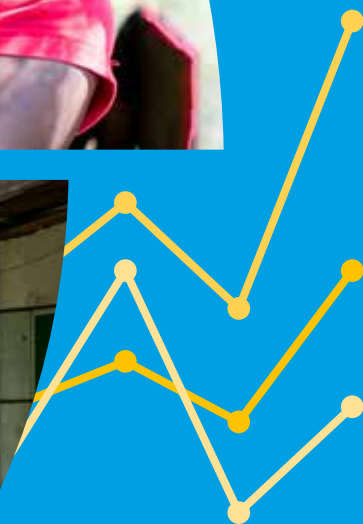


Engaging with public financial management challenges in the health sector

A resource guide for a problem-driven approach
for UNICEF country offices



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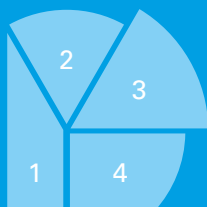
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Engaging with public financial management challenges in the health sector

**A resource guide for a problem-driven approach
for use by UNICEF country offices**



Contents

Acronyms and abbreviations	v
Summary	1
Introduction: Public finance reform for health service delivery, and the role of problem-driven approaches for government-led reform	8
PART 1: PROBLEM-DRIVEN APPROACH	17
<hr/>	
1.1 The problem-driven approach, step-by-step	17
1.2 Where and when the approach will be relevant	26
1.3 Conditions that need to be in place	28
PART 2: A CHECKLIST FOR IDENTIFYING PUBLIC FINANCIAL MANAGEMENT BOTTLENECKS	37
<hr/>	
2.1 Resource adequacy and allocation	39
2.2 Resource flows	41
2.3 Resource use and accountability	42
Annexes	45
Annex 1 Frequently asked questions	45
Annex 2 Outline of a Summary Report on PFM Challenges in the Health Sector	51
Annex 3 Diagnostic tools available	53
Annex 4 Proposed structure for an overview of financing in the health sector	55
Annex 5 Stakeholder mapping	57
Annex 6 Template for financial analysis	59
Annex 7 Resources flows in the Health Sector in Mozambique	61
Annex 8 Principles for facilitating a PDIA approach	63
Annex 9 Examples of supporting a government-led problem-solving process	65

Boxes

Box 1	'Good' problems for institutional reform	4
Box 2	Problem identification in Timor-Leste	5
Box 3	Problem-driven approaches to institutional reform	12
Box 4	PFM and health services delivery – necessary but not sufficient	14
Box 5	Coaching or brokering roles in Problem-Driven Iterative Adaptation	23
Box 6	Example of consensus building on procurement reforms in Namibia	25
Box 7	Lessons from a pilot on PFM for subnational health services in Tanzania	35

Figures

Figure 1	Steps in Component 1 of the approach	2
Figure 2	Steps in Component 2 of the approach	3
Figure 3	Illustrative example of a flow of funds diagram for the health system in Mozambique	61

Tables

Table 1	The steps of Component 1	19
Table 2	The steps of Component 2	21
Table 3	What type of problems can this approach address?	26
Table 4	Where is this approach suitable?	27
Table 5	Questions relevant to Component 1	29
Table 6	Questions relevant to embarking on Component 2	32

Acronyms and abbreviations

CABRI	Collaborative Africa Budget Reform Initiative
IMF	International Monetary Fund
JFMA	Joint Financial Management Assessment
LICs	Low-income countries
LMICs	lower middle income countries
NGO	non-governmental organization
PDIA	Problem-Driven Iterative Adaptation
PEFA	Public Expenditure and Financial Accountability
PETS	Public Expenditure Tracking Surveys
PF4C	Public Finance for Children
PFM	public financial management
UNICEF	United Nations Children's Fund



Summary

What is this document trying to achieve?

This resource guide sets out an approach to the identification of public financial management (PFM) barriers to health services delivery to better inform UNICEF programming and partnerships in countries. Where there is interest from government partners, the approach can also be used to support and guide governments to identify, prioritize and overcome these barriers.

The approach builds on some of the latest ideas on technical support for PFM and institutional reforms, and explores how these could be more effective. It draws on original research into the relationship between PFM and health services delivery,¹ and a subsequent paper reviewing existing diagnostic tools.² It also builds on experiences with 'adaptive' approaches³ that support public sector policy and governance reforms, most notably Problem-Driven Iterative Adaptation (PDIA) – an approach developed by Harvard University and tested in the field of PFM by the Collaborative Africa Budget Reform Initiative.⁴

This resource guide also incorporates practical lessons learned from applying the approach in UNICEF country offices, as well as consultation with stakeholders and partners. It may evolve further as UNICEF country offices use or adapt the approach to suit the needs of their context or counterparts.

While this approach was developed for application in the health sector, it could be adapted to other social sectors as well.

Components of the approach

The approach offered in this paper has two distinct components which should be approached separately and sequentially.

Component 1: Identify and prioritize PFM-related bottlenecks in the health sector

Component 1 supports UNICEF country offices to identify and understand PFM-related bottlenecks to health service delivery in their contexts. This involves consultation with close government counterparts and other stakeholders to confirm and validate the identification, as well as scope potential opportunities for practical solutions.

¹ Welham, B., et al. (2017) Public financial management and health service delivery: necessary, but not sufficient? London: ODI.

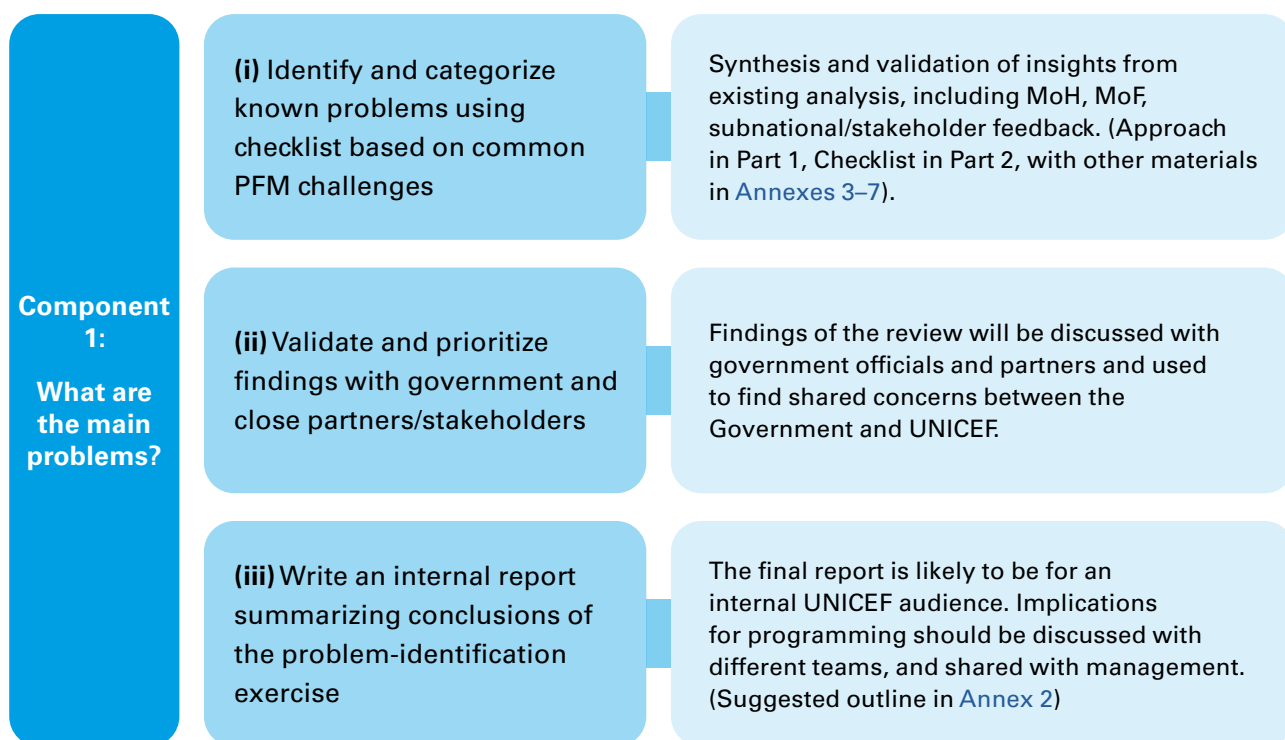
² Hadley, S. et al. (2020) 'Review of public financial management diagnostics for the health sector'. ODI Working Paper 574. London: ODI.

³ For a longer list of different models and resources see: <https://twpcommunity.org/our-archive>

⁴ Andrews, M. et al (2017) Building state capability: evidence, analysis, action. Oxford: Oxford University Press

The guidance for Component 1 provides a methodology for synthesizing information and identifying PFM-related problems in health services delivery (Part 1). It also provides a framework, categories and terminology with which to rapidly identify and group potential PFM-related bottlenecks in the health sector (Part 2). These provide a way to structure and triangulate existing knowledge, including insights from UNICEF’s support for front-line service delivery and feedback from key counterparts in the government and development partners. The intention of Component 1 is to synthesize and leverage existing analysis and diagnostic work, although additional research may be undertaken if needed to fill specific identified knowledge gaps. The final product will include a report for discussion within UNICEF ([Annex 2](#)) that can inform UNICEF programming and engagement with the government and other stakeholders.

Figure 1: Steps in Component 1 of the approach



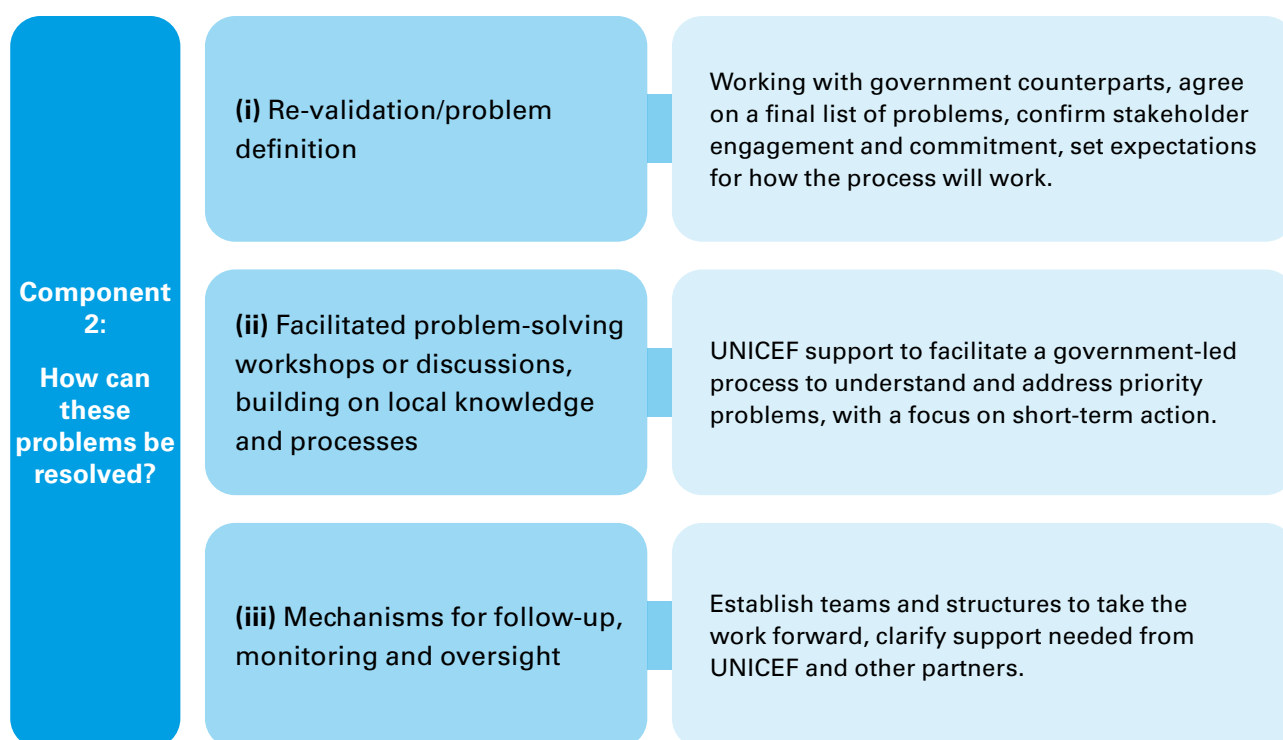
Component 1 can stand alone and is mainly under UNICEF control. It is designed to be deliverable within the resource envelope that a typical UNICEF office is likely to have for this work (see [Annex 1: Frequently asked questions](#) for more detail).



Component 2: Validate and respond to PFM-related bottlenecks affecting the delivery of health services

Component 2 is a potential follow-on activity designed to support governments where there is a clear desire to strengthen health public finance processes through structured enquiry and problem solving. It aims to support coordination across different government agencies to unpack priority problems, build the authorizing space for change and take short-term corrective actions that build on existing systems and local knowledge. UNICEF's role changes from synthesizing knowledge (Component 1) to a convening and brokering role in support of a government-led reform effort (Component 2).

Figure 2: Steps in Component 2 of the approach



Component 2 should be considered after Component 1 is completed, and when government has confirmed its interest and commitment to solving PFM-related challenges. It is not an automatic follow-up to Component 1, and will only take place in specific circumstances. If necessary, an intermediate step may involve an internal workshop and/or a group meeting with a small group of trusted stakeholders in the government to confirm shared understanding, interest and commitment to addressing the identified problems. The process of confirming shared agreement on problems, and government interest and commitment in resolving these problems is set out in detail in Part 1 of this resource guide.

The initial goal should be to help the government identify, refine and agree on priority problems with government stakeholders (see Box 1 for a summary of what makes a “good problem” for this approach). While this may sound straightforward in principle, it is rarely the case in practice, as different stakeholders will frame problems in different ways. Furthermore, the framing of a problem is often a first step toward building the political space to initiate a credible reform process.

Given that the process must be driven and owned by the government, Component 2 is expected to involve higher costs and less certain outcomes and timing than Component 1 (see [Annex 1: Frequently asked questions](#) for a guide on costs). The guidance mainly focuses on the approach to facilitating agreement on how to tackle a problem. However, reform priorities identified by the government may require resources beyond the support envisaged in this methodology, including both technical and financial support to the process.

Box 1: ‘Good’ problems for institutional reform

Addressing problems that matter is fundamental to Problem-Driven, Iterative Adaptation (PDIA). Recent guidance on implementing the approach dedicates a full chapter to the explanation of how problem-driven work should be undertaken. In particular, it emphasizes the importance of a ‘good’ problem’, that motivates and drives change.

‘Good problems’ should have three characteristics:

- (i) a good problem cannot be ignored and matters to key change agents;
- (ii) a good problem can be broken down into easily addressed causal elements; and
- (iii) a good problem allows real, sequenced, strategic responses.

Such problems are not simply ‘discovered’: they are constructed from the expressed needs and concerns of influential stakeholders.

Source: Andrews, et al. (2017) *Building state capability: evidence, analysis, action*. Oxford: Oxford University Press.

Component 1 should produce some important benefits. In many cases, there will be few documents that adequately synthesize the stock of existing knowledge on PFM in the health sector. Furthermore, a greater understanding of PFM-related problems in the health sector will provide UNICEF with information that can be used in their broader awareness raising, advocacy and engagement with government on health services delivery issues, particularly for primary health care. The problem identification process might provide new areas for discussion, engagement and evidence generation that may influence the government’s reform plans.

Key features

A key finding from the review of existing health PFM diagnostic tools was that the quality of stakeholder engagement in problem solving was much more important than the technical perfection of the problem diagnosis. There are numerous examples of high-quality analysis and tools which fail to attract government attention or influence the policy-making process. Even where the issues resonate, governments often face challenges tailoring high-level recommendations into more operational changes to day-to-day processes and services. Some of these experiences – both positive and negative – are evident in the delivery of a Public Expenditure Tracking Survey in Timor-Leste (see Box 2).

Box 2: Problem identification in Timor-Leste

In 2014, the World Bank published a Public Expenditure Tracking Survey (PETS) for the health sector in Timor-Leste. The framing of this study is a useful example of how UNICEF can take a ‘problem-driven’ approach to its own analysis of PFM problems in the health sector. It also highlights risks involved with focusing on diagnostics alone.

