

Guidelines for Developing a Health Budget Brief

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Please note that these guidelines (now in the second version) and the accompanying Excel-based template (first version) are working drafts that are intended to be periodically updated based on user feedback.

Table of Contents

INTRODUCTION	4
Background on budget briefs	4
Objectives of the guidelines	4
Structure of the guidelines.....	4
PART I. THE PROCESS	6
Shared accountabilities	6
Characteristics of a good brief.....	7
Data.....	8
What to do.....	11
PART II. THE TEMPLATE	12
Preface.....	12
Key Messages and Recommendations	12
Section 1. Introduction.....	15
Section 2. Health Spending Trends.....	19
Section 3. Composition of Health Spending	22
Section 4. Budget Credibility and Execution.....	26
Section 5. Decentralization and Health Spending	30
Section 6. Equity of Health Spending	33
Section 7. Financing the Health Sector	36
Section 8. Other Sector Issues and Reforms	40
ANNEX 1. SAMPLE OUTLINE	41

INTRODUCTION

Background on budget briefs

In 2015, UNICEF's Regional Office for Eastern and Southern Africa (ESARO) began encouraging country offices to develop budget briefs. Through the region-wide initiative, the number of budget briefs produced increased significantly. While just two country offices produced a total of six briefs in fiscal year 2015, this included 18 offices and more than 80 briefs in fiscal year 2017. Reflecting the utility and impact of these products, the Regional Priorities (2018-21) formalized the requirement for all offices to develop annual budget briefs as a minimum standard to support engagement in public financial management (PFM) processes. All published briefs are available on the [ESARO budget brief website](#).

Within this context, the budget briefs serve four main purposes:

1. Analyze and monitor budget allocations to sectors that are important for children in the current fiscal year;
2. Assess the efficiency, effectiveness, equity and adequacy of past spending to the extent possible;
3. Inform advocacy, through key messages for policy and financing changes; and
4. Increase staff knowledge on budget issues that are linked to sector results.

Objectives of the guidelines

These guidelines are intended to support the efforts of country offices to develop a budget brief for the health sector. The specific objectives include:

- Present strategic approaches based on lessons learned and good practices;
- Describe key concepts and address common misconceptions;
- Clarify accountability and responsibilities;
- Deconstruct a good budget brief; and
- Provide detailed guidance on developing content for the brief, including an outline.

Structure of the guidelines

The guidelines are presented in two parts as follows:

Part I. The Process

- Shared accountabilities: Who does what within the country office
- Characteristics of a good brief: Key considerations to bear in mind when analyzing data and drafting content
- Data: A list of suggested sources
- What to do: How to get started and ensure the budget brief is fit for purpose

Part II. The Template

- Section by section guidance: Describes the objectives, key considerations, possible data sources and content that should be included in each section of the brief and also presents sample figures and tables
- Outline: Provides a sample structure for the brief

Companion Documents

These guidelines are accompanied by two companion documents, which are available on [ESARO's budget brief external webpage](#):

- **Health Sector Budget Brief Template:** This excel-based tool should be used to produce all figures for the budget brief. Country offices are encouraged to change and produce additional figures where they see fit. However, any changes or additions should be an improvement on the figures presented in the template.
- **Budget Brief Impact Action Plan - A Short Guide:** The health budget brief should be accompanied by an action plan that describes how the main recommendations will be transformed into actions and influence. This companion document provides step-by-step guidance for developing an action plan, which covers: (i) key asks; (ii) expected results; (iii) target audience; (iv) partners; (v) actions; and (vi) progress. It also includes customizable examples (e.g. for indicators, activities) along with a sample template presented in the Annex. Importantly, the plan should take no more 1-2 hours to develop; it is intended to be a light exercise to give the office – and partners involved – clarity about what needs to be changed and how this can happen.

PART I. THE PROCESS

Shared accountabilities

It is strongly recommended that the health team in the country office lead the development of the health budget brief. Health staff should be familiar with the key policy and budget issues that need to be emphasized and also be able to identify useful indicators, relevant policy, strategy and planning documents, and budget data. In this regard, the health team should be responsible for: (i) collecting budget data and other documentation from government counterparts; (ii) supporting the analysis of the data, where capacity exists; (iii) drafting the different sections of the brief; (iv) developing and refining the key messages and recommendations; (v) sharing the draft with government counterparts for review and validation; (vi) disseminating the brief to relevant partners; and (vii) developing and leading the implementation of a budget brief impact action plan to operationalize the main recommendations of the brief.

The social policy team should facilitate the exercise and support the health team in developing the brief, but not lead or carry out the work. Depending on the country office context, support from the social policy team could include: (i) providing an introduction to the structure of the national budget and the types of information that are required for the sector brief; (ii) facilitating access to budget data through the Ministry of Finance when health staff are unable to obtain information from ministerial counterparts; and (iii) providing quality assurance, including reviewing figures/tables and the underlying data sources and calculations, identifying information gaps, ensuring the right information is presented, fine-tuning the narrative, helping to formulate strong advocacy asks, etc.

The social policy team is also responsible for engaging the health team at the outset to: (i) develop the impact strategy; (ii) agree on a timeline for finalizing the product; and (iii) support the operationalization of recommendations, where required (e.g. around PFM reforms or advocacy for greater financing).

Senior management has an important role as well. The Representative and Deputy Representative should be responsible for: (i) setting the agenda around the series of budget briefs within the overall context of the office-wide policy advocacy action plan; (ii) ensuring that section leads understand their roles and responsibilities; (iii) providing close oversight so that the brief is developed according to agreed timelines; and (iv) supporting the implementation of the impact plan through high-level advocacy and discussion, as required.

Characteristics of a good brief

Past experiences show that high-quality budget briefs have distinct features. The following is an initial list that should be kept in mind while analyzing data and writing content.

- **Logical structure:** The brief should be written in “title sentence” format whereby the first sentence of each paragraph clearly states the main point of the paragraph, while the following sentences elaborate and add detail. The majority of paragraphs should be describing data and information contained in tables, figures, etc.
- **Succinct and clear:** You are writing a budget “brief” – the aim is to be as comprehensive as the data will allow and short enough to describe the important points. A brief is not a place for comprehensive discussion or rambling!
- **Accuracy:** The analyses need to be factually correct. It is imperative that all data work is checked and double checked. Heed the “four eyed principle,” whereby two individuals review and validate tables, figures, etc. and the underlying data and calculations.
- **Plain and simple language:** Briefs are for wide circulation and advocacy. Non-technical language should be used as much as possible. With that in mind, the briefs are designed to relate to the national budget. Technical terms used in the national budget should be explained in the briefs.
- **Emphasis:** Decide how important a section is and how relevant it is to the country context. Not every section may be necessary. For example, if the analysis shows that there are no major issues regarding budget execution, the section can be dropped to keep the document succinct. Issues can be emphasized by including them upfront in the key messages and recommendations section and by addressing the most important issues first.
- **Answers the “how” and the “why”:** Rather than just giving an overview of budget information e.g. allocations to the health sector have decreased as % of the budget over the last four years, it is important to describe how the national budget has been increasing while allocations to health have remained stagnant, which could, for instance, reflect increasing priority to infrastructure spending in line with the government’s strategic plan to prioritize economic growth.
- **Brings out the child lens:** A UNICEF-supported budget brief is unique from budget analyses produced by other partners (e.g. UNDP, World Bank) because of its focus on the child. As such, it is important to clearly link the different analyses and findings to families and children as much as possible.
- **Presents inflation adjusted trends:** When analyzing spending trends over time, it is imperative that data are adjusted for inflation and presented in real terms; note that the companion [Health Sector Budget Brief Template](#) calculates this automatically.

- **Crafts well-informed, feasible recommendations:** Sensible and well-researched recommendations help to transform briefs from information into advocacy. However, no recommendation is preferable to a poor recommendation. Also, not every issue facing a country has a simple solution. For instance, improving fiscal space by increasing domestic revenue may also increase inequality, undermine PFM reforms and dampen economic growth. In addition, recommendations need to be informationally objective – that is, they should reflect data and evidence rather than opinions or beliefs about what is the best course of action, which could undermine the potential influence on budget negotiations and processes.
- **Supports ideas for future research and program interventions:** Where the analysis shows deficiencies in the information available, this could be the impetus for UNICEF to provide technical support or guide future research. Findings in the brief may also inform the programming priorities of different sections.
- **Follows the UNICEF style book:** The style guide provides instruction on spelling, language norms and referencing. It may be helpful to use footnotes while drafting. However, endnotes should be used for presentation so that the references allow room for graphics and do not disrupt the flow of the narrative.

Data

The health budget brief will require budget data from national and international sources (for comparisons), as well as information on the performance of the health sector. A list of possible data sources is included at the start of each section in the template in Part II.

As a starting point, it is important to note that budget data come in many different forms. The first is based on the budget classification system. Here there are three common systems used to present budget information, which include **administrative** (where budget data is aligned with the institutional structure of the government), **functional** (where budget data is aligned with different objectives or functions), **economic** (where budget data is aligned with inputs) and **program** (where budget data is aligned to the strategic objectives of the government) (see Box 1 at the end of this section for more information).

At the same time, for any given year there can be multiple types of budget information reported, including budgeted, approved, disbursed, outturn and audited (see Box 2 for more information). For the budget briefs, it is important to get budget allocations for the current fiscal year (the approved amounts) as well as actual expenditure (audited amounts) for as many historical years as possible to allow for analysis of budget execution performance as well as expenditure trends over time.

Health budget data

- ✓ Health budget documents, including the annual budget, Medium-Term Expenditure Framework (MTEF), consolidated spending reports, audit reports; Note that in most countries national budget data is publicly available on the website of the Ministry of Finance or the Treasury
- ✓ Budget speeches

- ✓ [World Health Organization \(WHO\) Global Health Expenditure Database](#)
- ✓ [Government Spending Watch Database](#) (this includes health budget data for FY2015-17 for 13 ESAR countries, in many cases covering actual/planned, by type of spending and by source of funding)
- ✓ [World Development Indicators \(WDI\) Database](#)
- ✓ [Public Expenditure Reviews \(PERs\)](#) with a focus on health
- ✓ Public Expenditure Tracking Surveys (PETS) with a focus on health
- ✓ [World Bank BOOST Initiative](#)
- ✓ [OECD-Development Assistance Committee database on Official Development Assistance \(ODA\)](#)

HIV/AIDS budget data

- ✓ [National AIDS Spending Assessments \(NASAs\)](#)
- ✓ [Global AIDS Response Progress Reports](#)

Other health sector data

- ✓ Health performance reporting
- ✓ Census data
- ✓ Health Management Information System (HMIS) – web-based data reporting, managing, collecting system; access is not generally public but can be granted by the responsible Ministry or possibly by UNICEF staff
- ✓ [WHO Global Health Observatory data repository](#)
- ✓ [World Bank Country Health Dashboard](#)
- ✓ [Institute for Health Metrics and Evaluation \(IHME\) Country Profiles](#)
- ✓ [Service Delivery Indicators](#) (for Ethiopia, Kenya, Madagascar, Mozambique, Madagascar, South Sudan and Tanzania)
- ✓ National Healthcare Sector Analyses or Plans
- ✓ Joint Sector Review reports

Budget Data Matrix

Document	Years of Data Availability				
	Proposed	Approved	In-Year	Year-end/ Provisional	Audited
Expenditure: Administrative					
Expenditure: Economic					
Expenditure: Functional					
Expenditure: Program					
MTEF		
Sector/MDA Policy Document
Sector/MDA Performance Report
Ministerial Budget Speech	

Box 1. Budget classification systems

1. **Administrative classification:** Breaks budget allocations down to ministry, department, agency (MDA) or other public entity, basically replicating the existing institutional structure of the government; these entities are responsible for managing the allocations assigned to them in the national budget.
2. **Functional classification:** Groups financial allocations according to their strategic objectives and broad purposes (e.g. for economic affairs, environmental protection, housing and community amenities, health, social protection).
3. **Economic classification:** Divides the budget into economic inputs, mainly wages and capital, to understand how the government is producing goods and services; the two main distinctions with economic classification include: (i) recurrent spending (principally on salaries for employees, but also continuous operational costs like electricity and internet for buildings or gas for vehicles); and (ii) capital spending (includes spending to develop new infrastructure or purchase vehicles or computers – also called development spending in some countries).
4. **Program classification:** A program is a group of activities aligned to the policy objectives of the government. Compared to functional classification, a classification by program takes into account the government's policy objectives and how these policies will be implemented. Programs may be divided into sub-programs which group together related activities and projects (e.g. increasing enrollment of girls under the primary education program, vaccination and disease prevention under increasing agricultural productivity).

For more information, see: Jacobs, D., Héris, J-H, and D. Bouley (2009) "[Budget Classification](#)," Technical Note, Fiscal Affairs Department, IMF.

