Securing domestic resources[1] for Investment Cases: Integrating Investment Case priorities into the Government Budget and tracking progress over time

Contents

[1] These guidelines are focusing on domestic funding as a separate note is being prepared to better guide the mobilization and tracking of external resource behind the IC. Ideally, we would want to have one system which tracks both domestic and external funding behind the IC at country level. However, this is not possible on a short-term basis as external and government health budget and expenditures are not stored in one database. Moreover, we are taking a step back because GFF has had limited results on mobilizing and aligning domestic resources behind IC priorities, hence the focus of this note on domestic funding, suggesting a road map to make that happen.

1. Why this note?

1.1. Background

The objective of the Global Financing Facility (GFF) is to accelerate efforts to end preventable maternal, newborn, child and adolescent deaths and improve the health and quality of life of women, adolescents and children by 2030 and thereby contributed to achieve Universal Health Coverage (UHC). A large funding gap remains – US$33.3 billion in 2015 alone in low- and lower-middle-income countries to scale up services, that the GFF intends to close by increasing financing from both domestic and international sources. For this, the GFF is supporting governments to develop prioritized Investment Cases (IC) that set out the government priorities that financiers can support.[2] To implement IC priorities, GFF support government in leveraging resources from the private sector, governments and donors external, including from the GFF trust fund.

Ensuring that ICs are increasingly funded by domestic resources, and thereby putting the health sector at a sustainable footing, is at the heart of the GFF's value proposition. Critical to make this happen is to create a strong dialogue between the Ministry of Health and the Ministry of Finance to ensure that the priorities of the IC are clearly reflected in the government budget and that one can measure their increase and utilization over time. While aligning IC priorities with the health budget is at the heart of the GFF value proportion, aligning countries' national plans with budget is not a new topic in Low-Income Countries (LIC). Over the last 20 years, several LICs have been trying to reflect national strategies' priorities in their budget through performance-based budgeting ng (Box 1). This approach contrasts with non-program budgeting in which economic categories (salaries, good, service, transfers) and administrative categories (ministries) are the central focus of the budget and not linked to sector output. In the health sector, a few countries have been trying to align National Health Strategy's priorities or program in budget through program-budgeting, a type of performance-based budget (Box 1). However, the process has been slow as it requires public financial management (PFM) reforms. One can say that GFF is committed to support countries accelerating such reforms as it sees program-budgeting or performance budget reforms as a vehicle to better track domestic resources behind the IC.

The implementation of this agenda (aligning IC priorities to MOH budget structure) is complex. For instance, only a handful of GFF countries are working on creating a direct link between the government budget process and IC (or National Health Strategies) priorities. This important step has not been systematically embraced in all GFF countries.

1.2. Objective

The objective of this note is to provide practical guidance for all GFF focal points and TTLs working on GFF supported countries for how to ensure domestic resources are supporting the priorities of the IC. The note highlights critical steps to link IC priorities to the budget as well as tools to make that happen.

1.3. Target audience

It is targeting TTLs and GFF focal points and Liaison Officers (Secretariat) active in GFF supported countries. Primarily countries that are about to develop or have an IC and/or prioritized NHS but have not yet created a strong link between its priorities and the MOH government budget. If the IC has already been developed the work described below will be retrofitted.

[2] In some countries supported by the GFF, the Government has opted for prioritized National Health Strategies instead of Investment Cases (e.g. Ethiopia and Tanzania).

1.4. Caveats

While this note is written as a standardized manual, we are aware that there are large differences between the countries where GFF is providing support. This work is also highly complex and requires skills and experience in the technical areas of health financing and PFM. We have written this note in an attempt to guide GFF focal points and TTLs who may not have this experience. At the same time, we recognize that prescriptions here cannot replace practical experience. To deal with this issue we recommend engaging local, regional or international consultants with these types of expertise. It is also possible to get in touch with the GFF HF team, specifically, in cases where needed data is not available.