The report notes that study was undertaken “to improve the flow of critical cash and in-kind resources to districts and health centres by identifying, and proposing how to relieve, the most critical impediments in the PFM cycle.” In practice, the scope of the PETS was limited to a specific subset of inputs used by health centres: operating cash, fuel for vehicles and generators, and vehicle maintenance and repairs.

These items were selected for a number of reasons. One was that they were the largest share of the ‘goods and services’ budget at the district level. But they were also the areas of spending which districts regularly ‘complained’ about to World Bank health staff. The Ministry of Health liked the PETS proposal because it was targeted at a very specific need and a clear and recognized issue. The aim was not to ‘identify a new issue’ but to document the underlying causes of a well-known problem – the flow of basic operating inputs to health centres – and open a space for dialogue.

The resulting diagnostic work quantified and documented the extent of the problem in a few selected subnational regions and health centres, but also sought to trace the problems back through government systems to understand the causes. The results suggested that challenges came from a combination of coordination failures in the PFM systems but also in health systems. These were later incorporated into the country’s PFM action plan managed by the Finance Ministry and PFM donor working group; however, a key concern was that neither the World Bank nor the donor group had the means to support implementation of the recommendations.

These experiences highlight the following:

- (a) How diagnostic work can begin with a clear problem identified through a UNICEF country office.
- (b) Even budget- and resource-related challenges are not always the result of failures of the PFM system alone.
- (c) Having the right capacity to provide follow-up support should be a major factor when deciding to engage in this kind of work.



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This approach has been developed with two features in mind:

- **It seeks to economize on the amount of original research that is needed to inform the diagnostic.** The data gathering approach starts from a checklist rather than a blank slate. The checklist is derived from knowledge and experience of this issue from across the world. Rapid feedback from stakeholders involved in the system is requested to identify a clear set of PFM-related problems in health service delivery. This is in preference to an approach that attempts to scan the entire landscape from the bottom-up. In this way, the work is focused on exploring specific questions about likely problems rather than undertaking open-ended research work to identify what these problems are.
- **In those situations where government demonstrates a clear interest in authorizing and supporting this work, the approach prioritises collaborative dialogue with stakeholders as a means of refining problem identification and delivering change.** This recognizes that the practical usefulness of tools such as this comes not just from the *technical details and quality of the original diagnostic work but also from the collaborative process of identifying priority problems and possible solutions*. UNICEF often has a comparative advantage in this role as a partner to government with a presence in the field and connections across different ministries through its health, education, nutrition, WASH, early child development and social policy teams. Critically, Component 2 of the approach is only likely to succeed where counterparts in government demonstrate an unequivocal interest in owning and delivering the exercise.



What is in this resource guide?

This resource guide is structured as follows:

- **Introduction: The approach and the evidence behind it.** This section situates the tool in context, recaps the evidence base it is drawn from, and outlines the reasons for its development. It explains the strengths and limitations of this approach and discusses where the approach will be useful as well as the resources needed for its execution.
- **Part 1: Overall process within a country context.** This section sets out for each component the context and process to be taken with this tool in-country. It considers the key variables of government engagement and UNICEF resources to suggest ways in which this tool could be usefully deployed depending on context.
- **Part 2: Checklist and guidance.** This section provides detailed guidance to support Component 1 of the methodology. This includes further information on the checklist which provides a basic organizing framework for analysis of PFM-related bottlenecks affecting health service delivery.

Annexes provide templates for the initial problem identification report from Component 1 as well as guidance for recommended activities such as stakeholder mapping.

ANNEXES		PURPOSE
1	Frequently asked questions	A brief response to questions which UNICEF country offices may ask about this approach, including on logistics.
2	Outline of a Summary Report on PFM Challenges in the Health Sector	A suggested outline of the main output from the investigative phase envisaged in Component 1.
3–7	Supporting tools and guidance for producing the Summary Report	Suggested analysis which UNICEF country teams and contractors can use to deliver Component 1 and the Summary Report outlined in Annex 2 .
8	Tools for facilitating a PDIA approach	A summary of the existing guidance and tools for using Problem-Driven Iterative Adaptation (PDIA) as envisaged in Component 2 of this approach.
9	Examples of supporting a government-led problem-solving process	Selected examples of support that UNICEF may be asked to provide once the problem-solving process envisaged in Component 2 has started.

Introduction:

Public finance reform for health service delivery, and the role of problem-driven approaches for government led reform

This introduction sets out what PFM is, why it is important to the health sector, and explores UNICEF's value add in PFM reform in the health sector. It also provides background on the two key features of the approach outlined in the rest of the paper:

- the *problem-driven approach*, and how it differs from other approaches to reform, and
- the proposed *checklist approach* to draw on and synthesize existing analysis and experience rather than primarily generating new analysis.

PFM and its importance for the health sector

The provision of adequate and reliable financing is central to the international commitment to achieve universal health coverage under the Sustainable Development Goal 3. Yet, in many countries, public sector funding for health services is inadequate, inefficient, inequitable, unreliable and poorly accounted for. Collectively, these PFM shortcomings undermine the coverage and quality of essential services, particularly within the context of primary health care and at community level.

PFM comprises a series of interlinked sub-systems that oversee budgeting, executing and reporting on the use of resources across the public sector.⁵ Effective PFM systems in the health sector provide an essential foundation for service delivery by:

- promoting prudent budget decisions and sound macro-fiscal conditions for delivering services in the long-run;
- preparing realistic, policy-based budgets to guide evidence-based health spending and complementary services such as water, sanitation and transport infrastructure;
- providing a reliable flow of public funds and in-kind resources to deliver health services affordably to the communities, as close to them as possible during budget execution while minimizing wasteful expenditure; and
- supporting the accountable and efficient use of health resources through reporting and oversight mechanisms.

⁵ Andrews, M., et al. (2014). This is PFM. Center for International Development, Harvard University.



While many factors may undermine the quality of health services, examples of PFM challenges in the health sector are commonplace in countries at different income levels. In practice, these issues are particularly problematic in low-income and lower-middle-income countries. Public Expenditure Tracking Surveys have identified a range of problems that were used to develop the checklist in Part 2 of this resource guide.⁶ In Chad, for example, just 1 per cent of non-wage health expenditures for regional health administrations was estimated to arrive at the health-facility level, with significant variations across regions. In Cambodia, such ‘leakages’ resulted from a combination of in-year spending cuts and the tendency of middle levels of government reducing transfers to facilities rather than rationalising their own budgets. In Brazil, under-execution was partly associated with poor management and partly with cumbersome processes and procurement procedures.

It is important to recognize that service delivery challenges have numerous causes, many of which are interlinked, and PFM-driven problems cannot be fully isolated from other issues. Even if all PFM-related problems were resolved, other service delivery bottlenecks would remain. Further, many PFM problems affecting service delivery recur across a number of sectors – they are not specific to health and may require cross-sectoral remedies or changes to central PFM systems or processes that sit outside the responsibility or influence of a health ministry or local government (provincial, district or municipal) health department. Given UNICEF typically engages with governments across multiple sectors and at different levels of government administration, a problem-driven approach may offer a mechanism for UNICEF to facilitate multisectoral approaches and solutions.



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⁶ Welham, B., et al. (2017) Public financial management and health service delivery: necessary, but not sufficient? London: ODI.

UNICEF's value add in PFM in the health sector

UNICEF is a leading agency supporting health systems strengthening and health service delivery in low- and lower-middle-income countries (LICs and LMICs). UNICEF's Health programme focuses on strengthening primary health care as the foundation of Universal Health Care and the delivery of integrated, prevention-focused services and support across childhood. Strengthening health systems is critical to the supply and delivery of quality, affordable primary health care to expand access for the most vulnerable children and adolescents. UNICEF supports primary health care - especially at the community level - by focusing on multi-sectoral policy and action, integrating services in health, nutrition, early childhood development, HIV and AIDS, water, sanitation and hygiene and social protection, and by empowering communities. To reach zero-dose communities, UNICEF strengthens community health systems and provides promotive and preventive care to remote communities around the world.

UNICEF's engagement with PFM focuses on opportunities to achieve results for children and families across its key programme areas, including health, education, nutrition, early childhood development, water and sanitation, child protection and social protection. UNICEF is a leading technical partner in public finance at the sector and subnational level, working closely with sector ministries such as ministries of health, at multiple different levels of government, in addition to its engagement with ministries of finance. This can complement the role of international public finance institutions that work closely with ministries of finance rather than sector public finance stakeholders, such as the International Monetary Fund (IMF), World Bank, Global Financing Facility, Regional Banks and some bilateral donors.

One criticism of the PFM reforms supported by international organizations has been the limited links with the delivery of public services, such as health. In recent years, agencies like the World Bank have focused more closely on the nexus between PFM and service delivery, and this has created a common area of interest with UNICEF.⁷ UNICEF does not seek to compete with the specific expertise or role in public finance reform of international finance institutions such as the World Bank or IMF, but due to its global footprint, government partnerships and social service programming expertise, it offers specific insights and expertise in relation to PFM issues in social sectors. In particular, UNICEF's important complementary strengths and value add include:

- strong links and partnerships with health ministries, ministries of local government, and local government authorities responsible for health service delivery;
- a long-term, on-the-ground presence that has built strong relationships and a shared understanding of underlying health sector problems and opportunities, including national and subnational presence in many countries;
- considerable experience of health policy and programming with teams that work on primary health care and community health care delivery at the front-line, and can advocate with authority about the real-world experience of local service delivery;
- partnerships with legislatures and civil society organizations in areas related to budget transparency, accountability and participation;

⁷ For a discussion of these changes see Miller, M., et al., (2021) *Public finance and service delivery: what's new, what's missing, what's next?* London, ODI. See also the 2019 IMF [Strategy for Engagement in Social Spending](#), and [Guidance Note](#) on social spending safeguards.

- capacity to identify and engage in multi-sectoral approaches, with programming expertise in complementary and related areas such as nutrition, water and sanitation, social protection and education; and
- relationships with finance ministries and in understanding of core PFM systems and processes through Social Policy Public Finance for Children (PF4C) Programming.

What is a problem-driven approach?

The approach laid out here aims to reflect the emerging ‘new consensus’ on supporting government-owned reforms with problem-driven approaches (see Box 3). A ‘problem-driven’ approach contrasts with traditional approaches to research and advisory work on institutional reform that have been critiqued for being:

- **solution-driven** in that they tend to work from a pre-defined idea of what ‘good’ looks like (often informed by international best practice) rather than working to identify what stakeholders themselves see as needing to change;
- **overloaded** in that they seek to strengthen numerous systems rather than focusing on a prioritized list of problems; and
- **overly ambitious** in seeking fundamental systemic change rather than gradually building capacity by addressing the immediate problems faced by public officials.

The new approaches put an emphasis on context and local understanding of problems – and the potential solutions. The approaches emphasize the role of external partners in facilitating and helping ‘join the dots’ between government counterparts searching for ways to address the problems that matter to them, rather than focusing on providing detailed solutions based on international norms and standards.

The approach proposed here builds on these ideas, and on Problem-Driven Iterative Adaptation (PDIA) in particular.⁸ It aims to rapidly identify and highlight a range of immediate PFM-related problems starting from a pre-determined list and relying mainly on existing knowledge to begin the process of prioritization and problem-solving. This focuses on understanding and unpacking the problems that are already known to stakeholders in the health system, instead of conducting primary research to discover those problems. It leverages UNICEF’s longstanding local-level knowledge of and networks in the health sector to rapidly identify and categorize PFM problems facing health service delivery, and – where the government shows commitment and interest, using existing relationships to facilitate the subsequent problem-solving dialogue in government.

⁸ Andrews, M., et al. (2015). “Building capability by delivering results: Putting Problem-Driven Iterative Adaptation (PDIA) principles into practice.” A Governance Practitioner’s Notebook: Alternative Ideas and Approaches, pp 123-133. Paris: Organisation for Economic Co-operation and Development (OECD).

Box 3: Problem-driven approaches to institutional reform

Over recent years, a new consensus has emerged on how international organizations can support institutional change in developing countries. This new consensus puts an emphasis on bottom-up, iterative searching for solutions that will address problems that have been identified and prioritized by local actors. This is a response to the perceived long-standing failures of 'traditional' models of institutional reform that often seek to replicate the same good practice solutions without sufficient regard for the country context. Indeed, evidence shows that most advanced economies have found very different ways to address similar PFM problems (see Andrews, 2008).

A number of sources put forward different formulations of this approach (e.g., 'Thinking and Working Politically'; 'Doing Development Differently'; 'Going with the Grain' and delivering 'Change in Challenging Contexts') but perhaps the best known is 'Problem-Driven Iterative Adaptation' (PDIA) (see Andrews, 2013). The approach developed here draws from many of the ideas in PDIA which differs from other approaches in that it is designed for working inside the government bureaucracy.

PDIA seeks to achieve strong buy-in from institutions themselves by focusing on solving real-world problems that concern politicians or public sector officials. It aims to avoid 'isomorphic mimicry' where institutions adopt the outward appearance of substantial change while overall performance remains unchanged and continues to disappoint.

A problem-driven approach changes the nature of external support for institutional reform (including those funded by donors). Rather than approaching poorly functioning institutions as a problem that external actors can diagnose, prescribe and treat, it suggests a different role. While external actors may be well-placed to share international examples and outline what good-practice looks like in other countries, it moves their primary role to a more relationship-based, 'softer' function of facilitating, convening and 'dot-joining' among institutions and their staff so that they can agree on what the problems are, and decide how they can be solved.

While this represents a new consensus on delivering institutional reform, it naturally brings its own challenges. Reform efforts may look basic (at least at first) as institutions begin to solve some of the easier problems. It also pre-supposes a genuine desire to improve performance within institutions which are primarily held back by a lack of expertise, and/or inability to effectively collaborate to problem solve internally or with other institutions. Moreover, the approach depends on having (or building) a strong 'authorizing environment' in the government that will support the reforms.

Sources: Andrews, M. (2013) *The limits of institutional reform in development: changing rules for realistic solutions*. Cambridge MA: Cambridge University Press; and Andrews, M. (2008) *Good Government Means Different Things in Different Countries*. HKS Working Paper No. RWP08-068. Cambridge MA: Harvard Kennedy School of Government.

Evidence base for problem-driven approach

This approach draws on evidence gathered through several routes, including both original research into PFM and health, and new theoretical approaches to delivering institutional change. In addition to empirical and theoretical evidence, the approach is also informed by UNICEF's practical experience and programming insights. The evidence base that informs this approach includes:

- 1) Theory and research on institutional reforms.**⁹ The paper draws extensively from the idea of Problem-Driven Iterative Adaptation (see Box 3), which has been described at length in research by Matt Andrews and others at Harvard University. This offers a framework for understanding successful public sector reforms that have been particularly influential for donors working on PFM.
- 2) Relationship between strength of PFM systems and delivery of health services.** A study by ODI reviewed the relationship between these two domains through both qualitative and quantitative lenses. It found evidence for a number of hypotheses. Significantly, for the approach presented here, its review of Public Expenditure Tracking Surveys (PETS) found numerous PFM-related problems in delivery of health services recurring regularly across countries. The paper categorized these recurring problems into a framework which informs this methodology (see Box 4).
- 3) Desk review of existing tools to consider PFM-related challenges to health services delivery.** ODI reviewed the existing suite of methodologies, tools and approaches that address the relationship between PFM and health service delivery. The strengths, weaknesses and gaps in these tools were assessed and factored into this approach.
- 4) Insights from UNICEF staff** from their practical experience in collaborative engagement with government on public finance systems, processes and capacity to strengthen the adequacy, efficiency, effectiveness and equity of public investment in child health.

The approach aims to *reduce duplicative research effort and minimize the requirement for primary fieldwork and data gathering*. It uses a checklist of the most common issues to rapidly scan for likely challenges with the PFM system. It then puts the emphasis on using this information to *facilitate discussion and collaboration to solve real-world problems* that are important for the government.

⁹ Andrews, M. (2013). *The limits of institutional reform in development: Changing rules for realistic solutions*. Cambridge University Press; Lawson et al. (2021) 'Interim evaluation of the CABRI building PFM capabilities programme – applying PDIA techniques to PFM problems in African Countries' Oxford: Fiscus Ltd; Levy, B. (2014). *Working with the grain: Integrating governance and growth in development strategies*. Oxford University Press; Williamson, T. (2015) 'Change in challenging contexts – how does it happen?' London: ODI.