Box 2. Key budget terms

- **Budget Estimates or Proposed Budget or Estimates of Expenditure:** The budget as presented to Parliament.
- **Approved Budget or Approved Estimates:** The budget as approved by Parliament, taking into account revisions during the approval process.
- **Revised Budget Estimates:** The budget as revised during the financial year, often presented at mid-year.
- **Budget Outturn or Final Budget Outcome:** Estimated actual spending at a particular time during the financial year or at the end of the financial year.
- **Audited Budget or Actual Budget:** Spending verified by the Supreme Audit Institution and presented to Parliament; this presents the final (or actual) spending figures for a given fiscal year.
- **Disbursed Funding:** Funding transferred from a central agency to a spending agency.
- **Utilized Funding:** Funding used (actually spent) by a spending agency.
- **Variance:** The difference between approved spending and actual spending.
- **Virement:** The transfer of funds between line ministries, programs, policy areas, expenditure categories or line items.

What to do

- 1. Ensure government ownership:** A critical starting point is to inform counterparts that UNICEF is planning to develop a health budget brief based on the approved budget for the current or upcoming fiscal year. In addition to facilitating access to budget data and other information, this initial consultation will help to ensure an audience to deliver and act on the recommendations once the brief is finalized. Where possible, country offices are strongly encouraged to jointly publish the brief with the Ministry of Health; their main roles would be to review and approve the draft, and also to provide the official logo to be included on the title page.
- 2. Get budget data:** In addition to the approved budget for the current or forthcoming fiscal year for your sector, the country office should get budget information for the past three years at a minimum – and ideally five. Please see the “Data requirements” section above to assist with sourcing and requesting data. If the budget/finance departments in the relevant ministries are not helpful or cannot provide the requested data, then information requests will need to be directed to the Ministry of Finance or Treasury. If this is your situation, then you will need to work with your social policy team.
- 3. Write the brief:** Use the guidance and template presented in Part II of this document together with the accompanying [Health Sector Budget Brief Template](#) to analyze the data and develop the content. Once drafted and reviewed by all relevant staff in the country office (including social policy) and ESARO (including health and social policy focal points), it should be shared with ministerial counterparts for feedback and validation. Any comments or data issues should be addressed, after which the brief can be finalized.

Note: Once using the excel-based Health Sector Budget Brief Template to organize and analyze budget and sector data for the first time, subsequent briefs should build on the previous database to produce updated figures and tables. This will ensure consistency and comparability of information over time to understand whether specific spending trends are getting better or worse, and also significantly reduce the time to generate analyses and produce a new brief.
- 4. Develop an action plan:** To effectively operationalize the main recommendations from the brief, it will be important to put together a short action plan to give the office clarity about what needs to be changed and how this can happen. The plan should broadly include: (i) key asks (lifted directly from the brief); (ii) expected results; (iii) target audience; (iv) partners; (v) actions; and (vi) progress. As mentioned earlier, customizable examples and a very short template plan are provided in the [Budget Brief Action Plan - A Short Guide](#). This is a light exercise that should not take more than 1-2 hours.
- 5. Execute the action plan and document progress!**

PART II. THE TEMPLATE

Preface

- This is optional, but you can consider including a short paragraph that summarizes the purpose of the briefs and its link to the series being produced. While this could be presented on the cover page or one of the first pages, including as a footnote, it could also go on the last page of the document. Sample text is provided below:

This budget brief is one of **four** that explore the extent to which the national budget addresses the needs of children under 18 years in **name of country**. The briefs analyze the size and composition of approved budget allocations to sectors that affect children in fiscal year **2019/20** as well as offer insights into the efficiency, effectiveness, equity and adequacy of past spending. The main objectives are to synthesize complex budget information so that it is easily understood by stakeholders and to put forth practical recommendations that can inform and make financial decision-making processes better respond to the needs of children and poor households.

Key Messages and Recommendations

Objectives

- Provide one sentence summaries of the most important key findings and accompanying recommendations, presented in order of priority.

Key considerations

- This section serves as the conclusion of the brief (there is no standalone “Conclusion” section). It is deliberately positioned at the start of the document and written in succinct, bullet point format to focus attention on what matters. The single page presentation also allows this to be used as a standalone summary note for dissemination and advocacy purposes. Please also note that the key recommendations should serve as the foundation for developing the budget brief impact strategy.
- This should be the final part of the brief that is written; there is a short “takeaways” sub-section at the conclusion of each section in the brief, which will facilitate the development of this content.
- Each finding needs to be accompanied by a specific recommendation or ask – what we want the government to do.
- The recommendations need to be meaningful and actionable.
- The draft messages and recommendations should be widely shared to get suggestions for improvement, including with the social policy team, the communication team, senior management, development partners, civil society actors (where relevant) and ministerial counterparts.
- There should not be a key message and recommendation for each section and every issue covered in the brief. It is, therefore, important to be highly selective so that only the most important issues are featured.

- The key messages and recommendations should be presented in order of priority from highest to lowest – e.g. if the government could only change one thing, that should appear first.
- Suggested length for this section: 1 page.

Content

- **Findings and asks on overall spending trends:** Describe total health spending trends (including real changes) and comment on the priority of health spending vis-à-vis the national budget and against targets in the national health plan/strategy and global benchmarks (e.g. 15% of the national budget as put forth by the [Abuja Declaration](#)). Based on the findings, formulate asks to improve overall spending trends.
- **Findings and asks on the composition of spending:** Summarize spending by: (i) different agencies that deliver health services; (ii) different levels of health (primary, secondary, tertiary); (iii) major programs within the different levels, identifying any exceptional priorities or imbalances; and (iv) recurrent and capital expenses. Based on the findings, formulate asks to improve the composition of spending.
- **Findings and asks on budget credibility and execution:** Describe any major variations between the approved budget and actual expenditure in the health sector as a whole or for different levels of the health system. Based on the findings, formulate asks to strengthen budget credibility and execution in the sector.
- **Findings and asks on the equity of spending:** Present per capita health spending by regions and/or by health facilities. Where possible, present the relationship between spending and income levels, ethnicity and performance indicators. Based on the findings, formulate asks to improve the equity of spending, including increasing or reallocating resources to more deprived regions or health facilities and/or revising sub-national allocation formulas, as appropriate.
- **Findings and asks on sources of financing the health sector:** Provide an overview of financing of the health sector, including any earmarked government income, such as through “sin” taxes. Summarize aid trends and the focus of external support (recurrent versus capital investments, different levels of the health system), making sure to note whether transfers are recorded on budget. Also present information on other financing trends (e.g. private spending, user fees) and options to increase spending, if appropriate. In addition, if you are in a middle income country and HIV/AIDS and vaccines are major issues, the government should be solely responsible for financing relevant services; if not, include this as a key recommendation. Based on the findings, formulate asks to reverse widening financing gaps, better maximize the use of aid or existing budgets to ensure sustainable financing, and/or to address formal/informal user fees. Be sure to call for recording aid on budget and using national systems if those are not current practices.
- **Other sector issues and reforms:** Based on country context and data availability, there could be a number of specific messages around key health policy reforms that impact spending, decentralization, the link between spending and results, etc. This is also the space to discuss any key messages related to the lack of coherence between existing policies and plans and the budget allocated to implement them. Formulate appropriate asks based on the findings.

Examples

- Real spending in the health sector has not grown over the past two years. Thus, there is a need to ensure that health sector allocations do not decrease in real terms in order to address the severe underinvestment and underlying challenges.
- Per capita expenditure amounted to US\$18 in the 2016/17 budget, which is far below the US\$33 per capita required to achieve the goals set out in the Essential Health Package recently adopted by the government. Efforts must be accelerated to identify alternative financing sources to ensure basic health objectives are adequately and sustainably financed.
- Ten percent of the current budget is directed to the health sector, which falls far below the government's commitment to scale up health spending and meet the Abuja Declaration target. The government should investigate the potential for introducing innovative financing mechanisms, including involving the private sector which will could boost investments by an additional 0.5% of GDP.
- Most of the health sector budget is consumed by personnel and administrative expenses. To achieve greater outcomes, including reduced infant mortality, larger investments are urgently required, which could potentially be gained by reducing the large wage bill and decreasing travel and training costs across government.
- Primary health care received only 7 percent of the health budget in the current fiscal year, which is the lowest portion of all the programmes within the health sector. If the government wants to achieve the SDGs related to this crucial component of public health, the budget needs to be increased urgently.
- The government has achieved the PEPFAR goal of 90-90-90, yet the cost of treating HIV/AIDS as well as the years of lost productivity from early HIV/AIDS-related deaths remains a huge recurrent cost for government. Given that HIV/AIDS rates remain among the highest in the world, more must be done to prevent new cases and provide more support victims.
- Budget credibility for both recurrent and capital spending items is erratic and significantly underperforming (62 and 83 percent respectively based on the latest data). It is recommended that a joint government, World Bank and UNICEF-sponsored Public Expenditure Review (PER) of the health sector be undertaken to understand the underlying challenges and identify solutions, which could significantly improve the efficiency and impact of investments.
- Health budget execution in is both low and erratic. Issues related to shortfalls in donor commitments, cumbersome procurement procedures and the spending capacity of ministries must be addressed as priorities.
- Allocations to districts do not reflect a needs-based prioritization, resulting in lower allocations to the worst-performing districts. The district allocation formula proposed by the National Local Government Finance Committee should be revised to reflect district-specific health indicators and approved.
- The majority of donor resources are spent off-budget, which undermines budget planning and implementation processes and heightens the risk of duplicating services. In line with OECD-DAC best principles, donor funding should increasingly flow through national systems. This is a joint agenda, which requires the government to prioritize strengthening the PFM system to minimize fiduciary risk and donors to reduce project-based support modalities.
- The fast-growing population, coupled with the slow rise in the health budget, increasingly pressures households to cover medical expenses. The government needs to ensure that budget allocations are sufficient to implement the 2015 Health Policy that introduced free health services to women and children.

Sources: Adapted from select budget briefs.

Section 1. Introduction

Objectives of the section

- Provide an overview of key policy and/or strategy documents and recent sector performance.

Key considerations

- A country's investments in health should be guided by one or more policy and strategy documents.
- Suggested length for this section: 1-1.5 pages, including any graphics.

Possible data sources

- Health strategic plan, subsidiary policies, MDA strategic plans, global databases (WHO, World Bank), sector performance databases and reports.

Content

- **Health sector overview:** Provide a short overview of the health system, including the structure and the different ministries responsible for delivering health services.
- **Main documents and targets:** Describe the key health sector documents and the high-level targets (e.g. 5 to 10 year targets for average distance from a health facility, % of births attended by a midwife or spending targets).
- **Sector performance:** Offer a picture of the performance of the health sector, highlighting the key statistics summarized below. Based on your country context, 2-3 indicators should be presented in a time-series figure or graph to highlight some of the key challenges – e.g. high infant mortality rates, low numbers of doctors and nurses, high prevalence of people living with HIV, low access to antiretroviral therapy, incidence of new malaria cases, etc. Recommended indicators are provided below in Box 3. Be sure to include any information on disparities in the coverage of services based on location and/or wealth if possible.
- **Takeaways:** Using bullet points, summarize key findings and implications on poor households and children.

Box 3. Suggested indicators

- ✓ Life expectancy (years)
- ✓ Infant mortality rate
- ✓ Stunting or wasting rates
- ✓ Distribution of causes of death among under 5 population: birth complications (asphyxia), diarrhea, measles, malaria, pneumonia, HIV/AIDS
- ✓ HIV prevalence and/or number of people living with HIV (adults and children and adolescents)
- ✓ Physicians per 10,000 population
- ✓ Nurses and midwives per 10,000 population
- ✓ Hospital beds per 10,000 population
- ✓ Coverage of insecticide-treated bed nets (%)
- ✓ Births attended by skilled health personnel (%)
- ✓ Immunization coverage among 1-year-olds (%)
- ✓ Antiretroviral therapy coverage among people with advanced HIV infection (%) (by age)

Examples: Refer to Section 1 of the [Health Sector Budget Brief Template](#), which presents the data requirements for each figure, a short description of how the information should be interpreted, and suggested titles and sources. Some examples are presented below.

Figure 1.1. Strategic framework for health: Key policies, strategies and plans that guide the sector

Strategic documents	Key sector Outcomes and targets
Rwanda Vision 2020: A long-term, 20-year development vision	<ul style="list-style-type: none"> - A reduction of: <ul style="list-style-type: none"> - The maternal mortality rate from 1,070 to 200 per 100,000 - The infant mortality rate from 107 to 50 per 1,000 - Fertility rate from 6.5 children in 2000 to 4.5 children in 2020
National Strategy for Transformation (NST1)- 2017-24	<ul style="list-style-type: none"> - Eradicating Malnutrition <ul style="list-style-type: none"> - Implement two pronged strategies to eradicate malnutrition i.e. Prevention and Management of all forms of malnutrition (acute and chronic) - Enhancing the demographic dividend through ensuring access to quality Health for all: <ul style="list-style-type: none"> - Construct and upgrade Health facilities with adequate infrastructure: 100 per cent access to electricity and water - Improve Maternal Mortality and Child Health by reducing maternal mortality ratio to 126/100,000 in 2024 from 210/100,000 (2013/14) and under five mortality rate to 35/1000 in 2024 from 50/1000 (2013/14). - Ensure vaccination coverage and deliveries at health facilities at above 90 per cent; - Increase the number and quality of human resources (general practitioners, specialists, nurses and qualified administrators): <ul style="list-style-type: none"> - one medical doctor per 7,000 people from 10,055, - one nurse per 800 people from 1,142 - one midwife per 2,500 from 4,037 - Scale up efforts to raise awareness on reproductive health and increase contraceptive prevalence from 48per cent (2013/14) to 60per cent in 2024. - Strengthen disease prevention awareness and reduce Communicable and Non-Communicable Diseases (NCDs).
Health Sector Strategic Plan (HSSP) 4: 2018/19 – 2023/24	<ul style="list-style-type: none"> - Reduced prevalence of Stunting from 38 per cent in 2016 to 19per cent in 2024; - Ante Natal Care (ANC) coverage (4 standards visits) increased from 44 per cent in 2016 to 51per cent in 2024; - New-borns with at least one Post Natal Care (PNC) visit within the first two days of birth increased from 19 per cent in 2016 to 35 per cent in 2024;
Health Financing Sustainability Policy-2015	<ul style="list-style-type: none"> - Increased efficiency for improved quality and service delivery (value for money); - Strengthened Health Insurances and risk pooling systems; - Enhanced strategies and interventions for increasing domestic revenue for health including the community and private sector to monetize available expertise; - Strengthened the institutional environment for sustainable financing and ensure accountability in the health sector.