Box 1. Definition of Performance Budgeting and Program-Budgeting, a type of Performance Budgeting

Performance budgeting', 'performance-based budgeting' and 'budgeting for results' are similar terms, with a common uniting feature: they are all concerned with introducing performance information into budget processes. The OECD (2007a) has defined performance budgeting as a form of budgeting that relates funds allocated to measurable results. Robinson (2007) defines performance budgeting as a budget system that aims to improve the effectiveness and efficiency of government expenditure by linking the funding of public sector organisations to the results they deliver. **The reason for adopting a results-oriented budget is to overcome the inadequacies of the traditional line-item (or input-based) annual budget, notably its absence of focus on the purposes of public spending**. The shift to PPBB is intended to achieve greater clarity on the links between inputs, outputs and outcomes, and to provide a tool for budget decision making based on performance information. By making explicit the purposes and results of budget spending, budget programme managers can be held to account by the legislature and citizens**. In performance budgeting systems, budget managers are required to 'produce' outputs and to contribute to outcomes.** Budget managers are provided with spending authority and flexibility in choosing resources (inputs). Budget managers are held accountable before Parliament and the public. In contrast, in traditional budget systems, a central MoF controls budget processes and input spending. 'Input-based' budget systems weaken the responsibility of spending ministries to deliver results.

The pressures to introduce PPBB reforms have originated from individual countries, regional bodies in Africa, and the international donor community, which often has supported the reforms with technical assistance. For instance, the IMF provided technical assistance for the preparation of the directives of the West African Economic and Monetary Union (WAEMU) and the Central African Economic and Monetary Community (CEMAC) that were adopted by councils of ministers in 2009 and 2011. These directives require all 14 francophone member countries to move to programme budgeting. In some countries, international financial institutions required the adoption of MTEFs (early step towards PPBB) as a condition for the disbursement of loan and budget support.

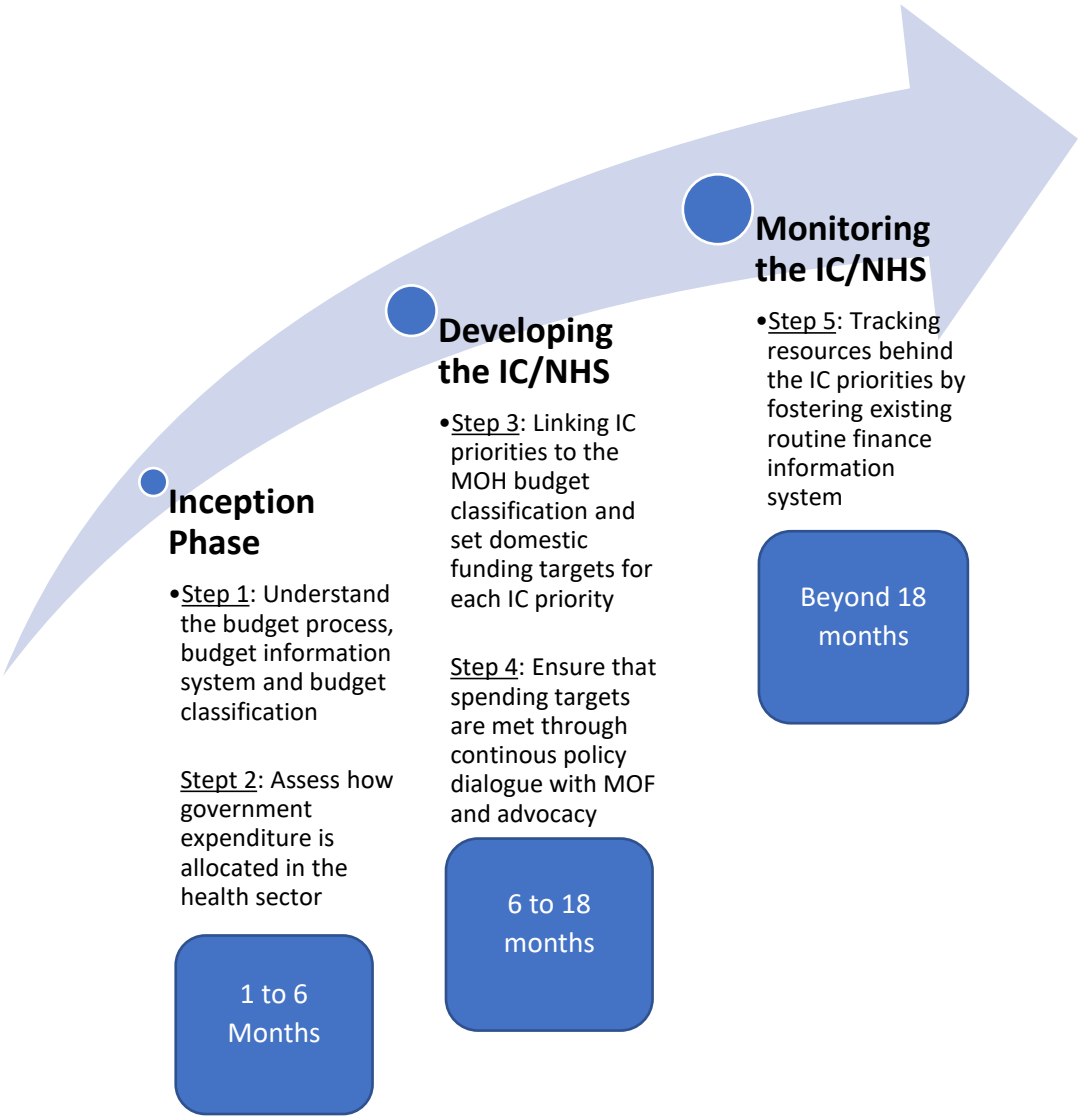
The key characteristic of all performance budgeting models is that they attempt to link budget funding and results. Some performance budgeting 'models', including **programme budgeting** (see below), are government-wide systems. Others apply **performance budgeting only to particular sectors**. Whereas some performance budgeting systems aim principally to improve expenditure prioritisation, others focus mainly **on improving spending *efficiency* and *effectiveness*.** Budget systems also have **to balance these aims with improvements in the *equity* of spending** (i.e. ensuring that poor populations benefit more from the spending policy).