Box 4: PFM and health services delivery – necessary but not sufficient

UNICEF's engagement in public finance prioritizes reforms, system strengthening and capacity building that has a concrete impact on delivery of essential services for children. Establishing if and how public financial issues affect health service delivery is, therefore, critical to help prioritize engagement in areas with the greatest opportunity for impact.

In order to identify PFM issues most likely to contribute to poor health service delivery, the development of this approach leveraged ODI's research into the relationship between PFM system strength and health services delivery.

In 2017, ODI reviewed all publicly available Public Expenditure Tracking Surveys (PETS) covering the health sector. These were coded so that the issues raised in the handling and management of public funds in health services could be compared, quantified and analysed. The review found that across the studies, PFM-related issues that recurred frequently could be classified under three headings:

- **Resource adequacy and allocation:** inadequate funding overall; inequity in funding between central and local government, and between service delivery units; and inefficiencies in the mix between funding for capital, recurrent and staff wage expenditures.
- **Resource flows:** delays in transfer of financial resources; delays of transfer of in-kind resources; and non-transfers of expected resources.
- **Resource use and accountability:** absenteeism among staff; high cost of medicines; waste, corruption and fraud; underutilization of resources that are provided; capture of resources for low-value activities; and audit responsiveness.

Not all case studies exhibited all challenges. However, they were sufficiently frequent across the sample to provide a set of issues that are likely to be common in many low- and lower-middle-income countries' health systems.

These insights formed the basis of the checklist presented in Part 2, which was further refined based on insights from UNICEF programming in this area.

Source: Welham, B., et al. (2017) Public financial management and health service delivery: necessary, but not sufficient? London: ODI.

How to use this resource guide

This resource guide sets out the key principles of the six elements in the approach ([Part 1](#)) before explaining the checklist ([Part 2](#)), and offers some basic templates and background materials to help implement the approach in the [Annexes](#).

UNICEF country offices should:

- 1) Follow the general principles but adapt the approach to the specific country context.** The approach is broken down into two components and several steps, each with a specific purpose. The guidance helps adapt the approach to maximize its relevance and impact in different contexts. Knowledge of PFM will vary in each country office, relationships will be better with some stakeholders than others, and the level of resources available for initiating, implementing and following-up on the approach will be higher in some countries than others. Stakeholders are also likely to have their own demands to which the country office will need to respond.
- 2) Carefully consider the factors that will influence success of each component.** Supporting institutional reforms as an external organization is hugely complex with highly uncertain outcomes. While problem-driven approaches such as this are widely considered to be more effective in supporting PFM reforms than other types of external assistance, they still require many factors to be in place. These factors are discussed for each component in Part 1, and the overall approach has been structured to help UNICEF country offices manage the associated risks, including by separating the activities in Component 1 (which is more investigative) from Component 2 (which aims to facilitate a dialogue in the government and promote change).
- 3) Ensure that the checklist is used appropriately.** The checklist has been developed to help reduce the time it takes to identify important challenges that are shared concerns for UNICEF and its closest government counterparts. However, like all tools, it has some limitations. The questions cover a broad range of PFM systems and are likely to produce a long list of issues which need to be prioritized. The questions are based on common challenges, so should not preclude the prioritization of issues that are more specific to the country context, or most important to the government. Relatedly, the checklist focuses on PFM challenges, but this should not limit discussions of other aspects of governance or financing if stakeholders believe these are more important to address. Finally, the initial identification of a problem does not substitute for the careful reflection and analysis needed to galvanize stakeholder interest and identify appropriate measures to address it.

These flexibilities to adjust the overall activities based on context mean that this process requires more investment of UNICEF staff time than running a standard diagnostic process, such as a public expenditure review. It may also require specific skills in coaching and facilitation. It also offers an opportunity to improve the ownership of the problems identified and increase the chances that the resulting reforms will be embedded and sustained.



PART 1: PROBLEM-DRIVEN APPROACH

This part of the resource guide provides information on when and how to use this problem-driven approach. First it provides an overview of the two components in the approach:

Component 1: Identify and prioritize PFM-related bottlenecks in the health sector; and

Component 2: Initiate a joint-UNICEF-Government process to validate and respond to PFM-related bottlenecks affecting the delivery of health services.

While these two components are sequential, they can and should be pursued separately. UNICEF country offices should embark on **Component 1**, using the approach to improve UNICEF *internal understanding* and awareness of PFM-related bottlenecks in service delivery and explore whether relevant stakeholders share similar concerns.

Component 2 may be undertaken where conditions are favourable and have been carefully considered by the UNICEF country office (discussed in Section 1.3 and the risk matrix in Table 6). This would continue the engagement to design a joint-UNICEF-Government process to validate and respond to a small number of high-priority PFM-related bottlenecks.

Following the overview of the approach, Section 1.2 describes the general context where this approach is likely to be most suitable (the type of problem; type of country; and capacity requirements for the UNICEF country office) and whether the process will ultimately inform UNICEF country programming (internally focused), or be used to support government reform (as part of a PDIA partnership). Section 1.3 provides some guiding questions to help country offices decide whether or not to use the two components of the approach. Tools to support the implementation of this approach are provided in Part 2 and the Annexes.

1.1 The problem-driven approach, step-by-step

Component 1: Identify and prioritize PFM-related bottlenecks in the health sector

Component 1 involves work to:

Step 1: *Identify the PFM-related bottlenecks, barriers and problems* affecting health service delivery using the checklist to survey and organize knowledge from existing evidence and consultations with key stakeholders;

Step 2: *Validate* (or refute) the identified problems, learn about existing remedies and explore shared priorities with trusted partners in the government;

Step 3: *Write a report* to summarize the identified and validated issues, including practical proposals to incorporate the findings into UNICEF work.

The process of using the checklist to identify problems is set out in [Part 2](#). Additional tools and guidance for delivering Component 1 are available in [Annexes 2-7](#), including for stakeholder analysis that is important for ensuring that UNICEF is engaging with the right people and institutions across the PFM and health systems.

Component 1 seeks to integrate an understanding of PFM challenges into UNICEF-supported programmes. The aim of the first two steps is to identify and validate a priority set of problems in consultation with trusted government counterparts, while step 3 documents conclusions and insights to inform UNICEF programming and engagement.

- **Step 1:** uses the checklist (provided in Part 2 of this resource guide) to explore:
 - *What do we know already about PFM challenges in the health sector? And*
 - *How closely does this match the views of relevant stakeholders?*
- **Step 2:** uses this information to engage with a small group of trusted stakeholders in the government and determine
 - *Which issues are most important to them? And*
 - *What actions are already being taken to address those problems?*
- **Step 3:** documents the conclusions from the analysis and discussions and asks
 - *What implications does this have for UNICEF's support to government programming going forward?*

These steps are described in Table 1 and are estimated to require 30-50 days to deliver depending on the scope of materials to be covered and the number of groups that will be consulted (see [Annex 1: Frequently asked questions](#) for more details). The activities could be delivered in-house or contracted externally. If the work is contracted out, the UNICEF country office should ensure that relevant staff members remain closely engaged throughout the process.

The aim is to deliver Component 1 including the report (Step 3) quickly. So, rather than a prolonged and detailed research process looking at primary data gathering and analysis, Component 1 should take only 8–12 weeks (2–3 months) and set out the most salient issues identified by stakeholders and existing studies organized using the checklist outlined in Part 2. If necessary, Component 1 may involve an *internal workshop* and/or a group meeting with a small group of trusted stakeholders in the government to confirm shared understanding, as well as initial feedback on interest and commitment to address the identified problems.

**Table 1: Steps of Component 1**

STEP	ACTION
Step 1	Identify PFM-related bottlenecks, barriers and problems faced in health services delivery using the checklist
<p>Comments</p> <p>The checklist should draw on existing and readily available evidence developed by other tools and research, as well as feedback from stakeholders. Completion of the checklist should involve a combination of:</p> <ul style="list-style-type: none"> (i) UNICEF staff consideration of the main bottlenecks identified in the checklist (see Part 2); (ii) Desk-based review of recent country reports on health services delivery and/or PFM systems; and (iii) Consultation with government stakeholders, front-line delivery staff and key partners. <p>Taken together, these steps should provide a reasonable summary of the main PFM-related problems affecting health services delivery. The process should be carried out diligently but does not need to be exhaustive or elaborate at this step. The expectation is that further collaboration will check and validate the findings.</p> <p>The balance between (i) and (ii), which can be largely desk-based, and (iii) which may involve limited fieldwork will depend on the extent of previous research and resources available. If there is interest, this step could include limited primary data collection, including fieldwork to gather views from subnational governments or health facility managers. Emphasis in such instances should be on collecting information on primary health care institutions and not be limited to hospitals delivering secondary and tertiary care.</p> <p>The checklist in Part 2 and the annexes offer various background materials, notes on existing diagnostics, and templates for financial and flow of fund analysis which can support the evidence mapping or feed into the final report produced in Step 3. In some cases, country offices will already have undertaken in-depth analyses of health financing and/or PFM arrangements, in which case Steps 1 and 2 would build on existing knowledge and engagements.</p>	
Step 2	Validate the identified problems and explore shared priorities
<p>Comments</p> <p>Having identified problems that need addressing through separate streams of research, the findings should be synthesized and validated with a small number of trusted stakeholders (focusing on counterparts in central and local governments).</p> <p>This will help confirm the identified problems, and bring together knowledge from different sources (e.g., UNICEF staff, donors, local-level health workers, central ministry staff, desk-based review of documents). This is an opportunity to make links between the problems that have been identified; to ensure that there is a more-or-less agreed view of what the important PFM-related problems are between UNICEF and its closest stakeholders; and to learn more about relevant reforms that are already planned or in process. Insights from primary health care institutions and provinces or districts with major service delivery disruptions of deficiencies can be particularly useful.</p> <p>This step can confirm and secure internal agreement with trusted networks and within UNICEF before having public or open discussions of the problems. It may involve bilateral meetings with different stakeholders or a small workshop of trusted counterparts in government, depending on the context and how the initial exploration of issues was conducted.</p>	
Step 3	Report and briefing note to summarize issues
<p>Comments</p> <p>Two products are proposed to focus messages based on audience needs.</p> <p>The aim of the report is to capture the shared understanding of the PFM-related problems identified in health services delivery that could be discussed with government counterparts. The briefing note is intended for internal purposes, setting out implications of the findings for UNICEF programming. These could be combined if the main report is written primarily for a UNICEF audience.</p> <p>Drafts should be presented and discussed internally before being finalized, possibly using an internal workshop involving UNICEF teams and implementing partners. This is also the point in the process to consider whether or not to pursue Component 2 of this approach or to follow-up with the issues raised through other means (see section 1.3).</p> <p>Annex 2 provides a suggested outline for a summary report on PFM challenges in the health sector.</p>	



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Component 2: Initiating a joint-UNICEF-Government process to validate and respond to PFM-related bottlenecks affecting the delivery of health services

The outcomes and timing of Component 2 are expected to be less certain than for Component 1. As noted above, Component 2 may be pursued only in certain instances when there is interest and commitment from key Government counterparts and conditions for reform are favourable. Sections 1.2 and 1.3 discuss these conditions in more detail and offer a set of questions to guide the country office in making the decision.

If the conditions are favourable, and there is an indication of government interest in tackling PFM-related challenges and to work closely with UNICEF – Component 2 may be initiated. It will facilitate a government-led problem-solving process and establish a mechanism for following-up on agreed actions. UNICEF can play a supporting role to catalyse the initial discussions to agree on priority problems and possible solutions and then support the government teams taking forward agreed actions.

The guidance on Component 2 focuses on initiating the stakeholder dialogue on PFM challenges affecting health services, and building momentum behind efforts to address those challenges. This involves three steps:

- **Step 4:** Re-validation and extension of the problem identification process to ensure government owns the results
- **Step 5:** Facilitation of a series of problem-solving workshops/meetings/discussions to advance the process of supporting identification of solutions;
- **Step 6:** Institution of mechanisms for follow-up and oversight.

Table 2 describes these steps in detail. Financing and fund-flow analysis and stakeholder mapping can also help inform who should be engaged (see [Annexes 5-7](#)).

**Table 2: Steps of Component 2**

STEP	ACTION
Step 4	Re-validation and extension of the problem identification process to ensure government owns the results
<p>Comments</p> <p>Consultations will be held to get agreement on participation of relevant officials in the problem-solving workshops in Step 2 and confirm the list of issues that will be considered in the workshops. This is also an opportunity to explain the approach and set expectations among participants and their managers over the level of effort required and the extent of UNICEF's support.</p> <p>This step may involve some repetition and re-working of the consultations from Component 1. This is necessary to ensure that government stakeholders have greater buy-in of the conclusions and findings of the problem identification work as well as the process for solving those problems.</p> <p>If government staff have shown interest and engagement from the beginning and issues are largely agreed upon, then it may not be necessary to re-validate findings, and the process can move quickly to the next steps. If that is the case, senior managers should ideally nominate a small group of officials (5-10 people) that will drive the process forward.</p>	
Step 5	Facilitate a series of problem-solving workshops/discussions to begin to identify solutions
<p>Comments</p> <p>This step aims to identify and prioritize a limited number of lower-level, concrete actions that can help solve the most immediate problems faced by officials and that avoid overloading them by building on existing systems and capacity. The focus of this step is not on solving all challenges through systemic level reform.</p> <p>If starting with a larger group, the workshop may need to be staggered to begin with a general discussion of the priority issues before continuing the problem solving with a smaller group of officials. In general, it should be possible to cover the following issues:</p> <ul style="list-style-type: none"> • Understanding the PDIA approach (1/2 day) • Identifying and agreeing on key challenges (1 day) • Framing and breaking down the problem (1 day) • Possible solutions and next steps (1 day) <p>When designing the engagement, refer to the tools available from the Building State Capabilities programme.</p> <p>The final agreement should include</p> <ol style="list-style-type: none"> (i) priority issues to be addressed, (ii) a shortlist of solutions, with a recommended starting point and short term actions that contribute to solutions, and (iii) decisions on who will do what and how often the team will meet and present to management. <p>Resource requirements associated with identified solutions and responses to problems should also be identified.</p> <p>Agreement on these elements is needed to progress. In cases where a longer process of consensus building is needed to agree to a reform path, it may be possible to move forward with Component 2 if there is agreement from key managers. Critically, UNICEF should be looking for evidence that some consensus is emerging on at least some areas among key stakeholders that have power to reinforce and take the dialogue forward.</p> <p>The focus on immediate problems to be solved locally alongside a timeline for delivery is expected to offer a more concrete and direct process of change than some of the broader and higher-level conclusions and recommendations that emerge out of standard diagnostic and strategy processes.</p> <p>Delivering this step successfully requires skilful facilitation and strong collaborative working style, and UNICEF should ensure it has sufficient internal experience (see Box 5), or engage specialist skills in this area. Knowledge of PFM and country health systems will also be helpful to steer the dialogue. It is important that external views and solutions do not dominate the discussion.</p>	

STEP	ACTION
Step 6	Mechanisms for follow-up and oversight
<p>Comments</p> <p>In order to track progress and ensure accountability, oversight and follow-up mechanisms are needed. Options should be discussed and agreed with the participants in the workshop and presented to management for approval.</p> <p>The nature of this oversight will depend on the nature of the discussions that have taken place, the kind of reform actions that have been agreed, and also the role of other sector reform strategies in monitoring reform. It may be best to integrate these decisions into other monitoring frameworks, such as a sector working group. In other cases, a guiding intergovernmental committee and task force may be appropriate. If specific managers have the drive and authority to lead the reform, then officials may report to them.</p> <p>It is important that the team(s) allocated tasks meet regularly (e.g., weekly) and that there are regular opportunities to get feedback from managers (e.g., monthly) as solutions are developed and implemented.</p>	

Each step will need to be adapted by the country office to suit the context and lessons learned from Component 1. Exactly how to adapt the approach will vary. In some contexts where UNICEF is working with a strong government partner that wants to drive forward change and has some authority to do so, the process may quickly move to supporting a small group of officials working on these aims. In other cases, it may be necessary to have a broader consultation and take a more inclusive approach to the workshops in order to build a shared understanding of the problems and develop a list of possible solutions.