Figure 1.2. Under five mortality trends, 2001-2017

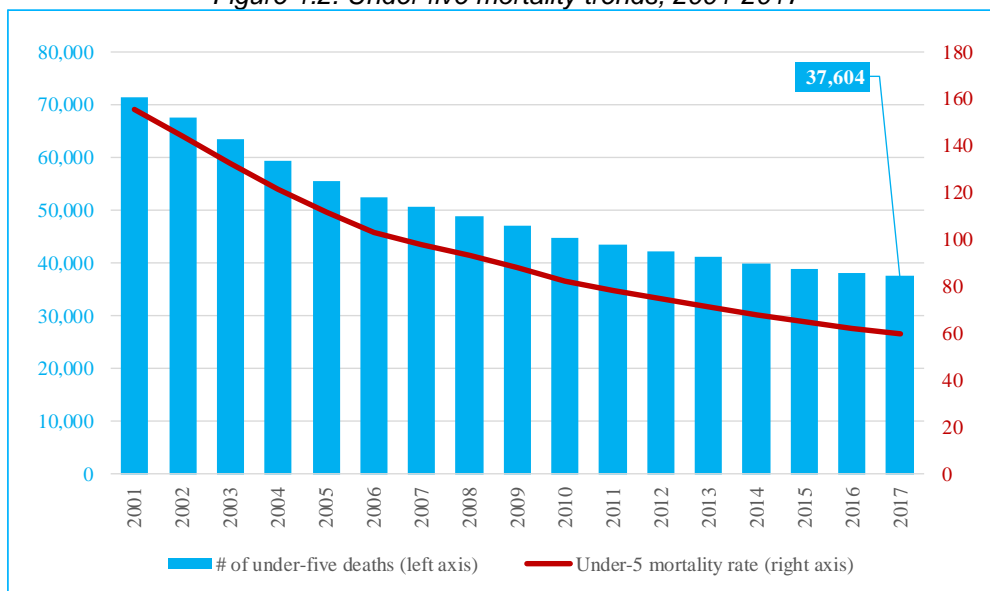


Figure 1.3. Main causes of disability adjusted life years (DALYS) among children under five, 2016 (% of total; colors represent change since 2000)

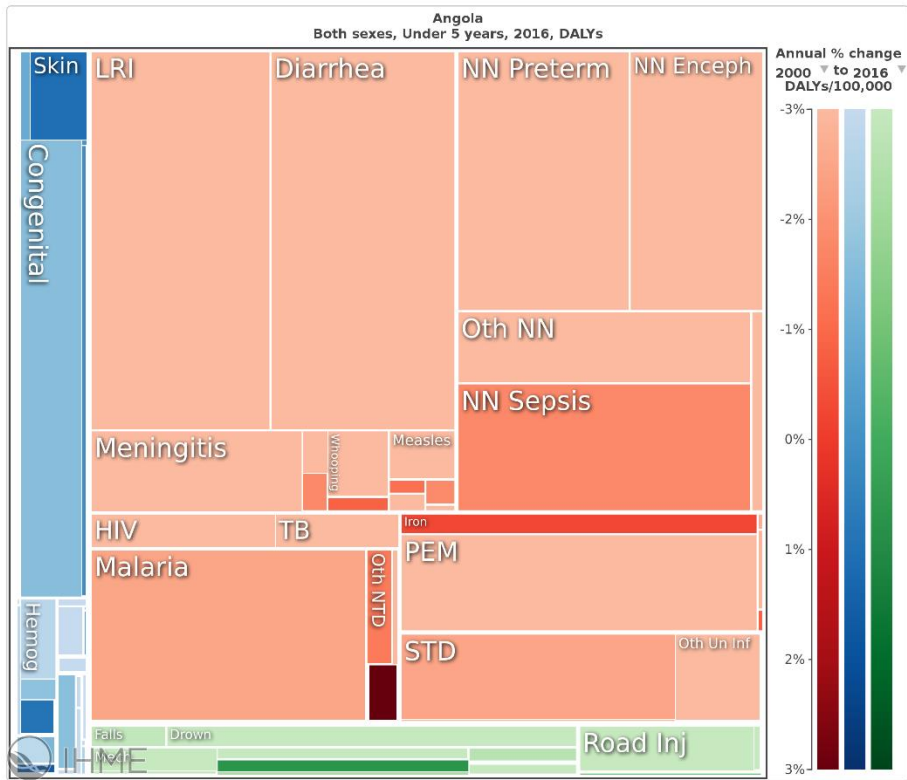


Figure 1.3. Changes in main causes of DALYS among children under five, 2000 to 2016

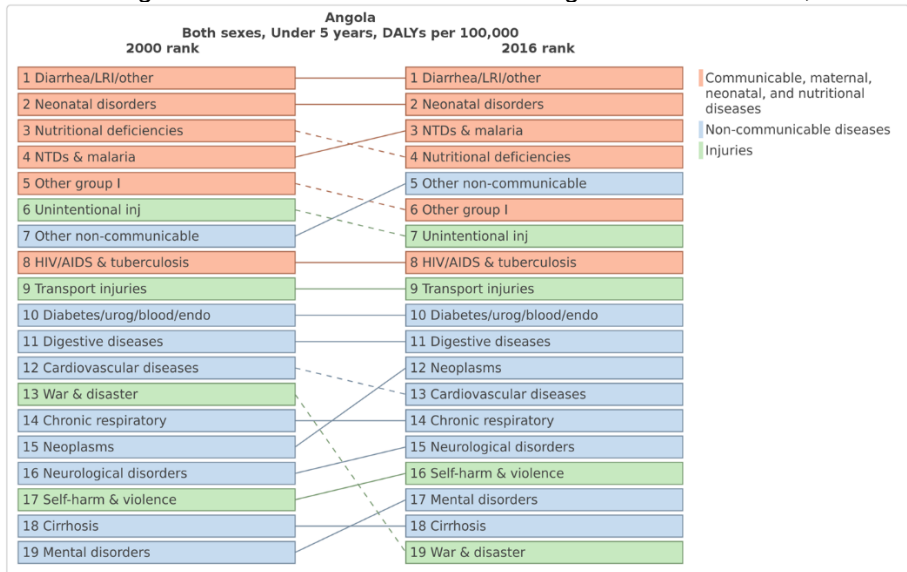


Figure 1.4. Birth attendance by skilled health professionals in select countries, latest available (as % of total)

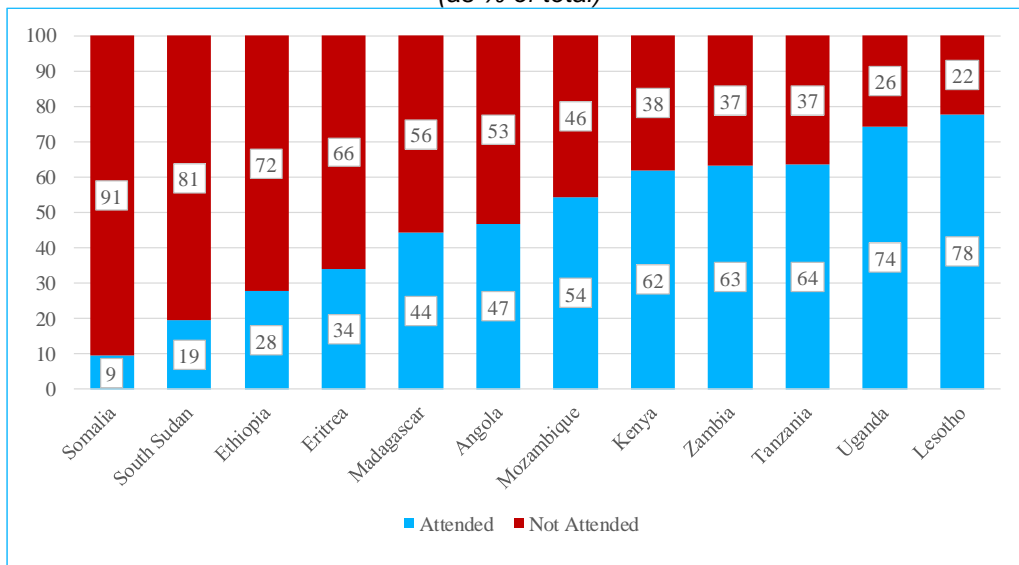


Figure 1.5. DPT immunization trends among children ages 12-23 months, 2001-17 (in numbers and as %)

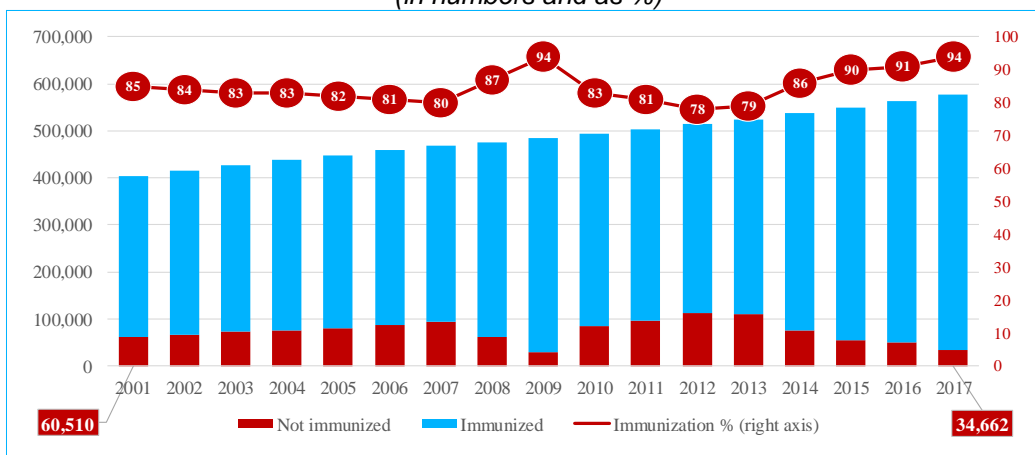
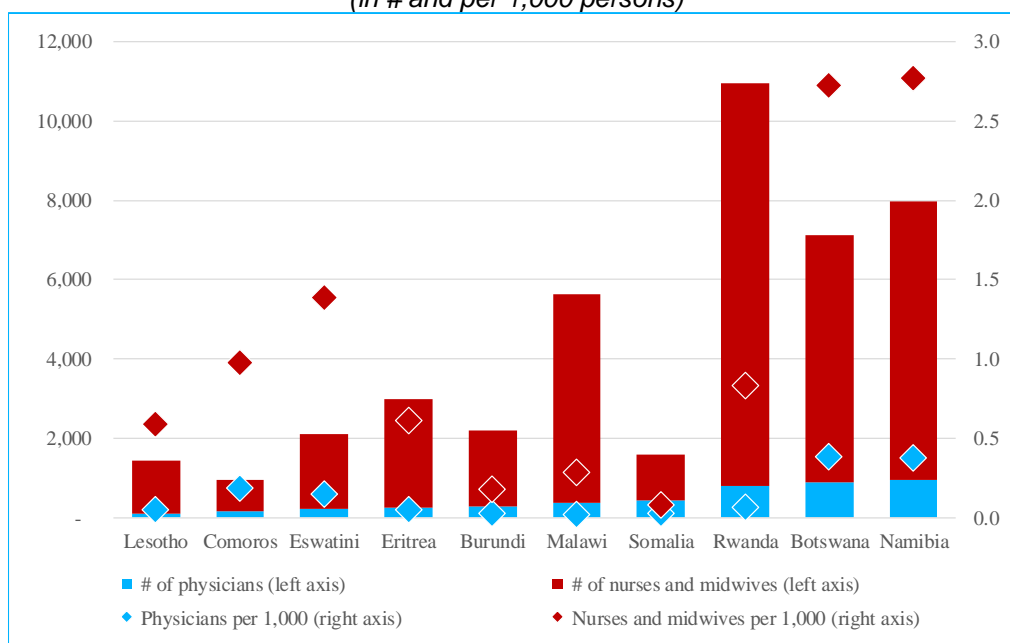


Figure 1.6. Size of the health workforce in select ESAR countries, latest available (in # and per 1,000 persons)



Section 2. Health Spending Trends

Objectives of the section

- Present health sector spending trends over time, understand the overall priority of the health sector within the national budget, and compare against national and international targets as well as to similar countries.