Programme budgeting is a form of performance budgeting in which budget expenditure is planned and managed by programme. The objectives of each budget programme are clearly specified and formally approved by the government and the legislature. Programmes may be divided into sub-programmes and/or activities, with which performance indicator and targets can be associated. A fully fledged programme budgeting system contrasts with a non-programme budgeting appropriations system, in which economic categories, such as salaries, goods and services, transfers and capital, and/or administrative categories (e.g. ministry) are the central focus of the annual budget law or appropriations act(s).

Source: Collaborative African Budget Reform Initiative, 2013. Performance and programme-based budgeting in Africa: A status report

2. Proposed Phases and Steps to initiate that work

Figure 1. Summarized approach to securing domestic resources for IC/NHS



2.1. Phase 1: Inception Phase

Step 1. Understand the budget process, budget information system and budget classification

Objective: Collect basic information about the budget process, existing systems for tracking expenditures, structure/classification to understand how IC forthcoming priorities can be aligned to it and have increased funding over time.

Understanding the budget cycles and how expenditures are classified and tracked is critical, because this will influence how the priorities of the IC get codified in the budget. Changing expenditure tracking systems and charts of accounts is a slow process and goes beyond the Ministry of Health as they adopt the system used in the Government. Thus, to the extent possible the IC will have to adapt to the budgeting classification system and not the other way around.