As a general guide, Step 4 should set expectations and settle on the key problems that will be explored and prioritized through the workshops. Step 5 should end with a common agreement on the priority problems, options to resolve those problems, and an initial set of short-term activities that will help put the option into practice. The final step should be to help establish a small group of officials with a mandate to take the process forward with plans for regular meetings (e.g., weekly) and frequent feedback to management (e.g., monthly).

The role UNICEF can play once the problem-solving process is established will vary considerably from country to country. It may involve coaching for the government team, technical inputs on specific problems, facilitating the dialogue and brokering agreements between stakeholders, drawing in support from other partners and donors or even designing and implementing a programme of work (see Box 5 for further detail on the role of coaching in this approach, and Annex 9 for some examples of ways that UNICEF can support a government-led problem-solving process). UNICEF is likely to play an important role supporting the government team(s) to sustain the early interest and momentum.

Box 5: Coaching or brokering roles in Problem-Driven Iterative Adaptation

Problem-Driven Iterative Adaptation (PDIA) identifies the common features of successful reform initiatives (Andrews, 2013), and offers tools for replicating this approach within a government reform team. One way that outsiders can support this process is to help the government team implement this approach, coaching the team in areas such as: framing a problem that they have identified in ways that motivates action; identifying entry points for addressing those problems; adapting reform plans during implementation; actively developing support and space for change; etc. This external support is effectively a substitute for extensive experience leading reform initiatives within the government – but has also proved valuable in organizations with high capacity, including the South African National Treasury.

The Collaborative Africa Budget Reform Initiative (CABRI) has worked with Harvard University to put this approach into practice at scale through the [Building Public Finance Capabilities](#) project. Government teams apply to join the programme, with fewer than 10 countries participating each year for a 12 month period. If included, the team receives an induction on the PDIA approach and coaching from CABRI during implementation, with a final workshop to share experiences with peers from other countries. CABRI has also run a variant of this approach with multiple teams in a single country, including in South Africa and Lesotho.

Another adaptive development approach is [Thinking and Working Politically](#). This is grounded in an understanding of what makes an effective donor engagement (Unsworth and Booth, 2014). It shares many features with PDIA, including an emphasis on locally prioritized problems and flexible interventions informed by regular feedback. However, there is a different role for external actors, including helping to ‘broker’ agreement on a problem and/or reform agenda across different stakeholders. This approach tends to be effective when policy, political or organizational silos limit the ability of a single team or organization to address a problem that they have identified. External actors can help facilitate and coordinate the decisions needed to tackle that problem.

Examples relevant to public finance include ODI’s [Budget Strengthening Initiative](#) in South Sudan, which helped align a government interest in receiving budget support with donor concerns with strengthening service delivery. Successfully brokering interests across the different stakeholders led to a reform which introduced the first fiscal transfers to state governments in order to finance local education and health services. Other well documented examples of this approach are The Asia Foundation’s [Coalition for Change Program](#) work on tax reforms in the Philippines and the [State Accountability and Voice Initiative](#) in Nigeria.

UNICEF has experience with both approaches. UNICEF and CABRI are collaborating on implementing PDIA in Eastern and Southern Africa. UNICEF has also played an important brokering role in recent support to procurement reforms in the health sector in Namibia (see [Box 6](#)). [Annex 9](#) has more examples of this approach.

With the process driven and owned by government counterparts, Component 2 is expected to involve less certain outcomes and timing than Component 1. During the initial steps of Component 2, the nature and cost in terms of staff time and budget for UNICEF support may evolve over time.

In order to adapt and accommodate such an evolution process, it may be useful to incorporate more flexibility into the project set-up and any contracting. For example, include a longer design phase before the initiation of any work, or a number of reflection points to review and adjust the approach to increase its impact, or a mechanism to close the engagement if momentum stalls. Leaving some of the budget unallocated may also help to be more responsive to changing needs.

If the three steps in Component 2 are successful in facilitating actions, UNICEF may need to respond relatively quickly to maintain momentum if there are demands from the government. The nature of this support may not be fully known in advance. One option is to plan to maintain some engagement with the government team once the three steps are completed. This could include a budget for 20-30 days for a consultant to mentor the government team as it takes on the PDIA approach internally, to provide secretariat or program management support to enable government taskforces or interagency groups to continue iterative reform, or provide a series of task-oriented workshops to facilitate discussions with stakeholders.

Overall, it is important that Component 2 is well resourced. The country office should strongly consider engaging a specialist(s) with facilitation skills to support the process, ideally an individual or team with experience in running workshops as part of a PDIA process. Expertise on PFM can also be useful during the dialogue and problem-solving process to help officials avoid challenges that have been experienced with poorly functioning PFM systems in other countries. However, it is important that external PFM experts do not dominate the discussions and that government officials with direct managerial and implementation responsibilities are able to explore solutions that will be a good fit for the local context.

When Component 1 does not progress into Component 2

The results of Component 1 will still be valuable if UNICEF concludes there is insufficient government interest, or other factors which preclude a move to Component 2 of the approach.

UNICEF can use the results of the problem-identification work to *inform country programming and partnerships* with government and other partners and stakeholders, including Country Programme Documents, country-level PF4C strategies, or health or multisectoral programming. The findings can shed new light on the risks and challenges in implementation of UNICEF-supported priority programmes. UNICEF may be able to adapt existing programmes, or develop new ones, that will generate a better understanding of issues not currently discussed.

The information can also be shared with other donor partners and/or non-governmental organizations (NGOs) working in public finance, health systems strengthening, or healthcare delivery to build or expand new partnerships, and ensure that the benefits of the problem identification can be shared as widely as possible. This includes during missions from international financial institutions such as the World Bank, Regional Development Banks or other external investors in health. In many cases, there will be few documents that adequately synthesize the stock of existing knowledge on PFM in the health sector. This is the kind of material that can be useful for a Technical Working Group for PFM or health systems strengthening.

Furthermore, a greater understanding of PFM-related problems in the health sector will provide UNICEF country offices with information that can be used in their *broader awareness raising, advocacy and engagement* with government on health services delivery issues. The problem identification might provide new areas for discussion, engagement and evidence generation that may influence the government's reform plans. In some cases, further government engagement and advocacy may be required before progressing from Component 1 to Component 2.

Box 6 offers an illustration of where this approach has been relatively successful, in Namibia, while Box 7 provides a brief discussion of the challenges implementing this approach in Tanzania, where the context for UNICEF engagement was less favourable than anticipated.

Box 6: Example of consensus building on procurement reforms in Namibia

Since 2020, UNICEF has played an important role in facilitating reform in procurement practices in the health sector of Namibia, applying a number of elements of the problem-driven approach outlined in these guidelines.

In this example, the approach was applied to health sector procurement challenges. Procurement constraints were a significant challenge for health service delivery in Namibia. Procurement of goods and services accounted for a significant share of the spending of the Ministry of Health and Social Services (MoHSS) in 2020 (around US\$250m or almost 50 per cent of the MoHSS expenditure). A number of reforms had followed the adoption of a new Procurement Act in 2015. Hardly any open tenders were floated, which led to frequent stock-outs and a high number of emergency procurements, which were not cost effective.

UNICEF Namibia recognized there was a communication and coordination gap between the finance and health ministries on procurement reforms – a gap also acknowledged by major international development partners. In 2020, UNICEF engaged with the ministries of health and finance to initiate a process to generate consensus across the ministries on the root causes of the procurement problems observed in the health sector, and where, how and by whom these could be addressed. As part of this process, UNICEF Namibia contracted a health-focused consultancy firm with expertise in health financing and procurement (Hera) to provide technical support. UNICEF Namibia also collaborated closely with key development partners, such as USAID and United Nations Development Programme (UNDP), which were supporting health and procurement reforms.

The process involved both an analytical phase and a brokering phase. The analytical phase started with a desk review and synthesis of the known challenges, followed by consultations with key stakeholders (including those in finance and health) to understand different priorities and perceptions of the problems. To give a sense of the scope of this work, a total of around 120 documents were analysed, and 36 key informants were consulted. The findings were organized around a customized set of good practice benchmarks for procurement.

The brokering phase started with co-creation meetings within the government and within development partner groups, and later these were joined together through a workshop to generate consensus across both groups. A Reference Group was initiated at the start of the study to ensure support for the study process, and was later formalized as part of the study recommendations to provide a platform for continued consensus building. The Reference Group reports to the Ministers of Finance and Health, who meet on a quarterly basis to review progress and approve recommendations.

Key achievements of the process include the adoption of pooled procurement and framework agreements for health procurement in the new Public Procurement Act, which came into effect in September 2022. With the success of the process to build a commitment within the Government, UNICEF has continued to provide support for implementing the agreed actions through a dedicated project manager.

A number of important lessons emerged from this process. The experience emphasized that effective communication and constant dialogue with the Government is necessary for successfully executing this approach, and consensus building between finance and health ministries requires a diversified set of skills and understanding of both policy domains. The experience also demonstrated that this approach can be usefully adapted to specific issues (e.g. focusing specifically on procurement using a tailored analytical framework rather than the broader PFM checklist in Part 2) to target specific entry points in contexts where problems have already been identified through previous engagements. It also demonstrated that the approach can be successfully applied in middle-income settings.

Source: Internal presentations by UNICEF Namibia, and Hera

1.2 Where and when the approach will be relevant

This section sets out where and when to use this approach in a UNICEF country office context and puts forward some relevant questions and considerations. In some contexts, other ways of supporting positive PFM-related change for health service delivery may be more appropriate. For example, UNICEF country offices may be able to participate in technical working groups steering PFM reforms and use this as a basis to raise issues that are emerging in the health sector (including those being discussed in the health sector working groups that are often managed separately with limited connections to the core PFM reform teams).

Which problems?

Is this methodology suitable for the type of health services delivery problems occurring in countries where UNICEF is working?

This approach is expected to be more effective in country contexts where UNICEF aims to:

- (a) identify the root causes of challenges at the front-line of service delivery in primary health care and community-based settings, or at the local government level which are of interest to both government and UNICEF,
- (b) encourage incremental changes in existing PFM systems rather than seek a comprehensive overhaul based on top-down application of international good practices, and
- (c) leverage the genuine desire for positive change among key stakeholders.

This yields a framework for considering where this approach might be most useful.

Table 3: What type of problems can this approach address?

	APPROACH IS GOOD FOR...	APPROACH IS LESS GOOD FOR...
PFM issues	Identifying the challenges and bottlenecks faced by front-line institutions delivering essential public health functions regarding the availability, flow and use of resources.	Issues related to aggregate spending patterns and overall accountability for public funds; overall health services policy issues; and behaviour and incentives of health staff (not related to salary payment).
Political economy	Identifying and highlighting coordination failures among institutions genuinely committed to making incremental changes to improve service delivery.	Directly challenging powerful vested interests who profit from the current situation and who wish to maintain the health sector as it is.
Scale and type of change	Identifying ways to improve the operation of public finance systems at a lower level, often at the margin, so as to progressively build more effective systems for the management of public funds within health services delivery, particularly in primary health care settings.	Encouraging comprehensive changes to government finance systems, to overall government policies and/or introducing pre-determined 'best practices'; and/or introducing these all at once.



Which countries and country offices?

The approach is also designed to work best in relatively stable, low-income and lower-middle income country settings where there is political commitment to strengthen health service delivery; and where it will be supported by UNICEF country offices with the following attributes:

- strong partnerships across the ministries of finance, health and local government;
- solid and nuanced understanding of how health systems function in front-line primary health care settings, including in decentralized contexts; and
- strong awareness of the domestic political economy of resource allocation and use.

This does not mean the approach cannot be used in other environments. In upper-middle-income countries, for example, it may still be possible to identify ways that PFM systems could be strengthened to enhance the value for money of health spending. Table 4 provides a general indication of the contexts in which the approach envisaged in this resource guide is expected to be most useful.

Table 4: Where is this approach suitable?

	APPROACH IS GOOD FOR...	APPROACH IS LESS GOOD FOR...
Country characteristics	<ul style="list-style-type: none"> • <i>Low-income and lower-middle-income countries</i> where PFM-related bottlenecks are common across many sectors and can significantly affect health financing or governance. • Countries where there is <i>not an established programme</i> already addressing the challenges of PFM and health, or where there is a strong interest to connect these more closely to challenges with health service delivery. • Countries where <i>government directly manages a large share of the health budget</i>. • <i>More stable or post-conflict contexts</i>. • Countries with a reasonable amount of <i>data and research</i> on budgeting and financing in the health sector to draw upon. And a record of transparency and sharing of government data. 	<ul style="list-style-type: none"> • <i>Upper-middle-income countries</i> where PFM systems are more developed, and the core PFM challenge is increasing VFM of health systems that are generally functional. • Countries where a <i>programme already exists</i> to address the challenges of PFM and health, though there may be ways for this approach to complement such programmes. • Countries where <i>health services are effectively financed and delivered by NGOs or other actors</i>; and/or where the private/voluntary sector delivers the majority of health care. • <i>Conflict-affected</i> countries or regions. • Countries with a <i>poor record of sharing financial data</i>, or very limited existing data and/or analysis.
UNICEF Country Office	<ul style="list-style-type: none"> • Large office <i>with strong teams</i> for social policy (PF4C) and health services or health systems strengthening. • Office with <i>effective relationships</i> with ministries of health, local government and finance. • Office with staff who have <i>experience with facilitating dialogue and reform processes</i>, and where there is ability to dedicate staff time. • Country programmes with regular <i>engagements with front-line primary health care facilities and local government</i>. 	<ul style="list-style-type: none"> • Office with <i>small health systems strengthening or social policy teams</i>. • Office with <i>limited relationships</i> with ministries of health, local government and finance. • Country offices where this approach will <i>mostly rely on contractors</i> to steer the process. • Country programmes that focus on health policy issues or concentrate on <i>vertically integrated single-issue health programmes (e.g. one-off vaccination)</i> with little engagement with country health systems at the front-line or subnational level.



1.3 Conditions that need to be in place

Considerations before beginning Component 1 to identify and prioritize PFM-related bottlenecks in the health sector

Component 1 involves synthesizing what is already known to UNICEF and its implementing partners, comparing this to the views of key stakeholders and validating the conclusions of this work with a small group of trusted government counterparts. The aim is to inform UNICEF engagement with PFM challenges in the health sector and lay the foundation for implementing Component 2. Table 5 provides some general questions to consider while deciding whether to initiate Component 1. Additional suggestions, including on the resources needed to implement this approach, are offered in [Annex 1: Frequently asked questions](#).

**Table 5: Questions relevant to Component 1**

INITIAL PROBLEM IDENTIFICATION
<p>Availability of resources</p> <ul style="list-style-type: none"> Do UNICEF offices have enough time to invest in gathering and synthesizing existing evidence and consulting with different stakeholders? Based on UNICEF experience to date, this may require approximately 25 days of staff time, and a further 50 days of contractor time if an office requires additional support on PFM. If using contractors, are there individuals or organizations that are trusted by UNICEF and/or the government with a strong knowledge of PFM and/or intergovernmental finance? Will UNICEF have the time to support the contractors with relationship management? Are there resources to have a day-long workshop with the different teams in the Country Office (e.g., Health, Social Policy, Nutrition) and trusted implementing partners?
<p>Relationships</p> <ul style="list-style-type: none"> Does UNICEF have good working relationships with ministries of health, local government/sub-national authorities and the ministry of finance? Is the Country Office able to easily access documents and data? Does UNICEF have regular discussions with mid- and senior-level civil servants? Does UNICEF have good links to the main development partners working on PFM and health systems strengthening? Is it possible to gather views from counterparts in local governments and primary health care settings and relevant health facilities without conducting formal fieldwork? Is the government generally responsive to UNICEF support and does it have a track record of investing political attention and financial resources in health services?
<p>Transparency</p> <ul style="list-style-type: none"> Does the government have a good record in sharing and discussing health data – both financial and non-financial? Will government partners be open about the problems they perceive to be important and what causes them? Are development partners willing to share project documents and information on their work in the health sector?
<p>Knowledge gap</p> <ul style="list-style-type: none"> Does UNICEF already have a good understanding of barriers and bottlenecks to service delivery that sufficiently covers issues related to PFM, including from other studies or research pieces? Are these well understood across the different teams in the Country Office (e.g. Health, Social Policy, Nutrition)? Has significant preparatory work already been conducted through other activities, such as the production of UNICEF budget briefs or public expenditure reviews?
<p>Sector reform strategy gap</p> <ul style="list-style-type: none"> Are existing sector reform strategies in place that adequately cover PFM issues, or PFM reforms that will influence the health sector? And if so, how will this work by UNICEF complement existing reform efforts? Is there scope to influence or inform existing reform efforts? Is there interest across different teams within UNICEF to engage more with PFM systems and reforms?
<p>Use of increased understanding</p> <ul style="list-style-type: none"> How will UNICEF use its internal understanding of PFM reforms and the governance of the health sector? How will the insights from this approach inform country programming or specific project needs in different teams? Are there opportunities to build UNICEF staff capacity or ways of working?