Key considerations

- All spending in the health sector should be presented in this section, irrespective of funding source (both domestic and donor funding that is reflected on budget). Note that there is no need to distinguish between funding sources at this stage, which will be discussed in detail in Section 7 on financing the health sector. Related, if off-budget spending is significant in your context, it will be important to mention the importance in the narrative of overall spending trends, but then refer to Section 7 where detailed analysis will be presented, if relevant.
- All spending on health, health regulatory bodies, national AIDS commission, transfers to hospitals, etc. should be summed into a single “health” sector.
- Total health spending should include national, sub-national and local level if possible; take care to avoid double counting (transfers from the central level to sub-national levels should not be counted twice).
- All spending figures should look at the latest five-year period. If MTEF estimates are available for the next 2-4 years, also include those, making sure to clearly note where estimates begin.
- Suggested length for this section: 1-2 pages, including any graphics.

Possible data sources

- Approved national budget, MTEF, audited or preliminary outturns for the past 4 years, approved/draft estimates for the current financial year, outer year projections, budget speech, Government Spending Watch, WHO, NASA.

Content

- **Size of public spending:** Present the evolution of government spending on health over time, including:
 - total nominal value
 - as % of the total government budget
 - as % of GDP
 - per capita spending (total nominal value of health spending divided by the size of the population); can also present in constant US dollars and in PPP terms using estimates from the [WHO's Global Health Expenditure Database](#) (although only up to 2014)
- **Public spending changes:** Discuss annual changes in health spending in nominal and real (or adjusting for inflation) terms (see Section 2 of the [Health Sector Budget Brief Template](#), which will automatically calculate these).
- **The priority of health:** Compare public spending on the health sector to spending on other major sectors in the national budget (only look at the 5-8 biggest sectors and group smaller sectors in an “other” category). If the proportion of resources going to health in the national budget has been decreasing in recent years, identify the areas that have been receiving greater funding (debt repayment, transport, security, etc.) – or vice versa.
- **Public spending against commitments:** Gauge your country's current financial commitment to health against (i) any national targets contained in policy or strategy

documents and (ii) the global health spending benchmark of 15% of the national budget as put forth by the [Abuja Declaration](#).

- **Public spending against other countries:** Compare health spending in your country with other countries (e.g. neighbors, similar income levels) and/or regional or sub-regional averages. International data can be drawn from the [WHO's Global Health Expenditure Database](#). Although these data are published after a lag of several years, a consistent methodology make them useful for international comparisons. For instance, you can download the following indicators: (i) government expenditure on health as % of total expenditure on health; (ii) general government expenditure on health as % of total government expenditure; and (iii) per capita expenditure on health in constant US dollars and/or in PPP. Also note that data from global sources is likely to vary from national estimates due to differing definitions, methodologies, reporting periods, etc., so be sure to include a footnote to discuss any discrepancies.
- **Takeaways:** Using bullet points, summarize key findings and implications on poor households and children.

Examples: Refer to Section 2 of the [Health Sector Budget Brief Template](#), which presents the data requirements for each figure, a short description of how the information should be interpreted, and suggested titles and sources. Some examples are presented below.

Figure 2.1. Nominal and real health sector spending trends, FY2011-21
(in billions of local currency -- base year is 2011)

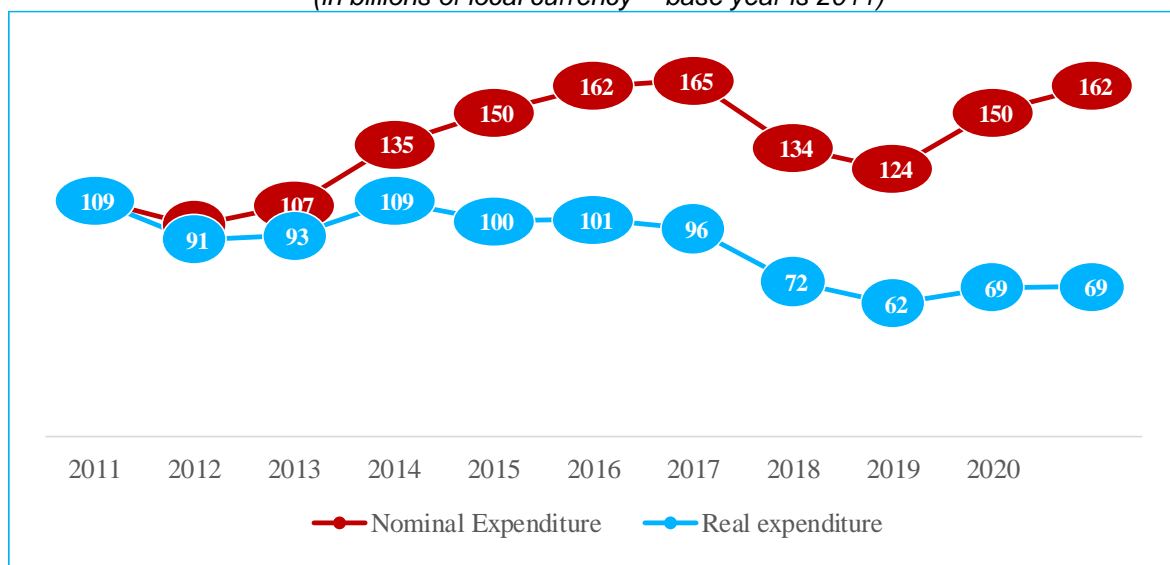


Figure 2.2. Composition of government expenditure, FY2016-20 (as % of total expenditure)

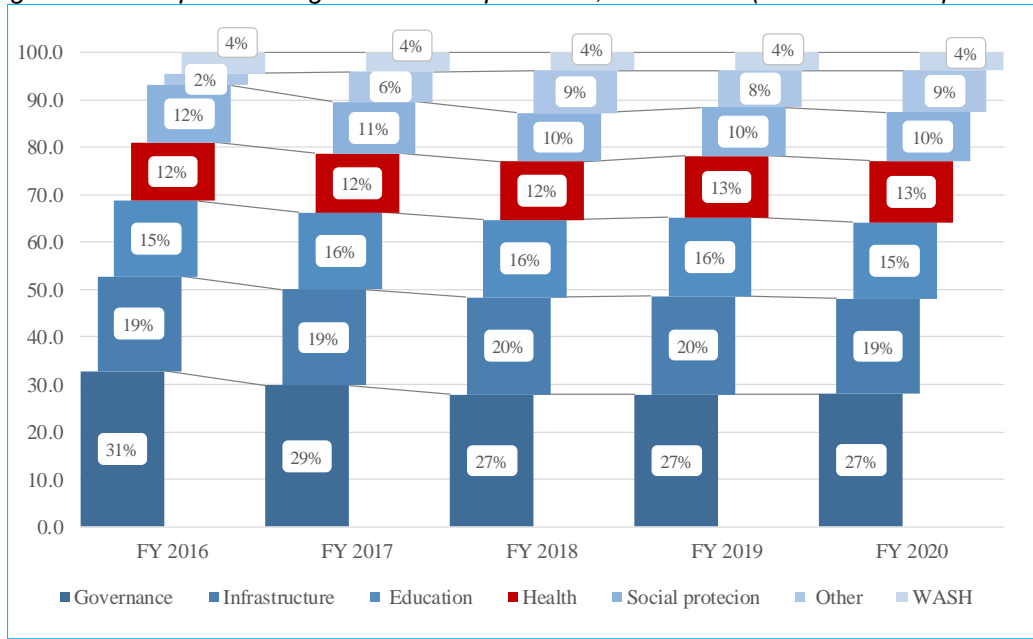


Figure 2.3. Health sector spending trends and international targets, 2011-20 (as % of national budget and a % of GDP)

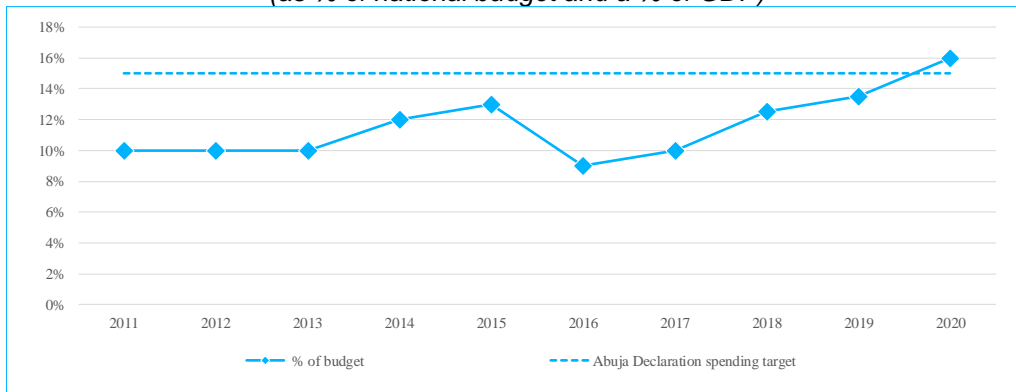
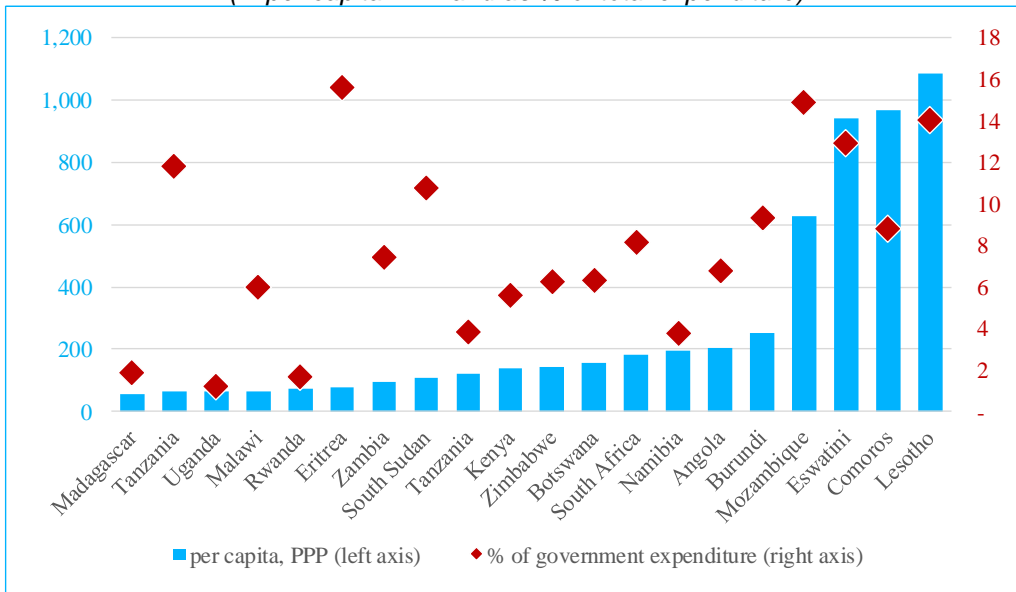


Figure 2.4. Health spending in select ESAR countries, latest available (in per capita PPP and as % of total expenditure)



Section 3. Composition of Health Spending

Objectives of the section

- Describe the composition of health spending, including by ministries/institutions that deliver health services for children, by levels of health and by the type of spending (recurrent and capital).

Key considerations

- As in Section 2, total health sector spending should include spending from all funding sources that is reflected on budget.
- Presentation of the budget by economic inputs is useful for budgeting and analytical purposes. Each country may have slightly different accounting standards and classifications. The government's accounting and reporting standards should be adopted for the brief.
- Economic classification is often divided into three categories:
 - *Salaries and wages*: This will normally include all wages, salaries and allowances for civil servants in the health sector, including clinical and non-clinical staff. Leave allowances and social benefits, such as health insurance contributions and pensions, will often be included in this category. The wages of contractors and personnel attached to particular development projects may not be included in this category but rather appear under development or capital spending (below).
 - *Other recurrent costs*: This category is normally a catch all for items that are not related to salaries or major investment projects. This could include items such as drugs, vaccines, utility costs and transportation costs, where it can be identified.
 - *Development or capital spending*: Countries often have separate mechanisms and procurement guidelines for managing large projects. To ensure capital or development spending is directed to the most beneficial projects, project proposals will often be examined to assess both their economic return and their alignment to national objectives. To reduce the risk of corruption, development spending will often abide by stricter procurement guidelines. Due to the heavy involvement of donors in ESAR, development or capital spending is often divided into domestically financed and donor or internationally financed. Donor projects may also involve co-contributions from the government resulting in two sources of funding for the same project.
- When looking at recurrent and capital spending (economic classification), certain items (like salaries) can consume an inordinate amount of the health budget. Public Expenditure Reviews (PERs) can help to analyze unjustifiable spending and will be an important information source for this section if one has been produced in recent years. Alternatively, if a PER of the health sector has not been carried out in the past four years, this would serve as a strong recommendation for the brief and action point for the office.
- It is a good idea to compare the recurrent and development budget to relevant performance indicators, such as drug stock outs or staffing of health centers. Where there have been major cuts to the "other recurrent" budget, expect to find increases in the number of drug stock outs and the number of facilities without water or power.
- Many countries have a policy to increase spending on primary and preventive health care to maximize health gains given limited financial resources.