Box 1 . BOOST Definition and Application

Definition	Getting Support from the WB BOOST team (Governance GP)
• BOOST, an analytical tool that can be used to improve the quality of public expenditures that is based on data obtained directly from finance ministries. The tool is an easy-to-use Excel spreadsheet. Data in the BOOST is taken directly from national integrated financial management information systems (IFMIS), which is cleaned and formatted into a common template for all countries, and then validated against national expenditure and accounting reports. BOOST can also be adapted to expand data availability to sector-specific information, such as sector inputs (health facilities, workers, drug distribution), performance (service provision), and demographics (poverty). • A key added value of Boost data is that it is clean, harmonized between countries and publicly available. The BOOST data initiative was initiated and managed by the WB Governance GP to ensure the harmonization of data and public access and they also support country teams with this product (please see below). • In Ethiopia for instance, the BOOST will consolidate several existing databases encompassing government financial data and help mapping the priorities of the IC (=Health Sector Transformation Plan) under the existing MOH classification to track whether there is an increase of domestic resources behind the HSTP Priorities.	• The GFF Health Financing team has set up collaboration with the BOOST team. Its manager is Massimo Mastruzzi (mmastruzzi@worldbank.org). There is a list of BOOST coordinators in all countries with a BOOST (see annex). Should there be an interest in developing a BOOST to strengthen the tracking of domestic resources and better align resources of IC with MOH budget, you can contact Massimo and ask him what the steps would be (there is normally discussion with the country economist and few Program Leaders). • If you work in a country with an existing BOOST and you would like to use BOOST to better tracking domestic resources and better align resource of IC with MOH budget, you can contact country BOOST coordinator to see how s/he could help you or link it with the PFM consultant who may do that work. • Not all BOOST country coordinators will have the capacity to do that work. In the case of Ethiopia, the BOOST coordinator is helping GFF with these requests but in the case of Senegal, it is a separate PFM consultant who does so, working with the BOOST coordinator in case he has questions. In the case of Ethiopia, the GFF is contracting with the BOOST coordinator for 30 days to match IC priorities to budget classification and finalize the health BOOST. In the case of Senegal, if need be, the GFF code can be charged by the BOOST coordinator for a few days, should the PFM consultant really need his support. Senegal has a fully-fledged BOOST while it is not the case in Ethiopia.

Source: Authors based on BOOST materials.

During IC development, review existing documents (e.g. Public Expenditure Reviews (PERs), Health Financing System Assessments (HFSAs) etc. and discuss with colleagues from the WB Governance Global Practice (GP) including colleagues who work on analyzing government budget and expenditure data

from e.g. BOOST[3] (see Box 1) colleagues, relevant development partners involved in health financing and representatives of Ministries of Finance and/or the fiduciary unit of MOH to understand:

A. ***The budget cycle:*** it is important to have in mind key dates of decision points and how it can be influenced as well as structure of the budget and planning process to understand how IC priorities enter this process once priorities of the IC are defined. For instance, in Mozambique, IC engagement with this process should begin at the start of each FY for planning health spending increases for the following FY, as summarized in Table 1.

Table 1: Annual Budget Formulation Calendar and IC Engagement Action Plan in Mozambique

Months	GoM Annual Budget Calendar	Priority Actions for Engaging with GoM IC Priorities
Oct - Dec	--	Begin discussions with MEF and MISAU DAF to get data from the last REO for health
Jan – Mar	Districts review plans and collect statistics to inform spending needs	Review previous year's data according to expected increases in investment (documents needed: e-SISTAFE data and Quarterly Health REO); Reviewing last year's PES global with suggestions on increases for the upcoming year
Feb – Apr	The medium term fiscal framework (CFMP) is elaborated – initial budget limits are communicated, and budget proposals are submitted for central government review	Begin discussions with provincial focal points about the budget process and expected budget targets for each spending unit
May 31	The central government communicates the second budget limit and budget guidelines	Adjust IC targets based on CFMP projections and budget limits for the year
Jun – Jul	Provincial and sectoral planning meetings are held	DAF working with Provincial DAF, and involving provincial focal points from the PHCS P4R, discussing IC priorities in the provincial budgets
Aug	Budget proposals are submitted and consolidated for provinces, districts and sectors	Review the PES Global in comparison to IC targets and discussions with MISAU DAF before their meetings with MEF on total sector allocations; Partners that provide off-budget support will align contributions with national health spending through the PES Global
Sept	The PES and OE are submitted to the Council of Ministers for approval by Sept 15th, then to Parliament for approval by Sept 30th	Review the final spending approved for the health sector in the OE as a proportion of total public spending and to select provinces
Dec 15	Final date for the approval of the PES and OE by Parliament	Begin discussions with DAF on allocations in the budget execution module (MEX) and funds flow to local facilities; Track mid-year budget adjustments