Considerations before beginning Component 2

Component 2, if conditions are favourable, begins joint UNICEF and government work to identify, validate and support the resolution of PFM-related problems to health service delivery.

Component 2 is more likely to be successful if there exists:

- **Government willingness/capacity to engage in this process.** This means government decision-makers with real authority and managerial influence over key health and PFM issues at various levels of government are interested in using the identified problems as the basis for a problem-solving exercise. This authority and willingness to engage may manifest in different ways, and may be affected by competition with other high priority sector strategies, reform fatigue, level of high-level political interest in health services delivery, and relationship between the finance ministry and the health sector (including any local government ministry) (see [Box 7](#) for an example).
- **UNICEF (or UNICEF-engaged technical support), skills resources and relationships to play a brokering and facilitating role in addressing PFM challenges in the health sector.** This approach puts an emphasis on ‘collaborative problem solving’ of the common challenges identified rather than ‘technical excellence’ of problem diagnosis (which is already facilitated to some degree by the initial checklist and consultations). Strong coaching and facilitation skills in the context of deep understanding of both PFM and health service delivery systems are very particular (as described in [Box 5](#)).

It is preferable if UNICEF staff are able to play the brokering facilitating role. This is because good consultants with skills in both PFM and coaching are not always available, the work relies on building trusting and long-term relationships, and because contracting modalities can restrict the flexibility of a consultant to respond to emerging demands and windows of opportunities.

- **Resources to follow-up on problems once a way forward has been agreed.** UNICEF should be prepared to provide resources for some immediate follow-up and/or work with other development partners who are able to do so. This includes ensuring time and resources to maintain networks, broker support from other development partners and facilitate ongoing discussions on PFM. Once started, some reforms can take many years to see through, particularly if they seek to shape behaviours in a large number of public entities or stakeholders. UNICEF’s close partnerships with government and its ongoing in-country presence are well suited to support longer-term, government-led reforms. If external technical support is being brought in, longer term support would need to be contracted using similarly long-term and flexible contracts.



Government engagement in the process and the **authorizing environment is particularly critical**.¹⁰ The problem-driven approach assumes a genuine desire to deliver positive change on the part of government, and a willingness to identify and commit resources (and political capital) to delivering this. If government is not interested in this process, the approach may be better used to inform UNICEF country programmes and upskill UNICEF country offices to engage in evidence-informed advocacy on these issues in the medium to long term.

Government interest is best gauged by actions and ‘revealed preferences’. These might include:

- (i) the release of data in a complete and timely manner,
- (ii) a letter of authority signed by the Permanent Secretary or equivalent position,
- (iii) nomination of a liaison person with the time, incentives and authority to support the engagement.

UNICEF offices should be alert to less committed expressions of interest. These may arise from a desire to maintain relationships with donors, to avoid revealing a conflict with political priorities in government, or any number of other factors.

Building on this, a number of questions can help decide whether or not to proceed from Component 1 to Component 2, and these are summarized in Table 6. It is extremely important to consider the questions related to resourcing and the government-authorizing environment.



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¹⁰ By the authorizing environment we mean an environment for decision making that provides space for the envisaged activity, but also encourages experimentation and ‘positive deviance’ – the space to move away from existing practice to explore different approaches which local experience suggests may bear fruit. Experience suggests that the authorizing environment is likely to be complex and comprise more than one individual or agency. It is, therefore, much more than the concept of a ‘reform champion’. In thinking about the authorizing environment, problem-driven thinking suggests the following questions: (1) what authority do we need? (2) Where can we find the authority that we need given how authority is structured? and (3) How do we get the authority we need and grow this authority over time? (Andrews et al., 2017).

Table 6: Questions relevant to embarking on Component 2**COMPONENT 2: LEARNING FROM COMPONENT 1 TO CONFIRM AND BEGIN RESOLVING PFM-RELATED BOTTLENECKS TO SERVICE DELIVERY****Availability of resources**

- Does UNICEF have sufficient staff time and financial resources, and sufficient flexibility in the budget and timelines to support a joint problem identification and problem-solving process over at least the medium term?
- Are there resources to support the preparation and delivery of 5-10 days of workshops for around 20 people, with 30-40 days for follow-up support from a consultant for the subsequent 6 months?
- Do UNICEF staff have the time and capacity to engage actively with this process and follow-up with the government teams leading the work?
- Are there individuals or organizations specializing in coaching or facilitation-based approaches (Box 5), and are the teams involved in Component 1 available to support the discussions?

Government engagement and authorizing environment.

- Is it possible to get a high-level authorization for the activity – not just for it to begin, but also for it to continue, and for specified staff to be released to work on it over several months or actively participate in relevant working groups?
- Is there support from management for officials to try new ideas that are not *off-the-shelf solutions* even if they might not always work out first time around?
- Is there evidence that most of the relevant stakeholders are interested in similar problems and/or are keen to see some of the problems identified in Component 1 resolved? How has this interest been demonstrated?
- Will senior management and decision makers be available and engaged to participate at key decision points in the process?

Relationships

- Does UNICEF have good working relationships with ministries of health, local government/sub-national authorities and finance?
- Do these relationships extend to the departments and officials which have the power to create space for reforms in the areas identified in Component 1?
- Have any of these partners demonstrated any interest in resolving these issues already?
- And are there any groups or individuals that may try to block the reforms over which UNICEF and its government counterparts have limited influence?
- What was learned about the effectiveness of these relationships and the interests of key stakeholders in Component 1?



Transparency

- What did UNICEF learn about the ability to obtain financial and non-financial health data from government in the first component?
- Is all required data now available?
If not, it should be a precondition for beginning Component 2, or be programmed with a clear break clause should data not be made available at least on a confidential basis.

Availability of coordination, facilitation and 'collaborative problem solving' resources:

A key element of this strategy relates to the ability of UNICEF to support the process of identifying and implementing solutions priority problems. Initially the focus will be on high quality facilitation, but UNICEF could also play a role brokering agreements between stakeholders and/or drawing in support for the government from other development partners.

- Does UNICEF have the skills and time to do this in house, or could they be offered specific training in coaching-based approaches to engagement? If not, can these skills be contracted in to support government?
- Is there sufficient flexibility in the budget and project rules to adapt to changing demands?
- If engagements are successful, and the government demands long-term support (e.g., 2-5 years) will the Country Office be able to respond accordingly?

Alignment with other strategies

- Does a problem-driven reform effort focusing on PFM-related bottlenecks to service delivery fit within the context of existing sector reform strategies, or does this cut-across or replicate existing donor/government efforts?
- Are other development partners supportive of UNICEF implementing this approach?
- Do these stakeholders agree that the issues that have been identified are important to address?

Any decision to continue with Component 2 of the approach should include specific details of how the approach will engage with and support existing strategies.



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Deciding whether to proceed

The goals of this work and the strengths and limitations of both the country office and country environment should be reviewed and considered prior to starting the work. This comparison should consider each component separately. It should reflect on the overall suitability of the approach and the specific considerations outlined above with respect to the two components.

Any decision on whether to proceed should involve UNICEF country office management and key staff from Health and Social Policy teams. Consultation with UNICEF regional offices is also encouraged. In some contexts, the country office may also want to meet collectively with a small group of trusted stakeholders in the government to discuss the approach before committing to take it forward.

In addition to consulting internally within the country office, consultation with a variety of knowledgeable parties outside government can help with the decision. It may be helpful, for example, to discuss with members of the donor community or with representatives from implementing partners who work closely with government on PFM or health systems strengthening. This could reveal, for example, where this work may be duplicating existing activities or overloading already stretched officials in some government departments.

If the initial review and consultations suggest the approach may not be practical, consider opportunities to improve these key conditions.

Box 7: Lessons from a pilot on PFM for subnational health services in Tanzania

From 2019 to 2021, UNICEF Tanzania used a draft of this PDIA approach to shape a study of public financial management challenges affecting subnational health service delivery. Overall, the study shed light on key bottlenecks and challenges in subnational health financing and made several policy recommendations for policymakers to consider.

However, due to the challenging environment during the COVID-19 pandemic and the sensitivity of health issues, the study's policy dialogue component was not successful in generating a debate with the government on the problems identified, emphasizing the importance of confirming the enabling environment, and developing action plans.

There were several different factors at play that influenced the experience in Tanzania that can serve as important lessons for country teams. Some factors related to context, and act as an important reminder that sometimes the context is not right for a problem-driven approach. The Tanzania study took place during COVID-19 when travel was restricted and the government was under scrutiny for its health response. Changes at the leadership level of the Ministry of Health complicated the working relationship with UNICEF, while the government had generally become less open to scrutiny. In such circumstances, the project should be developed in a way that can allow the strategy and outputs to be altered and even cancelled.

There were also lessons for implementation. For example, it is important to manage expectations and clearly explain the spirit of this approach, including the implications for process and outputs. In Tanzania, government counterparts wanted a product that provided in-depth research and concrete recommendations, rather than a product to initiate a more open-ended discussion on reform priorities as envisaged in this approach. Equally, when the relationships are complex, UNICEF country offices need to look for clear signals to confirm engagement and capacity for internal coordination. In Tanzania, data requests were not fulfilled, and the government steering committee only met once. Such signs can indicate limited prioritization from the government, which should prompt the country office to review its approach.

Despite these challenges, the research process for Component 1 generated interest from health sector donor agencies, and added value by providing one of the few general overviews of the financing and financial management landscape in the health sector. UNICEF Tanzania was able to leverage the research process and engagement to strengthen their shared understanding of challenges and opportunities to collaborate with other partners working in this space. Ultimately, the study findings will serve as solid evidence for future policy dialogues on improving subnational health financing in the country.

Source: ODI lessons learned note for UNICEF Headquarters, 2021



PART 2: A CHECKLIST FOR IDENTIFYING PUBLIC FINANCIAL MANAGEMENT BOTTLENECKS

This part provides a detailed introduction to the checklist that is designed to be used in Component 1 of the approach: the initial problem identification.

The rationale for having a checklist

The checklist provides the overarching analytical framework for investigating challenges with PFM that affect service delivery in the health sector. The approach is intended to limit the amount of time dedicated to primary data gathering and analysis, which may be needed later, if there is government interest in delving deeper into the issues raised. Relevant evidence for the problems will be gathered and synthesized where it is available in written documents and easily accessible financial data. The process is likely to reveal a number of issues that need to be put into context, analysed and synthesised. This will be done through discussions with government and close partners.

The checklist serves two general purposes:

First, it provides an *organizing framework*, which sets out the three categories of PFM bottlenecks, and

- problems in the allocation of resources;
- problems in the flow of resources; and
- problems in the use of resources (such as issues with staff recruitment, procurement or contract management).

Most PFM-related problems can be grouped using these three categories. Therefore, this is a way to summarize what is known about the PFM challenges affecting health services.

Second, the checklist provides a *prompt* for UNICEF teams to ask about some of the most common PFM challenges identified through international comparisons. Under each of the categories (resource allocation, flow and use), the checklist provides some guiding questions, key problems and illustrative examples of potential problems, along with the possible evidence sources. This is not intended to be a comprehensive list, but can help produce a relatively broad survey of likely problems relatively quickly.

Using the checklist tool should involve a combination of:

Understanding the general context of health financing and PFM systems. This should include describing the most important funding sources and the PFM arrangements associated with them. See [Annex 4](#) for a proposed structure for an overview of financing in the health sector to help understand PFM-related bottlenecks. In addition, [Annexes 5-7](#) provide more specific suggestions for considering the relationships between different entities, analysing the government health budget and illustrating complex health funding flows in a diagram.

Synthesizing existing knowledge from different sources, through three steps:

- (i) Consult UNICEF staff and implementing partners on the main PFM bottlenecks that they have identified in their work.
- (ii) Conduct a desk-based review of recent country reports on health services delivery and/or PFM systems (including common diagnostics listed in [Annex 3](#))
- (iii) Consult with government stakeholders, front-line delivery staff, and key partners.

These three steps should provide a reasonable summary of the main PFM-related problems affecting delivery of essential public health functions, particularly within the context of primary health care and for the most left out and deprived populations, and help to identify any area where further checks of validation may be required.

Steps (i) and (ii) can largely be a desk-based review of available documents and reports. Step (iii) may involve interviews or consultations depending on the extent of previous research and resources available. If there is interest, Step (iii) could include some limited focused primary fieldwork to gather views from subnational governments or health facility managers in primary health care settings.



Two approaches for applying the checklist

Health services in most countries are financed through many different channels, and PFM systems may be working better for some financing sources than for others. Reviewing all the questions for all funding streams may be valuable as a means to understand the many different ways that PFM systems are affecting health service delivery in a country. Such a broad scoping may be a challenge to deliver and interpret in an environment where there are a large number of funding sources managed by different entities and following different rules for allocation, execution and oversight in the PFM system. UNICEF country offices need to consider such issues of complexity when determining the most appropriate scope.

With that context in mind, there are two ways to apply the questions in this checklist:

1. Understand aspects of resource allocation, flow and use that are of greatest concern to UNICEF and its stakeholders before considering how these relate to different funding streams; or
2. Use the desk review and consultations to identify the important funding streams for health providers and ask if these are affected by the issues raised in the checklist.

The first approach (asking about the main PFM problems) will typically involve less time while the second approach (asking what PFM problems are affecting the main funding sources) will provide a more in-depth assessment and/or be necessary in the context of a highly fragmented health financing system.

It is important to emphasize that the checklist provided is a suggested framework for exploring the broad landscape of PFM bottlenecks that may be affecting health service delivery. UNICEF country offices may already have identified more specific problems where they want to engage. In this context, it is recommended to adapt or focus the checklist approach to fit with the more specific issues to be explored. This was the experience in Namibia (Box 6), where UNICEF applied the core principles envisaged in this approach to the challenges of procurement reforms.

2.1 Resource adequacy and allocation

Overall key question(s): To what degree do you see problems in your role in health services delivery related to the following issues of resources and their allocation:

- Which of these are most problematic for health services delivery, particularly in relation to primary health care and broader public health objectives?
- Do they apply to some funding streams more than others?
- Which of these problems could feasibly be addressed in the short or medium term?
- Which problems could be resolved within the health sector only, and which require more fundamental changes to the PFM system that will affect other sectors?