- Related to the above, this section will be important to highlight the level of government investments in procuring and delivering vaccines.
- Health centers and facilities require electricity and water in order to be effective. However operational budgets and mismanaged national utility companies can leave centers without vital utilities and hence jeopardize health outcomes.
- If not easily identified in the health sector budget, recent HIV/AIDS expenditure trends can be accessed and reported from alternative sources, including the UNAIDS-led [National AIDS Spending Assessments \(NASAs\)](#) and [Global AIDS Response Progress Reports](#).
- In countries with a high prevalence of HIV/AIDS, it will also be important to capture health services that are provided outside the remit of the Ministry of Health, such as in schools or social protection centers.
- It will also be important to capture investments in vaccines and other basic commodities that are important to your health country context.
- Suggested length for this section: 1-2 pages, including any graphics.

Possible data sources

- Approved national budget, MTEF, audited or preliminary outturns for the past 4 years, approved/draft estimates for the current financial year, outer year projections, budget speech, Government Spending Watch, WHO, NASA.

Content

- **Ministries/institutions:** Describe the spending trends for each ministry, institution and/or agency that is responsible for providing health services (Ministry of Health, Central Medical Supplies, Hospitals, National AIDS Commission, etc.).
- **Levels of the healthcare system:** Present the overall health budget by each level of the healthcare system – primary, secondary and tertiary.
- **Functions and/or programs:** Depending on the availability of information, present the overall health budget by functions of spending (medical products and equipment, outpatient services, hospital services, public health services, R&D, other) and/or by major health programs (if program-based budgeting is used in the sector). It is not necessary to present both of these; if there are multiple options available, select whatever analysis is most useful in terms of highlighting health sector challenges and supporting your narrative. If there is detailed budget information on major programs, like HIV/AIDS or vaccines, it may be strategic to develop a standalone analysis (see below).
- **HIV/AIDS:** If this is an important issue in your country, present trend analysis, including the % of the health budget allocated to HIV/AIDS programs. If available, it would also be very important to present spending information by: (i) *type of intervention* (the % of the HIV/AIDS budget devoted to prevention and treatment services); and (ii) *funding source* (the % of the HIV/AIDS budget financed by domestic resources and donor funding). This topic could be included in the main narrative, as a box or side bar within the main narrative, or as a separate special issues chapter – it will depend on the priority of the issue and the amount of available information. If HIV/AIDS spending is not easily identified in the budget, be sure to include this as a key recommendation.
- **Basic health commodities and delivery systems:** If vaccines and/or other commodities are an important component of your health system, present trend analysis of spending on individual items (vaccines, anti-malarial medication, bed nets, etc.) along with the accompanying implementation budgets (e.g. cold chain strengthening, campaigns, national health days, etc.). Depending on the number

of critical items in your context, this could be presented as an aggregated analysis (2 or 3 commodities presented in a single figure) or by individual figures. It would also be important to present spending information by funding source (e.g. the % of the budget for vaccines financed by domestic resources and donor funding). In addition, if there is information on per unit cost paid for different commodities – and if you think that the current prices are higher than those offered by alternative suppliers (e.g. from UNICEF Supply Division), you can customize a simple comparative analysis that would estimate the potential cost savings that could be achieved if the government were to procure the commodity from a different supplier. The analysis of spending on basic health commodities could be included in the main narrative, as a box or side bar within the main narrative, or as a separate special issues chapter – it will depend on the priority of the issue and the amount of available information. If spending information on basic commodities is not easily identified in the budget, be sure to include this as a key recommendation.

- **Economic classification:** Describe spending trends on wages and salaries (for doctors, nurses, community health workers), medicines and drugs, maintenance and other operational costs versus capital spending on things like constructing new community health facilities and hospitals. Is this the ideal balance given the key constraints in the health sector (i.e. is there a case for shifting spending away from one area to another, for instance, if there are health facilities without drugs or staff or vehicles without fuel)? Are there any particularly egregious expenditures (e.g. travel, fuel, salaries, allowances), and has any progress been achieved to address them?
- **Key gaps:** Are there key investments mentioned in the health sector plan or strategy that did not make it into the budget (more community health workers, specific medicines, cold chain equipment, construction of new health facilities, etc.)?
- **Takeaways:** Using bullet points, summarize key findings and implications on poor households and children.

Examples: Refer to Section 3 of the [Health Sector Budget Brief Template](#), which presents the data requirements for each figure, a short description of how the information should be interpreted, and suggested titles and sources. Some examples are presented below.

*Figure 3.1. Health sector spending by institution, FY2015-19
(in billions of local currency and a % of sector budget)*

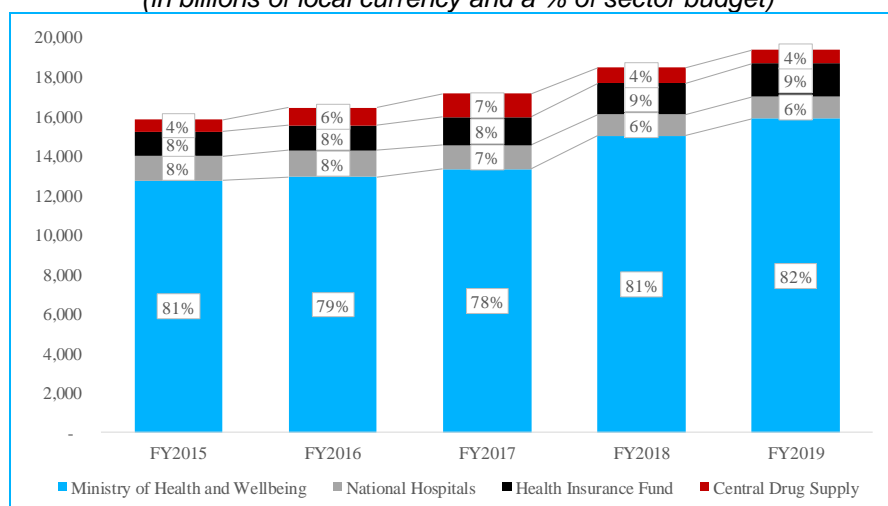


Figure 3.2. Health sector spending by service, FY2015-19
(in billions of local currency and a % of health sector budget)

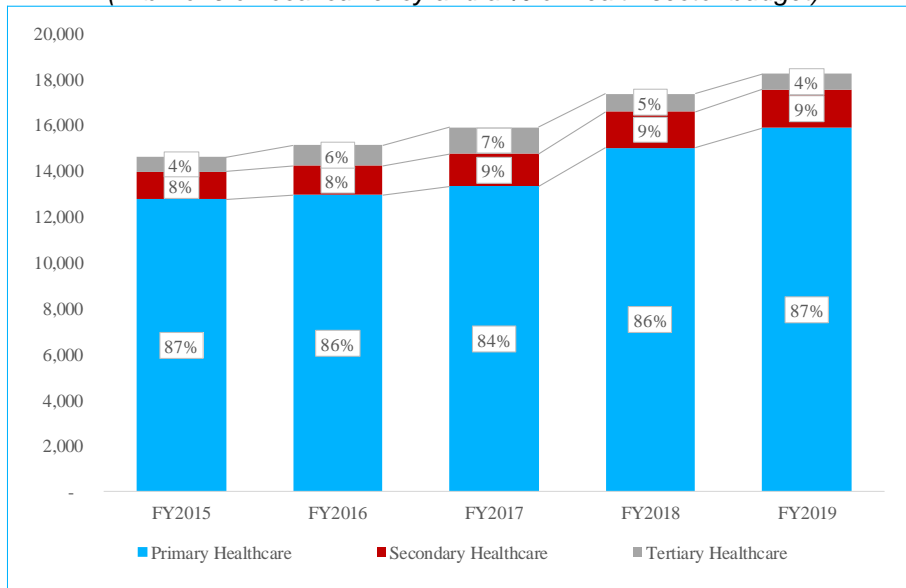


Figure 3.3. Health sector spending by program, FY2015-19
(in billions of local currency and a % of sector budget)

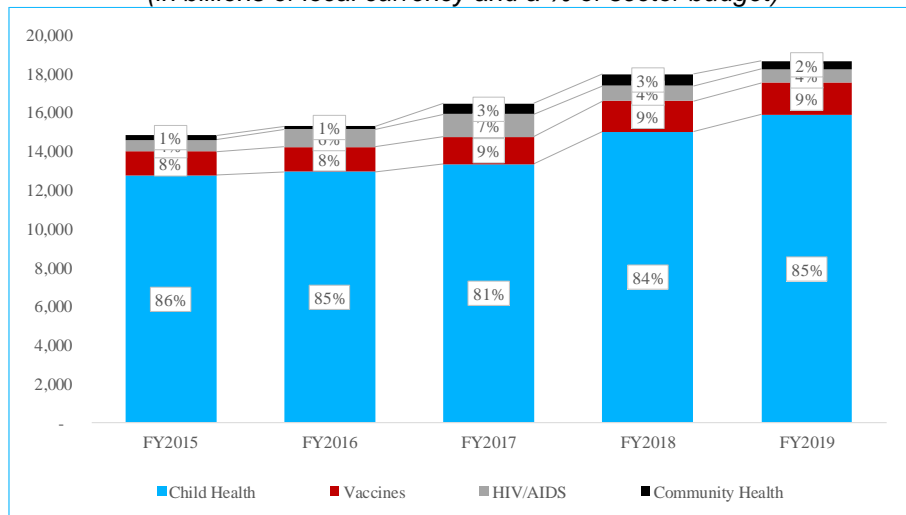
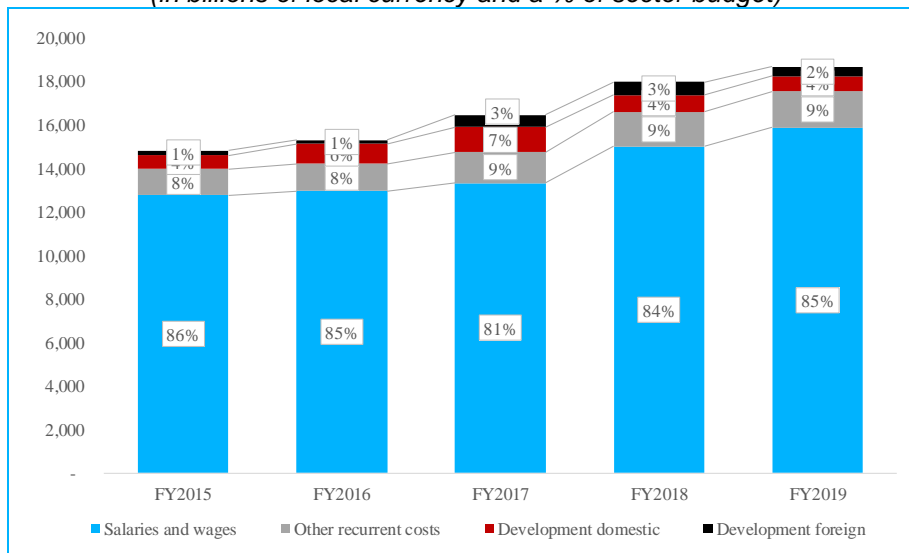


Figure 3.4. Health sector spending by economic classification, FY2015-19
(in billions of local currency and a % of sector budget)



Section 4. Budget Credibility and Execution

Objectives of the section

- Evaluate the credibility of the health sector budget (i.e. the relationship between budget allocations and actual expenditures) and the capacity of implementing agencies to spend available funds.

Key considerations

Budget credibility

- Budget credibility refers to the ability of the government to execute the budget as planned. This can be measured by the deviation between planned and actual spending – in other words, the difference between budget allocations in the health sector (or planned spending), which are approved at the start of the fiscal year, and actual expenditure, which is the total amount spent at the end of the fiscal year.