Source: Sally Tolbert, Mozambique PFM Briefing Note, September 2017

B. ***Budget/expenditure information systems:*** Start gathering information on the existing financial information systems at Ministry of Health or/and Ministry of Finance compiling domestic resources and potential issues:
   - Integrated Financial Management Information System (IFMIS) (See Box 3) are used to track government expenditures. Key questions are: Does an IFMIS exist? Does it capture all sources of domestic funding, including on-budget external financing? Is it operational at all administrative levels? If IFMIS is not user friendly for that mapping and tracking exercise, BOOST, an analytical tool with data from IFMIS, can help (See definition in Box 1).

[3] BOOST is a user-friendly platform to access budget and expenditure data for expenditure analysis. For more information: http://wbi.worldbank.org/boost/tools-resources/topics/general-techniques/how-usebuild-boost.

- Is there a BOOST? Is it used and more user-friendly than IFMIS or other existing finance database? Any specific challenge with IFMIS and BOOST? If no BOOST, would a BOOST help better tracking domestic resources behind the IC or National Health Strategy's priorities?

Box 3. IFMIS Definition and Application

- **An IFMIS is an information system that tracks financial events and summarizes financial information.** In the government realm, IFMIS systems must be designed to support distinctly public sector functions. They must be able to handle and communicate all the financial movements for the complex structure of budget organizations. Integration is critical to the operation of an IFMIS. Integration, using a common "data warehouse", ensures that every unit and every user adhere to common standards, rules, and procedures and helps safeguard against unauthorized or imprudent uses of budget funds. It also allows users anywhere within the IFMIS network to access the system and extract the specific information they need.

- **A variety of reports can be generated to address different budgeting, funding, treasury, cash flow, accounting, audit, and day-to-day management concerns.** IFMIS implementation often involves simultaneous efforts to unify budget classifications and the chart of accounts (CoA). Both codes and classifications will have to be brought into compliance with standard classification and accounting frameworks, such as the IMF's Government Finance Statistics and the International Public Sector Accounting Standards (IPSAS), and designed to accommodate diverse reporting requirements. Nevertheless, existing classification structures in the country should not be ignored.

Source: Rodin-Brown (2008), *Integrated Financial Management Information Systems: A Practical Guide*

C. ***The existing government budget classification system.*** Countries use different ways of classifying expenditures in their PFM systems. We listed an example from Mozambique below. It is important to ask whether classifiers exist and which classifiers could be used to map the IC priorities. The following question can help identify classifiers:
   - Are programmatic classifiers used? Are there any specific programmatic classifiers that align to IC priorities? Note that certain countries may have a program budgeting approach (See boxes 1 and 6) which will make the assessment of the classification system easier.
   - Are geographic classifiers used? How "low" are they used in the health system (Regions, Districts or/and Health Facilities)? Can you use these to determine whether you could monitor a shift of expenses to e.g. poorest regions or to PHC facilities through IC?
   - Inquire if existing classifiers are used. Is a large share of expenditures classified as "unclassified"? (this require data analysis [see step 2] but initial inquiry can give an idea about quality of data and help in step 2.

Table 2. Example of Classifiers used in the Mozambique MOH budget

Classifiers	Objectives/Description
Functional (e.g. defense, health)	Aggregates public spending according to government action areas related to the nature of State functions. Usually, these follows international standard Classification of the Functions of Government (COFOG). Developed by the OECD, COFOG classifies government expenditure data from the System of National Accounts by the purpose for which the funds are used. First-level COFOG splits expenditure data into ten "functional" groups or sub-sectors of expenditures (such as defense, health, education and social protection), and second-level COFOG further splits each first-level group into up to nine sub-groups. For health these are: Medical products, appliances and equipment, Outpatient services, Hospital services, Public health services, R&D health, Health n.e.c Here is more information on COFOG.
Administrative (e.g. hospitals, primary care units)	Aggregates public spending for each the state institution / spending unit responsible for budget formulation and execution.
Programmatic (e.g. health programs, reproductive health programs etc)	Tracks the government activities into programs and sub-programs in pursuit of government policy objectives and enables monitoring of results.
Economic (salaries, allowances, goods, services, subsidies, transfers etc.)	Identifies the economic nature of the expenditure
Geographic (e.g. province x, district y)	Allows separate tracking for the central government and each of the sub-national governments at provincial and district levels.
Sources of Funds (e.g. treasury, loans, donations, own revenues).	Identifies the source of funding. Detailed source ID identifies the specific development partner.