Section I: Checklist questions on resource adequacy and allocation

WHAT DOES THIS PROBLEM LOOK LIKE ON THE GROUND?	SOURCES OF EVIDENCE
1. Inadequate funding	
<ul style="list-style-type: none"> <input type="checkbox"/> Not enough money is allocated in the budget to meet official service delivery standards or government targets for improving health outcomes. <input type="checkbox"/> Certain policy commitments have overstretched the available resources or remain critically underfunded. <input type="checkbox"/> There are inadequate provisions for critical staff positions, procurement needs, operating costs or investments. <input type="checkbox"/> Essential medicines or vaccines have not been purchased or distributed. <input type="checkbox"/> Facilities are compensating for a lack of resources by charging formal or informal user fees or encouraging patients and families to purchase essential medical or care supplies in the market. 	<ul style="list-style-type: none"> <input type="checkbox"/> National budget and health strategic plan <input type="checkbox"/> National Health Accounts <input type="checkbox"/> Public expenditure reviews <input type="checkbox"/> WHO health financing diagnostic <input type="checkbox"/> Public Expenditure Tracking Surveys <input type="checkbox"/> Budget analysis and budget briefs <input type="checkbox"/> Sector or programme evaluation reports
2. Vertical and horizontal inequities in funding	
<ul style="list-style-type: none"> <input type="checkbox"/> Hospitals receive a disproportionately large share of resources compared to rural/regional health facilities and institutions delivering primary health care. <input type="checkbox"/> There is large variation in the amount of funding received by different regions of the country and this does not relate to need, population or other objective criteria. <input type="checkbox"/> Health spending or subsidies disproportionately benefit higher-income groups or regions. <input type="checkbox"/> Oversight and inspections are more common in urban areas than rural ones. <input type="checkbox"/> There is limited analysis or oversight of equity dimensions of funding. 	<ul style="list-style-type: none"> <input type="checkbox"/> Public expenditure reviews <input type="checkbox"/> WHO health financing diagnostic <input type="checkbox"/> Benefit incidence analysis <input type="checkbox"/> Budget documents <input type="checkbox"/> Budget analysis and budget briefs
3. Inefficient mix of funding	
<ul style="list-style-type: none"> <input type="checkbox"/> Resources are disproportionately allocated to central government or administrative departments rather than institutions further down the service delivery chain. <input type="checkbox"/> Financing is poorly linked to the prevalence or distribution of the disease burden, and services are financed even if they are not considered 'cost effective'. <input type="checkbox"/> Wages are paid but there is frequently no money for consumables like drugs, medical equipment or other day-to-day expenses. <input type="checkbox"/> Facilities continue to be constructed and equipment purchased, but staff and operational resources are not available for long periods, if at all, and maintenance is neglected. <input type="checkbox"/> There is a high degree of fragmentation in financing arrangements and/or big differences in administration or unit costs of inputs between funding streams. <input type="checkbox"/> Local governments and facilities delivering primary health care face challenges adjusting spending to meet local needs and demands for health services. <input type="checkbox"/> Resources are often used for low-value activities, and/or activities that are not directly related to health services delivery (e.g. lots of training, workshops, travel). 	<ul style="list-style-type: none"> <input type="checkbox"/> National budget <input type="checkbox"/> Public expenditure reviews <input type="checkbox"/> WHO health financing diagnostic <input type="checkbox"/> Budget analysis and budget briefs <input type="checkbox"/> Sector or programme evaluation reports



2.2 Resource flows

Overall key question(s): To what degree do you see problems in your role in health services delivery related to the following issues of resource barriers or bottlenecks:

- Which of these are most problematic for health services delivery, particularly in relation to primary health care and broader public health objectives?
- Do they apply to some funding streams more than others?
- Where in the service delivery chain are these problems emerging?
- Which of these problems could feasibly be addressed in the short or medium term?
- Which problems could be resolved within the health sector only, and which require more fundamental changes to the PFM system that will affect other sectors?

Section II: Checklist questions on resource flows

WHAT DOES THIS PROBLEM LOOK LIKE ON THE GROUND?	SOURCES OF EVIDENCE
1. Delays in financial resources	
<input type="checkbox"/> Salaries of permanent or contract staff are not paid on time.	<input type="checkbox"/> PEFA reports
<input type="checkbox"/> Operating budgets are not available at certain times of the year, or are released irregularly or with long delays.	<input type="checkbox"/> Public Expenditure Tracking Surveys
<input type="checkbox"/> It takes a long time to get suppliers paid.	<input type="checkbox"/> Public expenditure reviews
<input type="checkbox"/> Advances and imprest accounts are replenished slowly.	<input type="checkbox"/> Budget execution reports (including IFMIS reports)
<input type="checkbox"/> It is common for facilities to take supplies on credit or to take short-term loans from local bank branches or money lenders.	<input type="checkbox"/> Flow of fund audits
<input type="checkbox"/> Capital budgets are only accessed late in the year.	
2. Delays in in-kind and other resources	
<input type="checkbox"/> Facilities face drug stockouts and other shortages.	<input type="checkbox"/> Public Expenditure Tracking Surveys
<input type="checkbox"/> Drugs distributed are close to the expiry date.	<input type="checkbox"/> Tanahashi bottleneck analysis
<input type="checkbox"/> Fuel or other inputs cannot be accessed in a timely way.	<input type="checkbox"/> Audit reports
3. Resources are not transferred	
<input type="checkbox"/> Budget allocations are regularly cut/not released during the year.	<input type="checkbox"/> Budget execution reports
<input type="checkbox"/> Disbursements not in line with cash forecasts/ budgets.	<input type="checkbox"/> Public Expenditure Tracking Surveys
<input type="checkbox"/> Resources are withheld, captured or diverted at higher levels of government (e.g., to finance their administration).	<input type="checkbox"/> Tanahashi bottleneck analysis
<input type="checkbox"/> Resources (e.g., essential drugs) are purchased but not distributed.	<input type="checkbox"/> Audit reports
<input type="checkbox"/> Resources (e.g., essential drugs) are not purchased at all.	
<input type="checkbox"/> Money reaches subnational health administrators but it is unclear what happens to the money at this level, and it does not reach primary health facilities.	

2.3 Resource use and accountability

Overall key question(s): To what degree do you see problems in your role in health services delivery related to the following issues of resource barrier or bottleneck:

- Which of these are most problematic for health services delivery, particularly in relation to primary health care and broader public health objectives?
- Do they apply to some funding streams more than others?
- Which of these problems could feasibly be addressed in the short or medium term?
- Which problems could be resolved within the health sector only, and which require more fundamental changes to the PFM system that will affect other sectors?

Section III: Checklist questions on resource use and accountability

WHAT DOES THIS PROBLEM LOOK LIKE ON THE GROUND?	SOURCES OF EVIDENCE
1. Staff absenteeism	
<ul style="list-style-type: none"> <input type="checkbox"/> Staff are paid regularly but often not present for work. <input type="checkbox"/> Staff are not paid regularly and not present for work. <input type="checkbox"/> Staff are assigned to health facilities but have never reported for work. 	<ul style="list-style-type: none"> <input type="checkbox"/> MoH Annual Performance Reports <input type="checkbox"/> Human Resource Informational systems/ reports <input type="checkbox"/> Public Expenditure Tracking Surveys <input type="checkbox"/> Quantitative Service Delivery Study/Service Delivery Indicators <input type="checkbox"/> Tanahashi bottleneck analysis <input type="checkbox"/> Service Delivery Indicators
2. Inefficient procurement and/or other waste	
<ul style="list-style-type: none"> <input type="checkbox"/> Processes result in the procurement and distribution of unsuitable equipment, which does not meet the needs of health units. <input type="checkbox"/> Significant variations in costs of similar items between different funding streams, agencies or jurisdictions. <input type="checkbox"/> There is regular use of emergency procurement procedures for goods and services that were known in advance. <input type="checkbox"/> Regular procurement of items not included in the procurement plan. <input type="checkbox"/> Procurement that does not meet transparency or reporting requirements. <input type="checkbox"/> Poorly coordinated central procurement creates delays or confusion over what should be procured. <input type="checkbox"/> Limited use of generic or low-cost drug suppliers relative to other countries. <input type="checkbox"/> The facility has no say on what drugs are purchased, and they simply receive what they are allocated. 	<ul style="list-style-type: none"> <input type="checkbox"/> Public Expenditure Reviews <input type="checkbox"/> PEFA <input type="checkbox"/> Audit reports <input type="checkbox"/> Health facility survey <input type="checkbox"/> Essential drugs survey <input type="checkbox"/> Service Availability and Readiness Assessment (SARA) <input type="checkbox"/> Service Provision Assessment (SPA) <input type="checkbox"/> International Drug Price Indicator Guide



3. Corruption and fraud

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> There are large numbers of ghost workers or wages are frequently paid in error to the wrong people, or in the wrong amounts, or paid late. <input type="checkbox"/> Drugs, medical supplies, etc. are procured and paid for, but not delivered at the level expected. <input type="checkbox"/> Contracts are awarded wrongly or with inflated prices; are issued directly without following procedure; etc. <input type="checkbox"/> There are reports of money, supplies and/or equipment being stolen or misused; or of bribes being paid. <input type="checkbox"/> There are problems with the quality of financial reporting, inventories management and/or auditing. | <ul style="list-style-type: none"> <input type="checkbox"/> Audit reports (including for donors such as Gavi) <input type="checkbox"/> Parliamentary discussions/reports <input type="checkbox"/> Newspaper/civil society reports <input type="checkbox"/> Donor project documents <input type="checkbox"/> Payroll audits |
|--|---|

4. Underutilization of resources

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> The proportion of the budget spent in the health sector is below the total budget execution rate. <input type="checkbox"/> Staff positions cannot be filled. <input type="checkbox"/> Capital investments are either not started or not finished. <input type="checkbox"/> Procedures are slow or rigid which makes procurement or accessing releases difficult. <input type="checkbox"/> Capacity to adhere to processes is limited. <input type="checkbox"/> Sometimes the wrong items are purchased and there is a growing stock of under-used materials. | <ul style="list-style-type: none"> <input type="checkbox"/> Budget execution reports <input type="checkbox"/> Public Expenditure Tracking Surveys <input type="checkbox"/> Audit reports |
|--|---|



ANNEXES

ANNEX 1

Frequently asked questions

1. Why is this an approach and not a tool?

The advice in this resource guide is intended to provide UNICEF country offices with a new way of working at the intersection of PFM and service delivery in the health sector. That idea is to focus less intensively on generating new knowledge, but to leverage what is already known and move quickly into a discussion with key stakeholders on the space and opportunities to address the problems that they think matter most for strengthening health service delivery.

To help translate this idea into a more practical set of steps and actions that a country office can consider, the resource guide provides some *limited new tools* (including the checklist in Part 2), but mostly offers references to existing tools that have been used by other organizations, such as CABRI and Harvard University, to implement a problem-driven approach. Critically, this is more of a guide than a strict roadmap, and is written with the expectation that UNICEF country offices will adapt the methodology to the specific context that they work in.

2. Can this approach be applied in other sectors or areas of governance?

Yes, provided that elements of the approach, such as the checklist, are adjusted appropriately.

While this approach is written with a specific focus on PFM in the health sector, 'problem-driven' approaches have been applied to a wide range of sectors and issues (e.g., economic growth). The general approach proposed here and the generic guidance could be used by UNICEF teams in other areas, such as education or nutrition, where there is significant government involvement in the service.

However, much of the guidance provided here to help implement this approach is tailored specifically to the health sector, and would need to be adapted or replaced entirely for other sectors. The organizing framework offered in Part 2 considering the allocation, flow and use of resources is most useful for analysing public finance or PFM challenges. The specific questions in the checklist are geared specifically to the health sector.

3. Does this approach involve primary data collection and analysis?

Yes, but only to a limited extent.

Component 1 of this approach involves some limited primary data gathering and analysis. First, the UNICEF country office needs to clearly understand how the basic elements of health financing and sector governance relate to PFM systems. This may involve some basic analysis of financial information, for example, even if it is only updating or adding to the research conducted for a budget brief or similar study. Second, the process involves capturing the views of close stakeholders. However, much of the work for Component 1 will be making sense of the findings from such consultations and triangulating information across different sources (most of which will be secondary).

Component 2 does not envisage any primary data collection, unless this is something that government stakeholders identify as necessary to further their understanding of a problem.

There is, however, no reason not to consider using elements of this approach in conjunction with a more in-depth study if that is deemed necessary.

4. What deliverables should be specified if UNICEF is contracting specific technical support for this approach?

The precise deliverables will vary depending on how involved UNICEF country teams are in the process, and how they use the contractors to support the engagement with officials.

For Component 1 the main deliverables could include:

- **Inception report** with a proposal to adapt the methodology provided in this resource guide for Component 1 to the specific context, with a final approach to be agreed with the UNICEF country office.
- **A short report documenting the most important PFM challenges in the health sector**, as identified through UNICEF staff and implementing partners, a review of the secondary literature, and consultations with government officials and development partners. This may also include a specific reference to limited analysis of financial data using budget data or more granular information on revenues and spending, if available.
- **Facilitation of an internal UNICEF workshop** to discuss the findings of the analysis and consultations.

The country office should plan to take a lead role in drafting the briefing paper on implications for UNICEF's strategy.

For Component 2 the main deliverables could include:

- Proposal to apply the tools and approaches of Problem-Driven Iterative Adaptation (PDIA) or an appropriate alternative methodology to PFM challenges in the health sector in a specific country context.
- Facilitation of a workshop (or alternative engagement process) with key stakeholders identified together with UNICEF in order to:
 - Validate and prioritize the problems identified through Component 1
 - Initiate a process for identifying how to tackle the priority problems
 - Propose the government-led structures that will oversee the process
- Coaching the government team responsible for taking the agenda forward for 20-30 days over a period of 3-6 months.

For this Component, UNICEF country offices should expect to play the lead role in relationship management, at least for the first month or two.



5. How much will this approach cost and what are the cost drivers?

This resource guide was written with the intention that Component 1 and Component 2 could be initiated with a budget of around US\$40,000 to US\$60,000; however, costs will vary depending on many factors, including the depth of analytical work needed and the length and intensity of any engagement established through Component 2.

Component 1 is likely to require:

- UNICEF staff time (25-30 days) to get the project started, manage relationships, and participate in meetings and interviews where appropriate.
- Contractor time (30-60 days) and associated incidentals/travel costs. Contractors can be expected to take a lead on synthesizing information generated using the checklist approach and related analysis, and developing the report.
- Costs for a day-long workshop with UNICEF staff and implementing partners to discuss the approach and emerging conclusions from Component 1.

The amount of time allocated to UNICEF staff and the contractors will depend on the complexity of the financing and PFM arrangements, how much effort has already been invested by UNICEF to engage with these issues in the past, and the depth that the country office wants to explore particular issues.

If additional data analysis or fieldwork is incorporated, costs for Component 1 should be factored into the costs outlined above.

Component 2 is likely to require:

- UNICEF staff time (30-50 days) to initiate the problem-solving process and maintain the various relationships needed to build the momentum of the reform initiatives identified by the government.
- Contractor time (20-30 days) for facilitating/supporting the initial workshop and providing structured mentoring to the government teams on using a PDIA approach and for providing ad hoc expertise and guidance on PFM or health financing.
- Costs for an initial set of meetings or workshops (while the resource guide proposes an initial workshop, most likely over 2 days, UNICEF country offices may want to budget for three initial workshops to allow for validation, the establishment of the problem-solving team and working patterns, and for reflecting on the problem-solving process after 3-6 months).

There is considerably more uncertainty over the costs for Component 2. The government team may request deeper analysis on specific topics. They may demand more expert inputs alongside the mentoring for the PDIA approach itself. The team may require financial support to host the relevant meetings or conduct the right kind of consultations (e.g., visits to different subnational authorities or facility managers in remote areas).

More importantly, if Component 2 leads to a successful engagement, this may lead to further requests for UNICEF support.

6. How much prior knowledge or experience is needed in UNICEF?

This process will benefit from having in-house expertise on PFM and experience of PDIA (or similar) methodologies for supporting public sector reforms. Where a UNICEF country office does not have this expertise, it may be possible to either (a) draw on technical support from the regional office, headquarters or from other country offices, or (b) externally contract the relevant experience.

In cases where implementation of the approach relies on external contractors/consultants, it is still advisable to allocate time and/or resources to allow country office staff to stay engaged and learn from the process. An additional 10-20 days for UNICEF staff to work closely with the contractors, manage relationships and learn from the process will enhance the project and help develop the experience of country teams working on PFM reform in the longer term.

7. How long does it take to implement this approach?

This approach could be delivered in six months, but in cases where UNICEF undertakes both Component 1 and Component 2, then the country office should expect that it may need to engage for as long as two years.

Component 1 can be delivered in 8-12 weeks, depending on the intensity of the working period and the size of the team involved. A larger team, working fulltime should be able to conduct the background research and interviews over the course of two months. A small team combining this work with other assignments may need four to six months. Any additional fieldwork would potentially extend that period to 12 months. Contracting and scheduling often add to the timelines.

The guidance for Component 2 focuses on the first steps required to initiate a dialogue, which is expected to take two to three months, but could run for longer depending on how much the government is able to prioritize this work or the breadth of consultations needed to secure a consensus over the way forward. If there is already an established relationship with the government and Component 2 follows relatively quickly from Component 1, then it is possible that the validation and problem-solving workshop could be delivered in one to two months.