Budget execution

- Budget execution refers to the implementation of the approved budget. For the health sector, it can be measured by the difference between the total amount of funds released by the Ministry of Finance or Treasury to those ministries that are responsible for delivering health services and the total amount of funds that are actually spent by those ministries at the end of the fiscal year. Budget execution is a key component of budget credibility since unspent funds will affect actual expenditure.
- Budget execution is the processes of releasing funds, recording transactions, operating budget controls, monitoring budget implementation (including any necessary remedial actions), and systems to pay wages, manage contracts, measure performance, supervise, etc. It is often divided into five steps: (i) commitment; (ii) verification; (iii) payment order; (iv) cash payment; and (v) accounts.¹
- There are some general signs that indicate budget execution challenges:
 - *Large variations in planned versus revised and actual expenditures:* Is there an official explanation for the deviation? Is the official explanation reasonable? Could cost overruns have been predicted? Was the initial budget in line with historic trends or was it inflated and optimistic? What is the role of budget planning and approval processes?
 - *Systematic variations:* Does a particular program, activity, public entity or budget classification face revision every year? Is the regularly revised activity open to exchange rate or price volatility? Are revisions specific to one entity, which can be attributed to poor planning? Do specific entities regularly underspend, which can be attributed to a general lack of capacity?
 - *Late release of funding:* When does the Ministry of Finance or Treasury release funding to spending entities? Are funding releases on a monthly or quarterly basis? Are releases made toward the end of the month/quarter? Does the amount of funding released deviate from agreed cash flows.
- Some general causes of poor budget execution include:
 - Poor planning, accounting and cash management practices
 - Macroeconomic adjustments (e.g. result in downward revisions of revenue and hence the resource envelope)
 - Frontloading disbursements or uneven disbursements throughout the year

¹ <https://www.imf.org/external/pubs/ft/extend/guide4.htm>

- Inability of the spending agency to utilize budgeted resources due to insufficient human resources, delayed procurement processes, poor planning, technical challenges, etc.
- Report lags from lower levels, which mean that resources may have actually been spent but they have not yet shown up in the official accounting system
- Withholding of funds from the spending agency due to deviations from national budget guidelines (e.g. poor quality of cash flow submissions)

General

- In practice, budgets are rarely implemented exactly as approved. This can be for legitimate reasons, such as adjustments in policies in response to changes in economic conditions, or for systematic issues, like mismanagement, poor planning, unauthorized expenditures, low absorption capacity, fraud, delayed disbursements, etc. This section should aim to identify some of the key issues.
- The mid-year and year-end budget reports will contain official justifications for revising approved expenditures.
- To better understand the extent to which budget credibility and execution challenges may be affecting the health sector in your country, it will be important to quickly review (and cite!) broader PFM diagnostics that have been recently carried out, including Public Expenditure Reviews (PERs) and Public Expenditure Tracking Surveys (PETS), as well as pillars 1-3, 14 and 16 of [Public Expenditure and Financial Accountability](#) (PEFA) Assessments. The PEFA questionnaire, in particular, provides guidance on acceptable levels of deviations from the approved budget. For at least two of three years:

PEFA scoring PI1, PI2	A	B	C
Aggregate expenditure	±5%	±10%	±15%
Expenditure by classification	±5%	±10%	±15%

- What to assess? There are many aspects of budgeting that can be assessed for credibility, including approved and actual estimates according to the administrative, functional, economic and program classifications. Given the multitude of potential analyses, this section should be issue driven, so that it focuses on the specific areas where the greatest deviations are observed. At a minimum, comparisons between the approved budget and budget outturns by administrative and economic classification should be presented.
- Suggested length for this section: 1 page, including any graphics.

Possible data sources

- National in-year and end-year execution/performance reports, sector/MDA budget/performance reports, audit reports, secondary analysis, such as donor reports, Government Spending Watch.

Content

- **Budget credibility:** Describe any major variations between planned and actual spending. This requires comparing budget allocations alongside actual expenditure for as many years as possible. Data on mid-year revisions should also be presented if available. If you have this data, then you would present three data points for each year: (i) the planned budget (or approved budget or budget allocations) at the start of the fiscal year; (ii) the revised budget (or adjusted budget) at the mid-year review; and (iii) outturn (at the end of the year) or actual expenditure (after spending has been audited and verified). Ideally this analysis can be done for each of the different MDAs that deliver health services as well as according to

the economic classification of the health budget. If there are budget credibility concerns relating to the use of funds compared to approved budget plans, there may be value in exploring this data at the economic classification level to explore movements of funds between categories within a sector.

- **Budget execution:** If data allows, compare the funding released by the Ministry of Finance or Treasury to the funding utilized by the different MDAs that deliver health services. As above, it would also be ideal to do this analysis using the economic classification of the health sector budget.
- **Challenges:** Identify any underlying causes of poor budget credibility and execution, including systemic problems and sector-specific issues. Be sure to refer to and cite relevant literature where applicable. By comparing a MDA's budget outturn to the approved budget, a number of issues can be investigated. How does the MDA's budget execution compare to the national execution average? Was funding released from the Ministry of Finance or Treasury, but the MDA was unable to spend all of the available funding before the end of the fiscal year? Is this due to late disbursements or poor-planning? Is there a pattern of particular items being deprioritized (underspent) during the year?
- **Takeaways:** Using bullet points, summarize key findings and implications on poor households and children.

Examples: Refer to Section 4 of the [Health Sector Budget Brief Template](#), which presents the data requirements for each figure, a short description of how the information should be interpreted, and suggested titles and sources. Some examples are presented below.

Figure 4.1. Budget credibility rates in select institutions, FY2015-18
(deviation from amount approved as %)

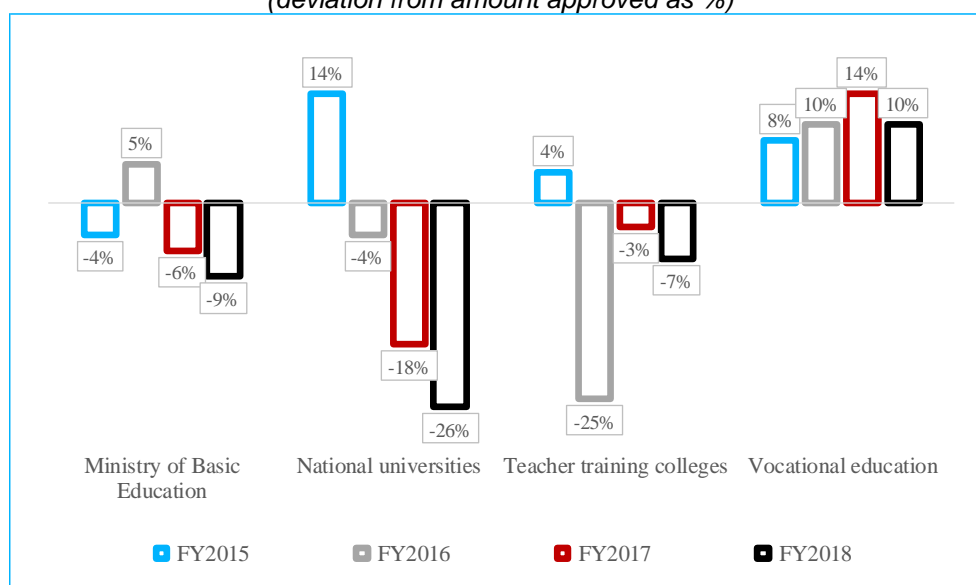
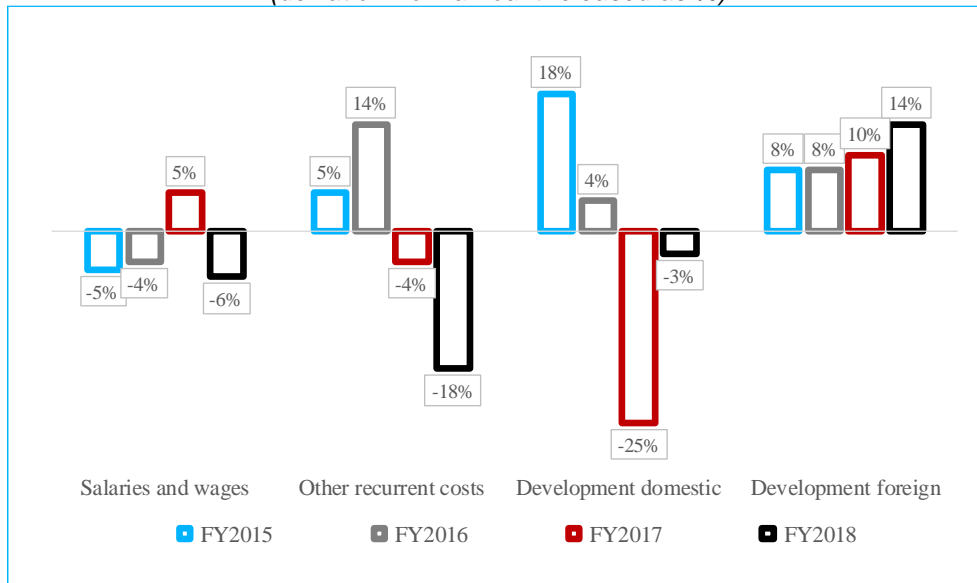


Figure 4.2. Budget execution rates by economic classification, FY2015-18
(deviation from amount released as %)



Section 5. Decentralization and Health Spending

Objectives of the section

- Understand how decentralization in the health sector contributes to equitable spending across different geographical units of the country.

Key considerations

- This section is optional and should only be developed if: (i) the health sector is heavily decentralized or currently going through decentralization reforms; and (ii) sub-national budget information for the health sector is available. If you are in a decentralized context and there are no data, a key message should be for the PFM system to generate disaggregated budget information which underpins equity analysis.
- Decentralized funding can be distributed to sub-national entities directly from the Ministry of Finance or Treasury or be channeled through a central institution – e.g. Ministry of Decentralization, Ministry of Territorial Administration, Ministry of Interior, Local Government Finance Agency, Grants Commission – which will also establish reporting and accounting practices. The national institution responsible for sub-national financing is likely to have the latest and most detailed information on budgets and performance indicators.
- Under a devolution model where powers are transferred to the sub-national level (see Box 5 for more information), the MDAs responsible for delivering health services are likely to have sub-national offices that receive the funding from the central level; these offices will also keep financial records.
- The primary structures used to finance sub-national governments – grants and formulas – need constant monitoring and revision to ensure that they are equitable and efficient. For example, it would be worth investigating how active the lead MDA for health has been in monitoring and revising the sub-national financing structure.
- Especially where decentralization is new or still an ongoing process, sub-national financing guidelines may not be strictly followed. If you have access to the financing formula and actual sub-national allocations, you can assess how closely the government has followed its financing guidelines, which can be a simple yet powerful analysis.
- Sub-national governments that closely adhere to national budgeting and accounting guidelines are more transparent and vice versa. Similarly, connecting sub-national governments to the national integrated financial management information system (IFMIS) can significantly boost transparency and accountability, while connecting lower-level health administrative units to the Health Management Information System (HMIS) can improve the quality and timeliness of performance reporting. If relevant, you can consider these issues among the recommendations.
- Suggested length for this section: 0.5-1.5 pages, including any graphics.

Possible data sources

- Decentralization master plan, transfers to sub-national governments, consolidated sub-national budgets.

Content

- **Decentralization context:** Discuss the functions that have been decentralized in the health sector and the degree to which the budget has been accordingly decentralized.

- **Sub-national funding guidelines:** Describe how funding is distributed to different regions (through a formula, grants or a combination of both) and the implications on the equity of spending. Are horizontal transfers to sub-national governments governed by a transparent, rule-based system? The PEFA guidelines (PI-7) detail issues related to horizontal government transfers.
- **Sub-national spending trends:** Explore recent changes in the health sector budget for sub-national entities and the composition of budgets – e.g. by comparing the % of total spending at national and sub-national levels. Is there more spending at the district level than the provincial or central levels? If so, account for the differences and discuss the impacts on the quality and equity of health services.
- **Spending disparities based on regions:** If you are not going to develop a standalone section on equity (see next section), then you can also include analysis of regional spending disparities here. If there are data on per capita spending by a regional unit (provinces, districts, communities, etc.) and/or an administrative unit (hospitals, health facilities, etc.), compare total funding levels. One good method is to present the per capita spending values on a bar chart that orders the units from lowest to highest; this illustration can make a convincing case on the need for increasing or reallocating resources to deprived regions or facilities, if required.
- **Takeaways:** Using bullet points, summarize key findings and implications on poor households and children.

Box 5. Key definitions

Decentralization: The transfer of responsibility and authority for planning, management, fundraising, resource allocation and other functions from a central government and its agencies to: (i) levels of local government; (ii) semi-autonomous public authorities or corporations; (iii) nongovernmental and voluntary organizations; and/or (iv) field units of central government ministries or agencies.

There are three different types of decentralization:

1. **Devolution:** The transfer of authority and responsibility for public functions to levels of (elected) local government. In devolution, local governments are considered autonomous and independent, operating within the bounds of the national legislative framework. However, in most cases, central oversight and control persist in various forms, including funding conditionalities. Devolution is strongly associated with political decentralization.
2. **Delegation:** The transfer of responsibility for public functions to semiautonomous public authorities or corporations (e.g. public housing corporations) and/or non-governmental and voluntary organizations. In delegation, the central government exercises its control through a contractual relationship that enforces accountability from the receiving authority. However, through this contractual arrangement, delegation also allows for some autonomy in decision-making, albeit less than devolution.
3. **Deconcentration:** The transfer of responsibility for public functions from the central government to field units of central government ministries or agencies (e.g. district water department or provincial water department). It is a shifting of the workload from centrally located officials to staff or offices outside of the national capital. Under deconcentration, the central government retains authority over the field office and exercises that authority through the hierarchical channels of the central government bureaucracy.

Source: de Wijn, M. (2016) [Global Stocktake of UNICEF Engagement in Decentralization and Local Governance, 2011-15](#), New York: UNICEF.

Examples: Refer to Section 5 of the [Health Sector Budget Brief Template](#), which presents the data requirements for each figure, a short description of how the information should be interpreted, and suggested titles and sources. Some examples are presented below.

