the AWP).

Funded by: In partnership with:

8 The foreword in the AWP (page 6) includes AIA which comprises of Linda Mama and other user fees but this is not allocated within the plan.