As a useful benchmark for Component 2, the PDIA project approach used by CABRI was set up to provide support to country teams over a period of eight months, with the first two to three months dedicated to team selection and induction to the approach. A recent evaluation of this scheme recommended extending support to 20 months in countries where there was demonstrable evidence of a high-quality, government-led process.¹¹

8. How should the country office assess the authorising environment?

There are many different ways to assess the authorising environment at the team, organization and institutional levels, with differing levels of formality.

The most formal approach is to use political economy analysis, or related techniques. Many development agencies conduct political economy analysis to guide their programming. UNICEF country offices may already have gathered political economy insights if they have undertaken a political economy analysis of the budget process¹² or examined PFM issues as part of a recent UNICEF Situational Analysis (SitAn). If further analysis is required, this will generally take time to implement and translate into project-level decisions.

¹¹ Available here: <https://www.cabri-sbo.org/en/publications/interim-building-pfm-capabilities-programme-applying-pdi-a-techniques-to-pfm-problems-in-african-countries>

¹² 2021 UNICEF Public Finance Toolkit, page 106, available at: <https://www.unicef.org/media/113276/file/UNICEF-Public-Finance-Toolkit-2021.pdf>

For this approach, it is more likely that the UNICEF county office will have to rely on informal means to understand the authorizing environment. For this, it is useful to explore two general questions:

- Do the government stakeholders interested in this reform agenda have the power to either (a) make decisions that other stakeholders will need to follow, or (b) convene the officials or political actors needed to build a coalition for change?
- Does the government have political incentives to strengthen health service delivery or PFM systems in the way that UNICEF hopes to see, or is there space to protect more technocratic interests to improve service performance without compromising other political priorities?

One way to answer these questions is to use intelligence gathered through local networks, including staff who have worked with the government for a long time. Another is to test the authorizing environment by exploring the revealed preference of government partners. For example, at the team level, are UNICEF government counterparts able to ensure that their colleagues in other departments or ministries participate in relevant meetings? At the organization level, is the government comfortable sharing financial information or data when requested? At the institutional level, is there general consistency between policy statements and budget allocations in recent years?

9. How should this approach link with other programmes and partners?

This problem-driven approach should coordinate with, leverage and build upon UNICEF's existing body of PFM and health sector analysis, partnerships and insights into service delivery and financing in the local context.

UNICEF should discuss initiating Component 1 and (particularly) Component 2 with government counterparts and other partners before starting the process; and maintain contact with key partners throughout implementation to avoid duplication. Where there are already established processes of PFM or health systems reforms, both Components can be designed in a way that reinforces those processes.

Initial preparation of Component 1 should avoid duplicating research or diagnostics planned by others. The process of consultation and synthesizing evidence should itself identify the on-going reform agendas that are relevant for alleviating PFM bottlenecks to health service delivery. The final report should give a clear indication of where progress is already being made, what actions are already planned and where there are clear gaps that government stakeholders would like to address.

Component 2 should avoid duplicating existing structures for PFM or health sector reforms. The aim is to support a government-led process, and it is the government that will have responsibility, in principle, for coordination across different stakeholders. However, there is the risk that poor consultation and planning before starting this engagement could create tensions between different parts of government and among development partners. It is important that country offices communicate the goals of this approach clearly with different stakeholders and maintain regular contact during the implementation phase.

10. Why should I use a problem-driven approach instead of conducting a technical assistance project?

There are reasons to believe that this approach is an effective way to support reforms. It is relatively low cost compared to standard technical assistance projects and has long-term benefits for building bureaucratic capabilities. However, success is not guaranteed and depends on several factors.

As explained in the summary and introduction, this approach builds on the latest knowledge of how international organizations can be more effective in the way that they support governance reforms. These ideas are influencing a wide range of organizations, including the World Bank, so UNICEF is not alone in looking to tailor an approach like PDIA for its programmes.

A recent evaluation of CABRI's Building Public Finance Capabilities programme,¹³ which has implemented PDIA techniques in a large number of countries, shows that government teams supported with coaching can tackle complex problems, such as the poor execution of capital investments, even in a relatively short period. More importantly, even where teams made less progress, most still reported positively on the approach and gained valuable experience managing a reform process in a way that they would not have done in a typical technical assistance project. This is important for strengthening overall organizational performance and leadership in the longer term.

¹³ Evaluation commissioned by the Bill and Melinda Gates Foundation Lawson, A, Hegarty, J., Harris, J, Harris, J., Falscher, A and de Toledo, G.A. (2020) Interim Evaluation of the CABRI Building PFM Capabilities programme – applying PDIA techniques to PFM problems in African Countries. FISCUS Public Finance Consultants

ANNEX 2

Outline of a Summary Report on PFM Challenges in the Health Sector

This outline provides a template for the Summary Report on PFM Challenges in the Health Sector, which is the main analytical output for Component 1 of the methodology in this approach. It may be customized depending on the audience and needs of the UNICEF country office. For example, the country office may want to focus on specific funding streams or parts of the PFM system where there are known issues or stronger relationships. There may also be elements of primary research included based on previous requests from the government.

Briefing notes

- **Briefing note for UNICEF at the conclusion of Component 1 (setting out implications of the findings for UNICEF programming)**
 - Issues identified
 - How the issue was raised and any evidence
 - What evidence exists and implications for service delivery
 - Underlying causes
 - Options for next steps within UNICEF
- **Briefing note to initiate a joint problem-solving process in Component 2 (if required)**
 - Issues identified with an indication of relative priority
 - What evidence exists and implications for service delivery
 - Efforts already being taken to address these problems
 - Proposal for a joint-Government-UNICEF process to validate and address PFM challenges affecting the health system

Outline for a summary report on PFM challenges in the health sector

- **Section 1: Context (refer to Annexes 4-7)**
 - How are health services financed?
 - Overall split public domestic, public external, private domestic
 - Split by administrative units (central/local delivery, hospitals, facilities, with a focus on primary health care)
 - Wage, non-wage recurrent and development funding, and funding channels (unconditional and conditional grants, insurance funding, own revenues, etc.)
 - Flow of resources chart (see [Annex 7](#))
 - Based on Public Expenditure Tracking Survey (PETS) methodology
 - Cash and in-kind funding, all levels of government

- Major health and PFM reforms
 - Health reforms
 - PFM reforms
- **Section 2: Understanding the issue**
 - What are the key challenges? (can use organizing framework from the checklist in Part 2 as a structure)
 - Resource allocation
 - Resource flow
 - Resource use
 - Why are they important?
 - Conceptual or actual links to services
 - Which organizations have been raising these as concerns
 - What might be causing these issues?
 - PFM systems
 - Other underlying causes
- **Section 3: Options for UNICEF engagement**
 - Where are the strongest links between UNICEF's work and the issues identified?
 - How could UNICEF respond better to these issues?
 - Strengthening the overall strategy
 - Adjusting existing projects and programmes
 - Initiating new areas of work or new ways of working
 - What issues need to be explored further?
 - Existing initiatives
 - Information gaps
 - Partnerships

[The final section would consider the appropriateness and benefits of implementing Component 2 of this approach]

ANNEX 3

Diagnostic tools available

This list is not exhaustive but provides some of the diagnostic approaches that will most closely overlap with the contents and aims of the Summary Report on PFM Challenges in the Health Sector outlined previously. It offers a useful starting point for UNICEF country teams gathering evidence as part of Component 1 of this approach. All sources of available information should be considered as part of Component 1.

Modified Tanahashi Bottleneck Analysis

- **Methodology:** Six determinants of effective health coverage (three supply-side, two demand side, plus quality¹⁴) are measured. The gap in coverage between each determinant reflects the size of the bottleneck to health system effectiveness. This analysis is usually done focusing on a specific set of services, or tracer interventions that serve as proxies for the broader functioning of the health system.

Public Expenditure Tracking Survey (PETS)

- **Methodology:** The PETS approach involves primary gathering of financial data at each administrative level of the health system, combined with qualitative interviews with officials to understand how resources are used. Some studies aim to trace all cash and in-kind resources, while others focus on specific health services (e.g., immunization) or resources (e.g., non-wage recurrent transfers).

Public Expenditure Review (PER)

- **Methodology:** Reviews the magnitude and allocation of budget spending as well as fiduciary concerns. Guidance typically suggests that a PER covers the efficiency of spending allocations as well, often using production frontiers to answer the following questions:
 - (i) What services does public spending buy?
 - (ii) What are the unit costs of delivering public services (or how can public services be expanded at least cost)?
 - (iii) Do institutional arrangements exist that stimulate cost efficiency?

Public Expenditure and Financial Accountability (PEFA) assessment

- **Methodology:** The PEFA framework benchmarks a country's PFM systems against a standardized set of good practices, rating each system on a scale of D to A based on the level of compliance with good practices. The framework has been tailored in some instances to the health sector, though the PEFA Secretariat have not endorsed an 'official' PEFA for a health approach.

¹⁴ Supply-side: Availability of essential health commodities; Availability of human resources; Accessibility – physical access of services; Initial utilisation – first contact of multiple contact services; Adequate coverage – continuity/completion; Effective coverage – quality/impact on health outcomes.

IHP+ Joint Financial Management Assessment (JFMA)

- **Methodology:** No clear methodology was found for this tool. The five-page Executive Summary document outlines the rationale and expected benefits from JFMA work, but does not specify the methodology to be taken. It does not specify which PFM areas, parts of the budget cycle or specific PFM/health service delivery tasks should be singled out for review. It does not set out what 'good' would look like, or put forward thresholds/metrics against which performance can be measured. It is not clear what framework is used for the evidence being gathered; or against what metric or measurement the data is being assessed.

World Bank FinHealth PFM and health toolkit

- **Methodology:** The methodology for this tool is yet to be published though an initial pilot is available for Armenia. It aims to offer a qualitative description and analysis across 24 specific areas for investigation, supported in many cases by specific quantitative data. It intends to provide an assessment of both upstream and downstream processes in managing finance and other inputs in the health sector covering key parts of the budget cycle, the relationship of financial inputs to best practice in health financing, and asks a range of questions about how these inputs combine to deliver health services on the ground.

Other relevant analyses that are not formal diagnostics

- Fiduciary risk assessments prepared by donors
- Government or donor led audit reports, including performance audits in the health sector and payroll audits
- Research studies or surveys on PFM, health financing health service delivery, and other related topics (e.g., Service Delivery Indicator surveys).
- Government strategy documents (e.g., PFM strategy, health sector strategy, etc.)
- Government analysis or performance reports (e.g., human resources for health analysis, supply chain, annual reports, etc.)

ANNEX 4

Proposed structure for an overview of financing in the health sector

Annex 4 sets out a structure for providing an overview of financing in the health sector that will help to understand PFM-related bottlenecks as part of the problem-identification process (Component 1). The analysis can also be used to provide the necessary context for the problems described in the Summary Report on PFM Challenges in the Health Sector, as shown in Section 1 of the proposed outline report (Annex 2). It describes the entities in the public health sector and the categories of resources that will be the subject of analysis in terms of resource allocation, resource flow and resource use. It is supplemented with frameworks and suggestions in Annexes 5-7.

Entities in the public health sector (the 'who?')

A large number of entities are involved in the financial management of public health services. At the central government level there are the various departments of the Ministry of Finance and Ministry of Health, as well as semi-autonomous agencies such as central procurement agencies and public enterprises such as state-owned insurance companies. Many of these structures may also be replicated in subnational governments, with regional or local treasuries, health management teams and logistics units. At the front-line, services may be delivered by primary health care centres and community health care systems that are fully public, or by private entities funded by the public sector.

These entities sit alongside other parts of the broader health system, which include private, not-for-profit and traditional health providers, private supply chains and pharmacies, insurance companies, universities and training institutes, and households. While these may be critical for the provision of health services, they are generally not responsible for the collection and use of public resources, so are not part of the public financial management system analysed with this checklist. Of course, in some countries, services will be delivered through not-for-profit or private sector providers and subsidies may be provided to private entities. In this case, the checklist may need to be reviewed and updated as part of Component 1 of this approach.

Annex 5 provides a framework for considering the relationships between these different entities.

Categories of resources (the 'what?')

The public finance system is typically organized through an accounting framework. In most countries, this distinguishes among several different kinds of resources:

- (i) revenues and grants;
- (ii) expenditures; and
- (iii) assets and liabilities, which may be financial or physical.

In practice the health financing system will be highly complex. To simplify this complexity, users of the checklist are encouraged to think about resources and resource flows across three dimensions:

- **What the resource is for.** Expenditures are typically distinguished between wage- and salary-related payments,
 - non-wage recurrent or operational costs, and
 - capital spending or investments.
- **Whether it is cash or in-kind.** Cash resources may be managed through formal intergovernmental fiscal transfers, for example, or collected directly by a facility. In-kind resources may include distribution of certain drugs, equipment or other inputs purchased by central or subnational governments.

- **The allocation process and rules.** Depending on the agency in charge, the purpose of the resources and the unit in charge of spending, there can be very different PFM rules in place for different funding sources. This distinction becomes particularly notable when different funding sources are used to pay for similar inputs or services, such as drugs or day-to-day operating costs.

These categories will vary to some extent between countries; nonetheless they form a good starting point for analysing most PFM issues. *Annex 6 provides a simplified format for analysing the government health budget, while Annex 7 offers a way to illustrate the complex funding flows in a diagram.*

It should be noted that there can be significant differences between the process and responsibilities for allocating funds in a budget as compared to the way they are distributed during execution. For example, non-wage operating budgets for facilities may be budgeted by a local government but transferred directly to a facility by the national treasury. For simplicity, the diagram should start with the process for allocation, but any discussions of emerging problems will need to reflect the realities of how budgets are executed.

Categories of problems (the ‘where?’)

The public finance system is often simplified using the budget cycle – with phases related to budget preparation, approval, execution, reporting and oversight. This picture is rapidly complicated when different levels of administration and different entities become involved.

For this reason, the checklist draws on a framework used in Welham *et al.* (2015), identifying questions related to:

- The allocation of resources, looking at adequacy, equity and efficiency
- The flow of resources, considering issues of reliability and timeliness
- The use of resources, in terms of efficiency and effectiveness

These categories aim to take the view from local governments primary health care service delivery providers, from the bottom-up. While questions of resource allocation and flow are taken to be mostly outside the control of a given entity, problems with resource use are more likely to be within the control of a local government or service delivery provider, though there may be incentive issues or administrative and capacity barriers to improving PFM.

Some common cross-cutting challenges

A number of overarching challenges are commonly identified in public finance systems in low income and lower-middle income countries that can impact health services.

These challenges include:

- Limited resources
- Poor planning
- Cash rationing
- Arrears building up
- Suppliers paid with significant lags or not at all
- Drug stockouts
- Weak accountability
- Fragmentation of funding and oversight

In other cases, there may simply be little information with which to understand resource allocation, flow or use, due to poor accounting and oversight frameworks.

ANNEX 5

Stakeholder mapping

Annex 5 offers a way to understand the accountability relationships in the PFM system.

*It can be used to support **Component 1** in two ways. First, it can provide a useful context for interpreting the answers that emerge from the checklist exercise. To do this, the checklist needs to be updated to reflect the specific roles and responsibilities of the country, as part of the overview of financing and institutional arrangements outlined in [Annex 4](#). Second, it can be used to decide which stakeholders to prioritize when gathering views on which aspects of PFM may be negatively affecting the quality of health spending.*

*This annex is also potentially useful for **Component 2**, when UNICEF will be looking to engage with key stakeholders in the PFM system in order to help resolve the problems identified. At this point, it may be necessary to map the stakeholders related to the problems in more detail, because roles and responsibilities will vary for different funding streams and different elements of the PFM system (e.g., budgeting vs procurement).*

In all PFM systems, different organizations will play a delivery, regulatory or oversight function, with variations in the structures for the Ministry of Health, local governments and facilities (especially hospitals). This is summarized in a generic way in the table below.

Delivery unit	Responsibility	Regulated by	Overseen by
Ministry of Health	Minister and Director General	Ministry of Finance	Legislature (with support from Audit Office)
Local government authorities (States/ Counties/ Provinces/Districts)	Mayor and Director General	Ministry of Finance, Ministry of Local Government, Ministry of Health	Local Council, Legislature (with support from Audit Office)
Facilities (and other providers)	Chief administrator or medical officer	Local Government, Ministry of Health	Local Council, Health Facility Committees

This provides the broad structure of accountability within the executive and between the executive and legislative bodies. However, organizational units are also divided within the executive structure in functional terms, supporting different aspects of PFM.