Figure 5.1. National and sub-national spending trends on the health sector FY2015-19 (in billions of local currency and as % of total)

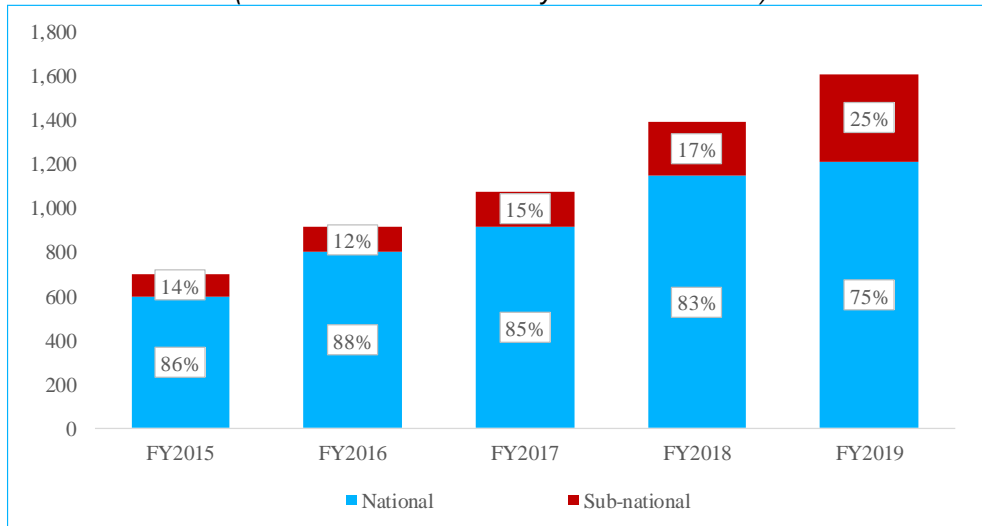
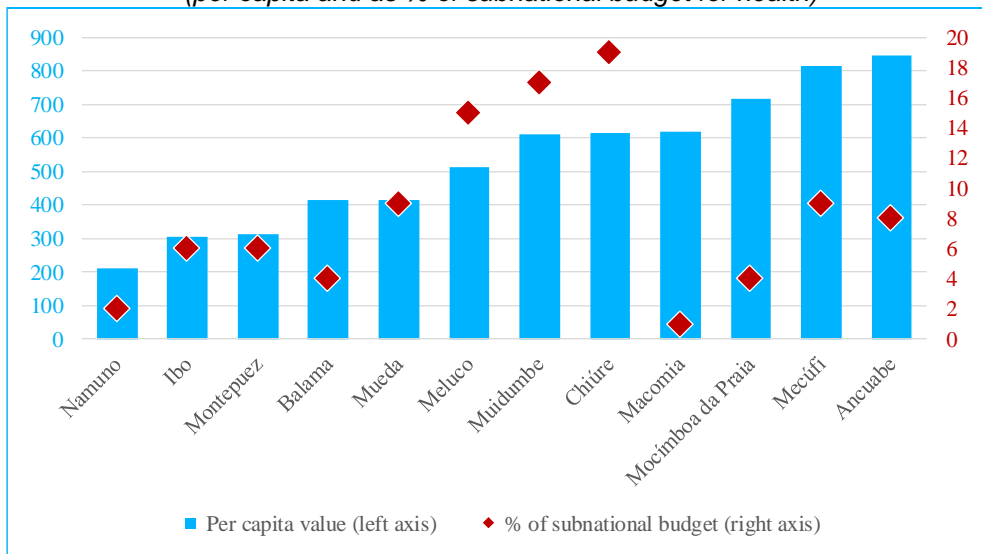


Figure 5.2. Health sector spending by district, latest available (per capita and as % of subnational budget for health)



Section 6. Equity of Health Spending

Objectives of the section

- Understand whether health spending is prioritizing the most disadvantaged persons and delivering results for all persons.

Key considerations

- This section is optional; it can only be developed if there is disaggregated data on education budgets and education performance and outcome data. Also, if your country is heavily decentralized, analyses of territorial equity of allocations or expenditure could be included in Section 5 (on decentralization), which would allow this section to be dropped.
- Understanding the equity of spending underpins UNICEF's core mandate to focus on and advocate for the most vulnerable households and children.
- The allocation of budgets to the health sector is considered inequitable if an advantaged (better off) group consumes a greater share of the resources. In contrast, equitable budget allocation is when the distribution of public resources compensates the initial disadvantages of groups considered to be disfavored, through an allocation of resources that is proportionally greater than the group's weight in the total population.
- There are two approaches to understand the distributive and structural dimensions of equity in the allocation of public resources to the health sector:
 - *Analysis of the distribution of resources by regions:* From an equity perspective, the most disadvantaged regions in terms of health indicators and more broadly, living standards, are expected to receive at least the same amount of resources as those received by better-performing regions.
 - *Analysis of the distribution of resources by individuals or groups:* This consists of analyzing the spending of public resources on health services according to the socioeconomic characteristics of groups or individual consumers.
- Data permitting, more sophisticated analyses using spending patterns and health sector performance indicators, like under 5 mortality rates or % of births attended by skilled health staff, can shed deeper insights on the equity of spending and results.
- Exercise caution when making recommendations regarding reallocations to poorer or lower performing regions. Sub-national allocations may only impact recurrent spending, which will not have a major impact on issues like increasing the number of local health facilities or hospitals to improve access; off-budget funds may also be significant and distort the funding picture. It will be important to understand whether poor health results are driven by a lack of funding or other performance factors, like lack of staff, stockouts, etc.
- Simple performance analyses may help identify good performers or outliers which could trigger additional studies and potentially find better ways of maximizing the impact of health budgets.
- Suggested length for this section: 0.5 page with graphics if including one analysis and up to 1.5 pages if including two or more analyses.

Possible data sources

- Sub-national/district health financing formulas or grants, decentralization master plan, transfers to sub-national governments, consolidated sub-national budgets, annual health performance reporting (disease incidence, distance from health facility, health worker to population ratios, etc.), benefit incidence analyses.

Content

- **Spending disparities by regions:** Make comparisons of per capita spending on health by region, district, etc. (the lower the level the better). Based on data availability, this analysis could be carried out for different levels of the health system or key services. Which regions, districts, etc. receive the lowest amount of funding once factoring in the size of the population, and is there a case for reallocating funding?
- **Spending disparities by income:** To take the regional analysis one step further, if there is data on poverty rates (or income levels) and per capita spending on health by region, district, etc. or by health facilities or hospitals, showing the relationship between these variables can be powerful. Are poorer regions, districts, etc. receiving at least the same funding levels as wealthier ones?
- **Spending disparities by results:** To gain insights on the relationship between resources and results, another compelling illustration can be developed if there is data on both spending and performance indicators by health facilities or hospitals. This would involve a scatter plot that places per capita spending on the x-axis alongside a performance indicator on the y-axis, such as those presented earlier in Box 3. In addition to distinguishing between good and bad performers, this can help to identify cases of “positive deviance,” whereby a small number of health facilities located in different areas of the country achieve impressive performance while using relatively fewer resources than most others. Although this would fall beyond the boundaries of a budget brief, this initial analysis could trigger follow up activities, including in-depth case studies based on field visits, interviews and deeper analysis of data, which could potentially reveal certain practices/standards/behaviors that lead to strong performance; these could be documented and then tested elsewhere.
- **Causes:** If severe spending disparities are identified based on any of the above analyses, it will be important to look at the underlying financing mechanisms, like per capita financing, capitation payments, the inter-governmental fiscal transfer formula, etc., as well as other drivers that favor certain regions or groups over others, such as household income, ethnicity, political economy dynamics, the presence of natural resources, geography (e.g. located close to major lakes or rivers), etc.
- **Takeaways:** Using bullet points, summarize key findings and implications on poor households and children.

Examples: Refer to Section 6 of the [Health Sector Budget Brief Template](#), which presents the data requirements for each figure, a short description of how the information should be interpreted, and suggested titles and sources. Some examples are presented below.

Figure 6.1. Per capita health spending and poverty rates by district, latest available

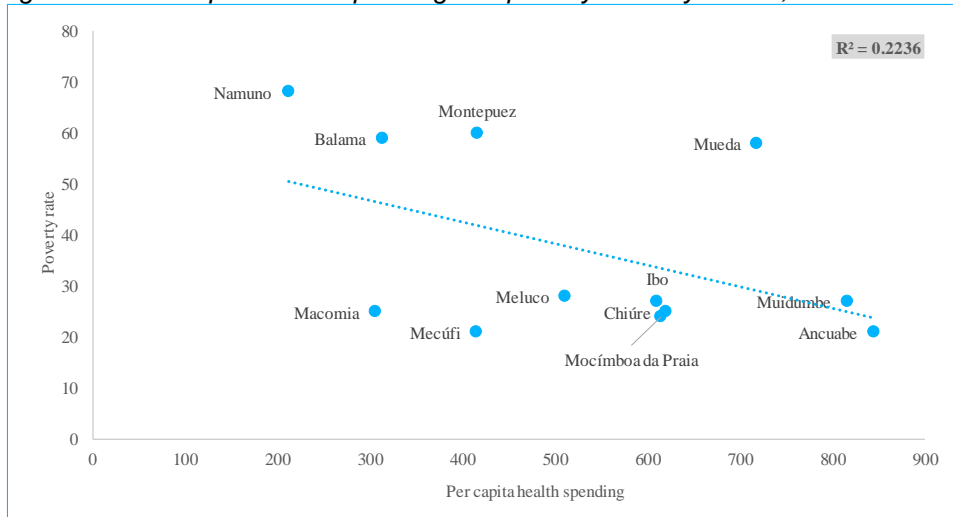
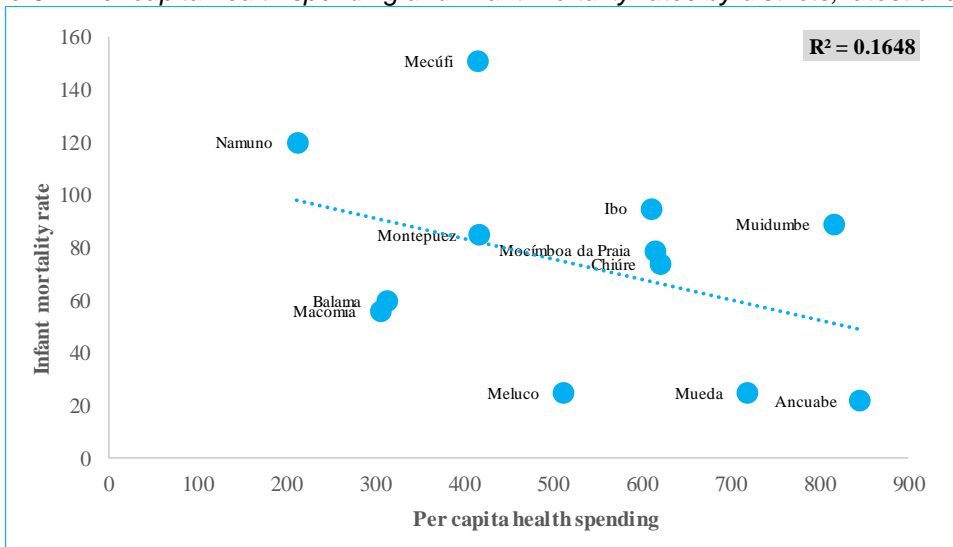


Figure 6.2. Per capita health spending and infant mortality rates by districts, latest available



Section 7. Financing the Health Sector

Objectives of the section

- Understand the main sources of financing for the health sector and identify potential vulnerabilities as well as opportunities for sustaining investments in the sector.

Key considerations

- The composition of overall financing to the sector can reveal issues of sustainability and equity.
- Health services can be financed through a mix of national and sub-national government revenue, donor funds, household funding as well as the private sector (e.g. private sector healthcare providers).
- Health services are often delivered by religious or private organizations but subsidized or financed by the government.
- In more advanced economies, national health insurance can be an effective way to pool risk and increase the resources available for the public health system.
- Donors are often a major funder of health services in ESAR; however, health services funded by donors may not be closely aligned to the country situation and/or burden of disease.
- Although international aid data used to be widely disbursed, the growth of sector program support (especially through budget support which is directed to specific ministries or spending items) has increasingly led to allocations that appear on the budgets of recipient ministries (known as “on budget”). If there is significant donor support that is not recorded on budget (i.e. it is channeled directly through a parallel service delivery system), this should be considered as a key recommendation in the budget brief.
- If there are difficulties obtaining data on foreign aid from the government, donor support to a country by specific sectors is recorded in the [OECD-Development Assistance Committee Creditor Reporting System](#), which can be used to fill any information gaps. In contexts where there is significant donor support to HIV/AIDS, funding from key donor sources, including the [Global Fund](#) and [PEPFAR](#), can be accessed through the respective links.
- Donor support is more effective if national systems are utilized and reported in the national budget. Among others, this can help ensure more predictable disbursements, avoid duplication of services or activities, and strengthen domestic planning and budgeting processes. If donor funding is unpredictable or erratic, this can also be a key recommendation.
- One of the most critical issues for UNICEF’s equity mandate is user fees, whether formal or informal. Being forced to pay out-of-pocket expenditures to access health services erodes the already limited disposable incomes of the most vulnerable households – in the best case scenario – or prevents children from receiving life-saving treatment – in the worst case scenario. As a result, it is imperative that the budget brief captures any available information on the size and scope of user fees and their role in limiting access to healthcare services.
- At the same time, it is important to recognize that user fees exist for many reasons, including the inability of public funds to cover the cost of providing quality health services. If this is a major issue in your country, then removing user fees could feature among the main recommendations, but with the caveat that the government is able to increase both spending and the performance of the health sector so that fees do not show up in other ways. If the public health sector is inefficient and

beyond immediate improvement, another possible recommendation could be to increase social protection support to help families cover the existing fees.