Source: Sally Tolbert, Mozambique PFM Briefing Note, September 2017

→**Deliverable/Milestones:** 1) A few paragraphs in the Aide Memoire or BTOR describing the MOH budget cycle, expenditure information systems, budget classification system and initial thinking of how prospective IC priorities could be map under and enter into the budget and planning process (see example from Mozambique below); 2) short-action plan or road map or next steps assessing what needs to be done to align prospective IC with the MOH budget to better track domestic resource increase.

Box 4. Initial thinking about how IC priorities could be linked to budget in Mozambique

Mozambique's budget is primarily structured as a line-item budget, with little information on programs or links to outputs. Within IFMIS, budget and expenditure information uses a classification system that categorizes each financial transaction by several dimensions in the accounting records. The most consistently tracked classifiers are the administrative, economic and functional classifiers, however the functional classifiers have several limitations that prevent their effective use for tracking maternal and child health expenditures. These limitations in the current budgeting process may present a potential obstacle in effectively tracking the IC priorities, however to effectively engage in the budgeting process, it will likely be necessary to create a version of the IC Costing Matrix that is aligned with the current budget structure in Mozambique.

Source: Authors

Step 2. How is government expenditure currently allocated in the health sector?

Objective: If not already available, produce a basic analysis of current government expenditures to create a baseline that can serve as a starting point for a discussion about expected expenditure shifts because of the implementation of the IC.

- This activity is part of the "next steps"; "road map" discussed in Step 1. This is something you can start prospecting in the beginning of the IC development process
- The World Bank and other partners often conduct PER or a HSFA or similar analyses that is a report which focuses on analyzing Government expenditures. What we propose in Step 2 is a "mini" PER. If the country you work on has a recent PER, Step 2 may not be necessary as you may be able to draw on existing information.
- If not PER, or similar report is available, we recommend that you hire a local or International Consultant (see TOR in annex and pool of STC) to conduct this analysis. The resources for this study should come from the resources earmarked for the IC development (GFF Bank Executed). The consultant can also be suggested by the Governance/BOOST team (if there is one active in your GFF country) or MOH or by a partner engaged in PFM or Health Financing (e.g., WHO, Gates, USAID, Global Fund). Additionally, this consultant can summarize the budget cycle and structure (done under step 1) if you haven't done it with great details. Ideally the consultant should be knowledgeable about PFM in general and have local knowledge about PFM in the country you work in.
- Conduct a basic analysis of existing budget and expenditure data using Boost Data/IFMIS or other databases to identify:
    - How is government expenditure currently allocated in the health sector? (for external financing that is on-budget, this should also be included in the analysis)
    - What is the budget execution rate for different spending units?
    - Reading from the data, what are the current challenges with the way expenditures are tracked? (e.g. large share of expenditures is not classified; certain codes are never used which inhibits an understanding of resources are allocated and data are not computed at decentralized levels)
    - Studying the data, start to reflect on what types of shift in the expenditure data could we see because of the implementation of the IC?

The aim of this process is to identify how expenditures are spent and to create a baseline for the IC.

→**Deliverable/Milestones:** 1) TOR and recruitment of a PFM or HF consultant to conduct mini-PER if not already done; 2) Baseline report on government health expenditures over the past 5 years by budget classifier, program, geographical areas including a study on budget execution and reflections on challenges with the current system.