Functional area	Ministry of Finance department	Ministry of Health department	District department	Health facility
Budget management	Budget Macro	Planning Finance	Planning Finance	In charge
Human resources	Budget Treasury	Planning Human Resources	Human resources Health	In charge
Accounting and cash management	Treasury Budget	Finance	Finance	In charge
Internal controls and financial compliance	Treasury Internal audit	Finance Internal audit	Finance Internal audit	In charge
Sector performance (varies considerably)	Budget Planning	Planning (and inspection)	Health	In charge

ANNEX 6

Template for financial analysis

Annex 6 provides supplementary information for Annex 4, offering a way to analyse the level and structure of the government budget for the health sector. As with Annex 4, it offers basic context for the checklist analysis in Component 1 and Summary Report on PFM Challenges in the Health Sector.

Financial analysis should cover the broad economic classifications of funding (salaries, operational costs and investment costs) and main administrative units within the health sector (the Ministry of Health, local governments, hospitals and health facilities). In practice, separating allocations in this way is not always simple. Allocations may be budgeted at the central government level, but distributed to local governments or health providers, as is often the case for drugs and donor projects (including many results-based financing schemes). At a minimum, the analysis should aim to identify the key financing sources for primary health providers and understand how these funds are provided.

Donor financing should be included in this background analysis, to the extent possible, focusing on projects that are included in the government budget. Donor spending is often grouped under a single category for management purposes, even if projects actually support capital investments, recurrent operational costs, or even salaries. Different donor modalities may be in place (e.g., budget support, basket funds, performance-based grants, direct delivery), and they may also use country systems to varying degrees at different levels of government. The initial analysis will only offer a general snapshot of donor involvement in many countries, which should be acknowledged when drawing conclusions.

Illustrative Snapshot from Country X

Vote	Wage	Non-wage recurrent	Development	Donor	Total
Ministry of Health	11	65	52	1,003	1,131
National Medical Stores	10	267	0	0	277
National Hospitals	39	29	8	0	77
Regional Referral Hospitals	73	29	21	0	124
Local governments	441	41	72	3	558
Other ¹⁵	18	42	20	64	144
Total Health	593	473	173	1,070	2,310
Total general government spending (excluding debt service)					20,000

The analysis should consider how financing has changed over time. This historical analysis should cover total government spending on the health sector as well as more detailed trends across the broad economic and administrative classifications outlined above, or (at a minimum) the key financing mechanisms. These should be analysed as a share of the budget, value in real terms, and value in real per capita terms, even if they are not presented in the final analysis. Historical analysis should ideally use 'actual' spending or analyse 'budgeted' and 'actual' spending.

Where possible, analysis should also consider the equity of resource allocations. This may include differences in per capita allocations across subnational regions and administrative areas or facilities, but may also capture aspects related to age, gender, poverty and other factors that matter for the provision of health care. Again, such analysis can be complex to undertake in practice, so this review may only draw on secondary analysis already published by others, or draw attention to clear gaps in the existing literature/commentary.

¹⁵ Countries with direct facility financing may have a vote for health facilities, or this may be incorporated within transfers to local governments.

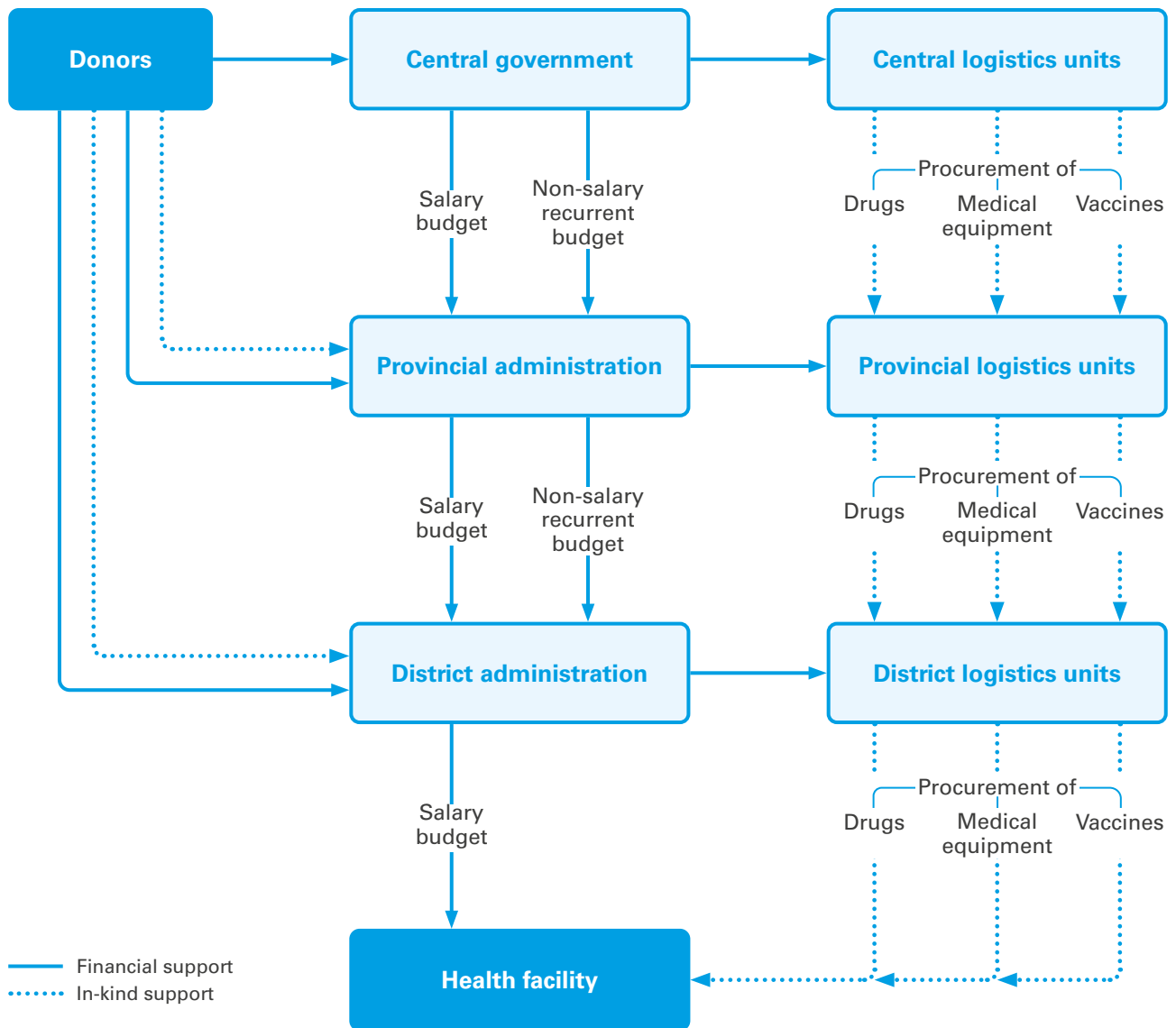
ANNEX 7

Resources flows in the Health Sector in Mozambique

The overview of financing for health services in [Annex 4](#) requires an understanding not just of how much financing is available ([Annex 6](#)) or the key actors involved ([Annex 5](#)) but also how resources move through the system. Without a reasonably clear picture of the flow of funding across public entities, it will be difficult to clearly explain the problems that stakeholders are identifying. If budgets are rationed, for example, which organizations play a role in re-prioritizing the budget? And how does this manifest through the different funding channels (e.g., salaries, operational budgets, in-kind supplies, etc.)?

One useful way to describe the basic architecture for financing health services across the sector is to produce a 'flow of funds' diagram like the one below. This approach is drawn from Public Expenditure Tracking Surveys, which often include such a diagram as part of the institutional mapping used to frame the study. As noted in [Part 2](#), the systems of resource distribution in a health system can vary considerably between countries. The example provided below illustrates this for Mozambique.

Figure 3: Illustrative example of a flow of funds diagram for the health system in Mozambique



Source: Lidlow (2006) in Gauthier, B. (2010) PETS-QSDS in Sub-Saharan Africa: A Stocktaking Study, Washington DC: World Bank

ANNEX 8

Principles for facilitating a PDIA approach

For nearly a decade, the Harvard Kennedy School of Government has been publishing tools and frameworks that can be used to facilitate a Problem-Driven Iterative Adaptation (PDIA) approach. Many have been combined in the *Building State Capability* book published in 2017, and numerous short videos can be viewed on [YouTube](#) and [VIMEO](#) where those involved explain the basic principles. In addition, the Collaborative Africa Budget Reform Initiative (CABRI) has implemented the PDIA approach as a multi-country programme, applying and adapting many of these tools for teams of government officials to apply in their day-to-day work.

Annex 8 briefly summarizes some of the most relevant elements from PDIA guides for UNICEF teams contemplating or implementing Component 2, in case the country office or facilitator wants to incorporate them as part of the 'problem solving' workshops. For those not already familiar with PDIA approaches, it may also be useful to [read this short introduction](#). Many of these activities are done first as individuals and then as a group to illustrate the different ways stakeholders view and understand a problem (or set of problems).

1. Constructing problems that matter

PDIA encourages officials to identify and frame problems in ways that will matter to important stakeholders.

This aims to distinguish between problems (e.g., we struggle to maintain overall budget control) and the absence of a known solution (e.g., we do not have a working medium-term budget framework). It also encourages officials to frame and communicate the problem and why it matters to stakeholders that have a high degree of influence over the problem, but with limited interest. This often encourages the use of data, but narratives are also important.

CABRI asks participants to spend 3-5 hours developing a narrative that explains the problem they want to see addressed. This may also require time in between workshops to gather data and prepare written output. However, the core questions that CABRI asks of participants in its workshop are:

- What is the problem you want to address?
- What is the extent and impact of the problem?
- Why does the problem matter?

Stakeholder power analysis is also a standard framework for grouping different stakeholders based on their level of influence and interest in the problems identified. See [building block 6 in this summary](#) of stakeholder mapping techniques. There are also free online apps to help the mapping, such as [this](#).

2. Breaking down the problem into manageable steps

As well as constructing the overall narrative, the PDIA process encourages officials to break down the problem in ways that will support feasible short-term actions that will have an impact on the overall objectives. This involves a number of frameworks for:

- **Identifying the main causes of a problem and possible entry points.** Use the 5-why's technique that asks 'why is that the case' five times to get to the root causes. These are written down, debated, grouped and then organized using an *Ishikawa (or fishbone) diagram* (see Figure 1 on page 18 of the [Harvard PDIA toolkit](#) for a generic illustration linking PFM and service delivery). Groups will discuss which are the most important contributing factors to a problem and which single factor will have the greatest impact on performance if addressed?
- **Prioritizing actions that are impactful but also feasible.** With the various causes mapped, the PDIA process next turns to identifying which of the underlying causes for a problem can be addressed without fundamentally overhauling the current context and where there is space for change. Space for change considers three dimensions: acceptability (will stakeholders agree), ability (is there capacity and resources) and authority (is there authorization and support) to act. Focusing on areas where all three conditions are in place carries the lowest risk. In other cases, it may be necessary to build the space for change by increasing acceptability, strengthening ability, or securing authority. This can be drawn as a simple Venn diagram for each issue.

3. Identifying and exploring solutions in a local context

Developing and testing options. PDIA will generally encourage participants to develop multiple options that could be used to address the sub-causes and/or build the space for change. These are sometimes gathered together as a **Search Frame** with actions listed, prioritized and then delegated to team members with a deadline to follow-through.

This builds towards a model of taking numerous small steps over a short period of time and regularly reviewing whether the actions are having the desired effect.

ANNEX 9

Examples of supporting a government-led problem-solving process

Annex 9 provides selected examples of the way UNICEF can support a government-led problem-solving process. It draws these examples from a wide range of donor programmes, including some run by UNICEF in recent years. This is not intended to be an exhaustive list, but illustrates the variety of different roles and approaches that a country office could consider alongside plans to implement Component 2 of this resource guide.

Facilitation and coaching on the reform process

As explained in Box 5, Problem-Driven Iterative Adaptation (PDIA) has explicitly adopted an approach that focuses on facilitation of a reform process rather than the provision of external knowledge and expertise. While this does not negate the benefits of expertise and international experiences, the emphasis is on finding local solutions to local problems as a means to build ownership and experience of the reform process (itself a capability).

Since 2017, the **Collaborative Africa Budget Reform Initiative (CABRI)** has worked with Harvard University to put this approach into practice at scale through the **Building Public Finance Capabilities** project. Government teams (typically of around six officials) apply to join the programme for a 12-month period. The team receives an induction on the PDIA approach and coaching from CABRI during implementation. CABRI has also run a variant of this approach with multiple teams in a single country (including in South Africa and Lesotho).

UNICEF and CABRI are collaborating to implement PDIA in several countries in East and Southern Africa in 2022–2023. There are already examples of UNICEF engagements that have involved a strong emphasis on facilitation, including in the area of procurement in Namibia (see summary in Box 6).

Building consensus through new diagnostic work and research

While this approach paper does not put a significant emphasis on new research, this does not mean detailed analysis of a problem is not helpful for initiating a government-led process. However, if new diagnostic work is central to the implementation of Component 2 or is demanded as part of the engagement, experience shows that the process for implementing the research and sharing its findings is as important as the quality of the work itself. This includes careful consultation on the questions to be explored with the institutions that hold power.

Box 2 provides a useful illustration from the design and implementation of a **Public Expenditure Tracking Survey in Timor-Leste by the World Bank** (Nixon and Bredenkamp, 2014). It offers two important lessons. One is that the study needs to focus on issues that have salience to decision-makers. Second is that diagnostics should be tailored to the question that is being explored, with the final Tracking Survey offering a much lighter and more qualitative approach than many other examples.

Another example is **ODI's research on health financing in Uganda** (Davies *et al.*, 2021). This was initiated by donors but was reframed in close consultation with the Ministry of Finance. The study was set up to include fieldwork and data collection from all four regions of the country to avoid perceptions of political bias, and involved government officials in the data gathering process. The findings were initially presented and agreed among a small group of technical officials in the Ministry of Finance before gradually involving more senior officials and later the Ministry of Health. The process generated a consensus over how to address the problems and nearly all of the recommendations were ultimately implemented.

UNICEF's support to procurement reforms in Namibia offers an example of how to adapt this approach to a more specific problem that has already been identified by previous engagements (see Box 6 for summary). This study developed a tailored review framework based on international good practice principles, with 11 categories to assess performance on procurement and PFM. This provided the main organizing framework for the review of evidence and stakeholder consultations in the analytical phase of the engagement. The use of good practices also offered a useful 'yardstick' to support the dialogue and consensus-building process within government.

Using external actors to broker reforms

As explained in Box 5, there are numerous examples of projects that have deployed technical assistance in a way that is politically informed and locally led (Unsworth and Booth, 2014). These tend to be projects with significant flexibility over how they use their financing and structure their activities – features which help technical assistance respond to windows of opportunity and changing demands in the government. They also put a significant emphasis on developing relationships and using these to help broker a consensus on reforms, not only in government but also sometimes with donors.

Examples relevant to public finance include **ODI's Budget Strengthening Initiative** in South Sudan, which helped align a government interest in receiving budget support with donor concerns with strengthening service delivery. Successfully brokering interests across the different stakeholders led to a reform that introduced the first fiscal transfers to state governments in order to finance local education and health services.

The Asia Foundation's Coalition for Change programme in the Philippines is notable for its support to reform sin taxes and significantly increase health spending in the country. The programme works by engaging experienced local actors, supporting the capacity of organizations to further the dialogue on key issues, and helping to develop networks and coalitions of actors interested in similar goals.

The Australian **Governance for Growth programme in Vanuatu** is a more complex project providing financing and technical assistance to different government ministries in areas related to economic and financial governance. Many features of the project were explicitly designed to encourage close working partnerships between the project team and their counterparts in the government, including having an office located in the Office of the Prime Minister (OPM). This incentivizes the team to align themselves to government issues and the small group of staff invests considerable time and effort into maintaining relationships across the political system and government bureaucracy, and leveraging support and expertise from other donors.



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