- This section should also take a close look at HIV/AIDS financing as well as the financing of basic health commodities, if these are major issues in your health system. For countries that have reached middle income status, governments should be covering all related costs; if not, be sure to make this a key message.
- If your country office has recently conducted a fiscal space analysis, this section offers an opportunity to present some of the headline options that could be used to scale up spending on health. Even if there has not been a recent fiscal space study, the option that could be the most effective for advocacy is how to maximize the impact of current health budgets (i.e. doing more with the same amount of resources). This information will be readily available if there is a recent PER or PETS. If not, there are a number of inefficiency indicators to look for from general health studies. Note that these issues could also be addressed in the final section of the brief (Section 8. Other Sector Issues and Reforms):
 - *Personnel*: High rates of nurse or doctor absenteeism, “ghost” doctors or community health workers, poorly trained or poorly motivated medical personnel, high vacancy rates or high turnover rates for certain positions, high per capita costs in general or wide variances across different regions.
 - *Goods and equipment*: Paying above market prices or not using generic brands (e.g. for vaccines, medicines, laboratory equipment, vehicles), stock outs (e.g. anti-malarial drugs) or supply bottlenecks (e.g. medicines are produced and the government pays to store them in a warehouse since it does not have capacity to deliver them to all health facilities).
 - *Infrastructure*: Underuse or overuse of local health facilities, hospital beds, etc.
- Suggested length for this section: 1-1.5 pages, including any graphics.

Possible data sources

- National budget, consolidated sub-national budget, health sector performance reports, health sector strategic plan monitoring and reporting, donor reports, global databases (WHO, World Bank), Government Spending Watch, OECD-DAC, fiscal space analyses.

Content

- **Financing snapshot**: This section should start by presenting a high-level picture of the main financing sources of the health sector over time, e.g. government revenue, foreign aid and private funding. The remainder of this section then allows for specific breakdown and analysis of each general category.
- **Government revenue**: Identify if there are any specific sources used to finance the health sector (e.g. revenue from “sin” taxes or other earmarked funds), including local revenue and domestic or foreign borrowing, if applicable, and describe trends over time.
- **Foreign aid**: Analyze the role of donor contributions if they play a significant role in financing health services in your country. This should describe the total contribution of donors to health as % of the total health budget, including the implications of growing or declining support, as well as the different funding modalities used (budget support, SWAp, donor pooling, etc.). It should also mention whether donor support is recorded on budget. Other questions to consider: Does the government have an aid management platform or similar reporting framework? Is donor reporting up to date? Is donor funding stable and predictable?

- **Private funding:** Discuss recent trends of household spending on healthcare services, which should present total health expenditure (THE) by public and private expenditure over time. If there has been a significant change in the balance between public and private spending in recent years, describe the main drivers. Also describe the extent to which out-of-pocket fees (formal and informal) are used to pay for public health services and how this has evolved in recent years. A useful analysis can be to compare household out-of-pocket payments with neighboring countries; comparable data can be drawn from the WHO's [Global Health Expenditure Database](#).
- **Financing of HIV/AIDS and basic health commodities:** If these are critical issues in your context, it will be important to incorporate this information in the above analyses or present a standalone analysis to capture financing – either in the narrative or a box.
- **Additional financing options:** Discuss feasible options for increasing investments in the health sector, paying special attention to the potential for improving the efficiency of existing resources (e.g. how much money could be freed up by eliminating ghost personnel or procuring vaccinations at a cheaper cost, or how much could actual expenditure increase if budget execution rates were close to 100%?).
- **Takeaways:** Using bullet points, summarize key findings and implications on poor households and children.

Examples: Refer to Section 7 of the [Health Sector Budget Brief Template](#), which presents the data requirements for each figure, a short description of how the information should be interpreted, and suggested titles and sources. Some examples are presented below.

Figure 7.1. Main sources of financing the health sector, FY2015-19
(in billions of local currency and as % of total)

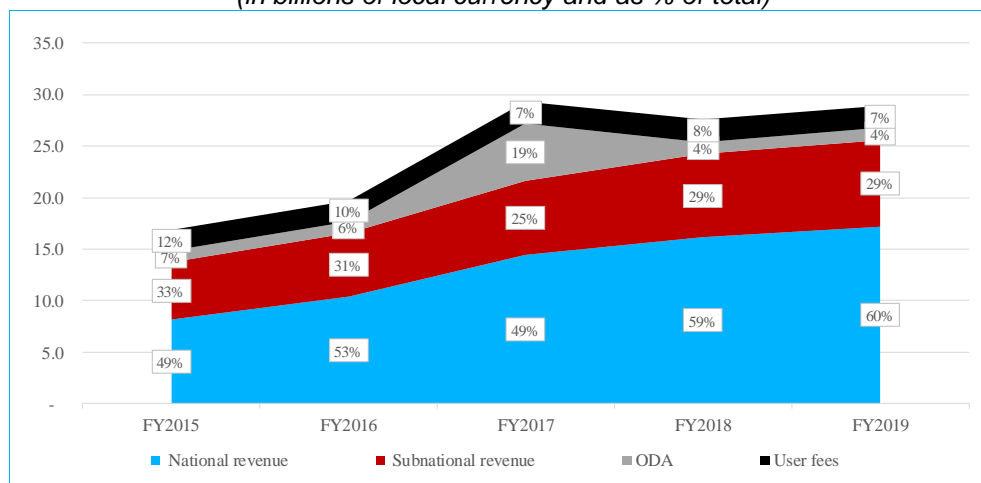


Figure 7.2. Donor funding by DAC and non-DAC members, 2017-19 average (as % of total)

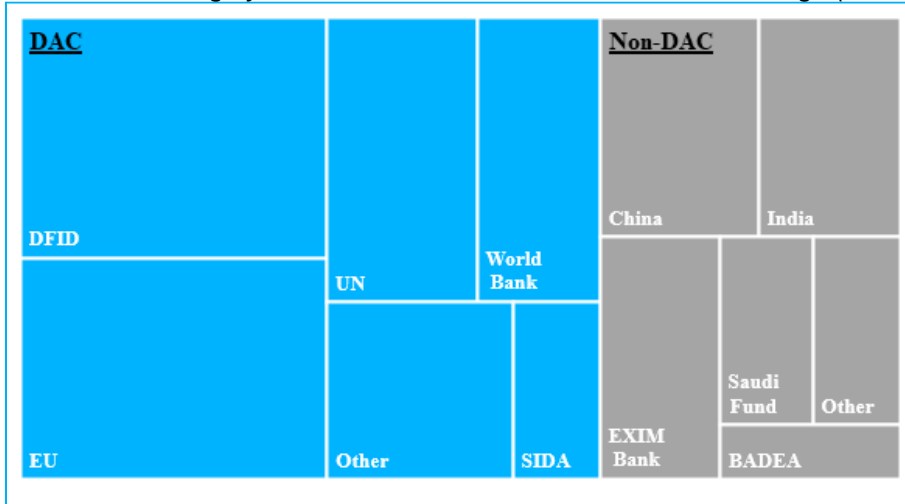


Figure 7.3. Figure X. Public and private health financing trends, 2000-14 (current health expenditure in US\$)

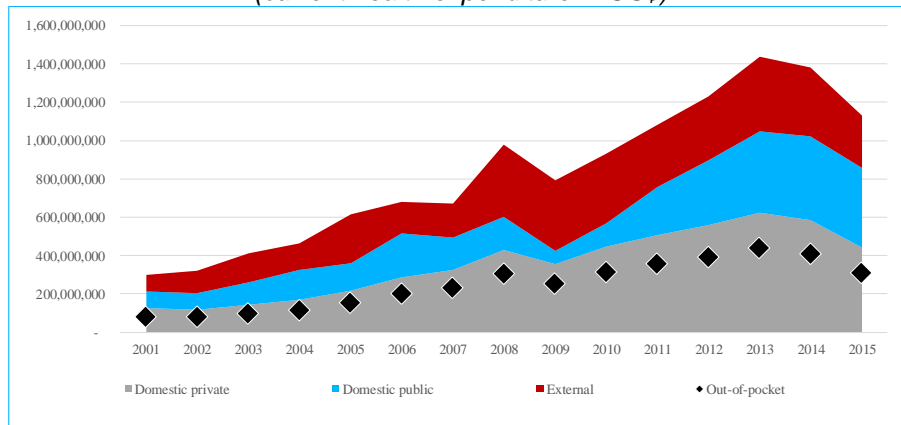
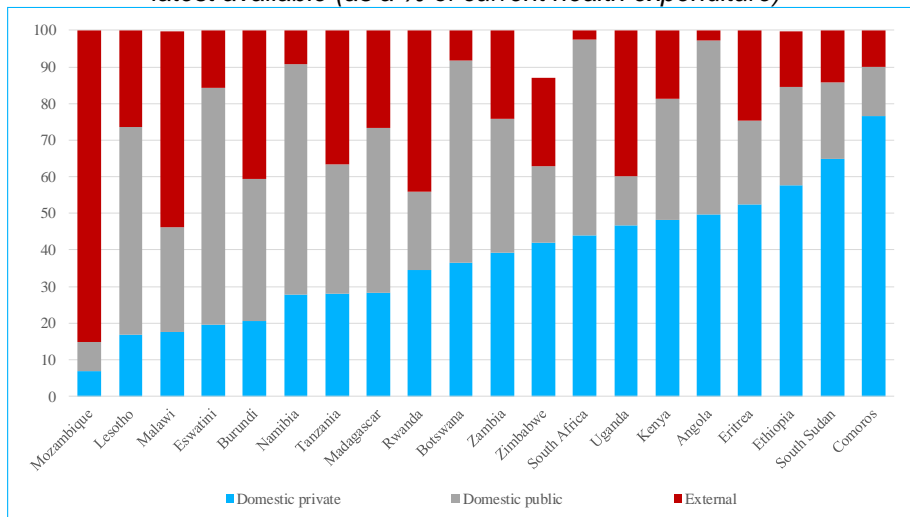


Figure 7.4. Figure X. Public and private health financing trends in select ESAR countries, latest available (as a % of current health expenditure)



Section 8. Other Sector Issues and Reforms

Objectives of the section

- This section provides a space to highlight any other important issues and reforms that impact health sector budgets that have not been discussed earlier in the brief.

Key Considerations

- Policy changes can oftentimes have more impact on health outcomes than a large change in budget allocations.
- Policy changes also have budget implications. New policies might be pursued without increasing the sector budget. In fact, there is often a lack of coherence between health policy and plans and budget allocation, and this section should highlight any relevant examples (e.g. how the budget can be more responsive to existing frameworks).
- This section can also be used to highlight pertinent research that can help make the case for increasing budget allocations, such as costing exercises or a cost of inaction of study, or improving the use of existing budgets, such as through poorly designed targeting policies.
- Suggested length for this section: 0.5-1.5 pages, including any graphics.

Possible data sources

- Sector policy documents, SWAp/donor reports, sector reform plan, national reform agenda, PERs, PETS, costing exercises, investment cases.

Content

- **Policy issues:** Examples of types of issues that can be discussed include:
 - Summarizing other pieces of relevant research, including costing exercises, cost of inaction studies, cost-benefit analyses, etc.
 - Comparing the cost of removing user fees to the total health budget
 - Reviewing proposed policies against likely budget realities in the MTEF for the health sector
 - Reviewing specific policies or practices and what they mean for:
 - Essential health package
 - Maternal and neonatal care
 - Human resources for health
 - Neglected tropical diseases
 - Free basic healthcare for all
 - Community healthcare
 - National health insurance
 - Accessibility of health centers
 - etc.
- **Takeaways:** Using bullet points, summarize key findings and implications on poor households and children.

ANNEX 1. SAMPLE OUTLINE

Key Messages and Recommendations

- List in order of priority

Section 1. Introduction

- Health sector overview
- Main documents and targets
- Sector performance
- Takeaways

Section 2. Health Spending Trends

- Size of spending
- Spending changes
- The priority of health
- Spending against commitments
- Spending against other countries
- Takeaways

Section 3. Composition of Health Spending

- Ministries/institutions
- Levels
- Programs
- Recurrent and capital spending
- Takeaways

Section 4. Budget Credibility and Execution

- Budget credibility
- Budget execution
- Challenges
- Takeaways

Section 5. Decentralization and Health Spending

- Decentralization context
- Sub-national funding guidelines
- Sub-national spending trends
- Spending disparities based on regions
- Takeaways

Section 6. Equity of Health Spending

- Spending disparities by regions
- Spending disparities by income
- Spending disparities by results
- Causes
- Takeaways

Section 7. Financing the Health Sector

- Financing snapshot
- Government revenue
- Foreign aid
- Private funding
- Financing of HIV/AIDS and basic health commodities
- Additional financing options
- Takeaways

Section 8. Other Sector Issues and Reforms

- Issue 1...