2.2. Phase 2: Development of the Investment Case

Step 3. Aligning IC priorities to the MOH budget process and classification

Objective: Ensuring IC priorities are reflected in the MOH budget or other line ministries' budgets with clear targets.

This process can start once you have an investment case with a list of priorities. Ideally, IC priorities will use existing priorities from a previous National Health Strategy which are identified in the budget and would make the alignment of IC priorities under the MOH budget easier. This is easier in countries which have a program-budgeting approach because one can link priorities of IC with program structure of the budget.

- Continue working with the PFM consultant in charge of mapping the final priorities of the IC with the budget classification. Depending on the country, the PFM consultant will use the existing IFMIS/budget structure or BOOST to conduct that work.

- Once this work has been conducted, The TTL, the GFF Focal Point and Liaison Officer supported by the PFM consultant hired under step 2, can initiate a discussion about what expenditures shifts for each priority can be expected because of to the implementation of the IC/NHS with Ministries of Finance and/or the planning/fiduciary unit of MOH (depending on who gets involved in these decisions). This discussion also needs to happen as part of the GFF country platform. Having said this, this is a highly political discussion and before embarking on it, it would be important to strategize on how the dialogue will be conducted and with whom. Engaging implementers or specific heads of programs in such dialogue may complicate matters as they have vested interested. Therefore, the sequencing of the meetings and who participate where is very important. We don't have specific recommendations regarding this as it is highly dependent on the country context and people involved. The following questions can be asked:
    - If the country uses programmatic classifiers (because they have program-budgeting) which programs will receive an increase/decrease in funding as part of the IC implementation?
    - Will there be a shift in allocations between different administrative levels of care (hospitals vs. primary care) or geographies (certain under resourced districts will receive more resources) and how can we expect this being reflected in the budget/expenditures (shifts in allocations to certain administrative and geographic units) ?
    - Set explicit and realistic expenditure targets that are defined on a yearly basis for the period of the IC. Ideally, the priorities of the IC should be tied to changes in allocations to specific budget categories or expenditure classifiers which can then be monitored and tracked both in their adoption in the budget and in changes in expenditure over time. This is the work that the PFM consultant will undertake in step 2.

- In the process of setting expenditure targets, it is important to also discuss political and bureaucratic constraints that MOH officials may face when shifting resources, e.g. it might not be possible politically/administratively (e.g. changes in resource allocation formulas may need approval by legislators) to move resources from one unit/area to another in year 1 and 2, but easier to do this gradually through incremental resource allocations.

- There may be other PFM priorities that come up from this work, e.g. technical assistance to strengthening the capacity of the fiduciary unit of the MOH to implement program budgeting, or supporting decentralized budget units to use budget classifiers etc.. That could be developed

into a TA program supported by the GFF Trust Fund (TF) or GFF Bank Executed (BE) to support the implementation of the GFF IC. This is also something that could be identified during the Inception Phase. It is important to discuss these types of programs with colleagues who support broader reform efforts in Public Financial Management outside the health sector. In many cases, national reform efforts that be piloted in a line ministry (such as health) and this may be an opportunity to receive additional support, resource and buy-in for reforms.

→Deliverable/Milestones: 1) Assessment aligning IC priorities under the MOH budget classification with clear expenditure targets; 2) Developed PFM TA program (if needed) that delineates clear areas of capacity strengthening for the PFM system to accompany broader budget reforms in the health sector (e.g., program budgeting), which also serves the interest of the GFF platform.

*Note: in countries which have already an IC and in which this work is retrofitted. Steps 2 and 3 can be done at the same time by a consultant, available staff or partner organization. . Not only will the consultant conduct a mini-PER but s/he will also map IC priorities under the existing MOH budget classification to monitor on the increased of IC priorities over time. However, it is important to notice that expenditure targets need to be discussed with Government in political dialogue and cannot be decided by a consultant***.**

Box 5. Mozambique: highlight issues between IC priorities and budget and what was done to address this issue

As part of the preparation of the IC an analysis of public expenditure data and fiduciary and PFM systems were conducted. This analysis revealed serious PFM weaknesses (e.g. limited human resources and capacities for key FM functions, particularly at decentralized levels, weak internal controls and auditing, and low procurement capacity, especially for medicines, civil works and equipment). These weaknesses reduce the value-for-money of health expenditure, while making it difficult to effectively track how existing resource are being spent. The analysis also revealed misalignment of the IC costing with national budget classifiers and inadequate use of those classifiers in e-SISTAFE (IFMIS system) as well as that existing cost-centers fail to capture expenditure at health facilities below the tertiary care level. To address these issues, the GFF and partners are supporting the Government through capacity building, awareness raising and on-demand studies to improve PFM systems, and to recommend required reforms to track expenditures in a more meaningful way. This line of work will contribute to strengthen PFM systems and improve the monitoring of expenditure shifts over time according to the identified IC priorities. The deliverables for the first year of this program included (a) evidence that IC priorities are included in next year's provincial budget allocations, (b) -Report tracking health expenditures per the priorities of the IC for year 1 of implementation, (c) analysis of how current reporting structure needs to change to track expenditures in a more meaningful way and clear recommendations for implementation of needed changes. The support will continue for years, but initial steps are undertaken to strengthening existing systems and improve budget and expenditure tracking in the future.

Source: Authors

Box 6. DRC: when developing a PNDS and the Program-Budgeting Reform become an opportunity for aligning the IC priorities with the MOH budget

DRC developed an investment case (IC) in 2016, endorsed by the Ministry of Health in 2017. The investment case focuses on 12 priorities in 14 provinces with the weakest health indicators. The main cost driver is a package of maternal, child and adolescent health services (Priority 1) which is to be implemented via strategic purchasing (Priority 5) and the single contract (Priority 9) at provincial level, a tool by which donors and provincial authorities pool and monitor resources to implement the RMNCAH package in addition to key health system activities. While the IC was aligned 100% to the Plan National de Development Sanitaire (PNDS) or National Health Development Plan, both priorities of the PNDS and IC were not anchored in the budget. A detailed resource mapping exercise of the IC was undertaken to map external resources which each IC priority. This exercise also included mapping resources of government, but this was made almost impossible as the program structure was input-based and based on program which neither fit the PNDS nor the IC. Hence it was not possible to follow government resources for the specific PNDS and IC priorities using the current MOH budget structure. To address this shortage, the GFF team had thought to revive the existing BOOST tool in order to map the priorities with the input-based classification, which would have required a considerable data cleaning effort. However, in 2018, the Minister of Health decided to update the PNDS given its weak performance, using the prioritization process of the GFF IC and linking it to program-budgeting which had been launched in DRC but was still not implemented. Now the PNDS has 3 new priorities which are: The provision of the RMNCAH Package to 50% of the population, including preventive NCD measures (Priority 1), Health System Strengthening (Priority 2) and Governance (Priority 3). The committee in charge of finalizing the PNDS is working with a PFM TA to align those 3 priorities with the current budget and update the classification in the context of a broader governmental program-budgeting reform. This reform requires performance indicators for each priority as well as commitment from both government and donors to be included in the program-budgeting template to determine incremental government contribution to implement the PNDS for the next 4 years. Because the IC priorities are aligned with the PNDS, there is no additional work to be done to align IC priorities with the MOH budget and monitor the domestic funding flows of the IC. This can be done automatically once program budgeting and a solid IFMIS is in place. It may however take 1 to 2 years to ensure that program budgeting structure is not only in place nationally but also at provincial level in order to monitor whether domestic mobilization under IC priorities is happening in the 14 poorest provinces of the IC.

Source: Authors

Step 4. The process of reallocation and influencing the budget process

Objective: **Ensure that spending targets are met through continuous policy dialogue with MOF**

- The TTL, GFF Focal Point and Liaison Officer, supported by the PFM expert will discuss with the planning unit of and the MOH as well as GFF country platform how to ensure that spending targets set out in step 3 are reached.
    - This will require an understanding of the MOH *budget cycle* as per step 1. It is very probable that depending on the starting point of the IC development, it may not be possible to secure domestic funding behind the IC priorities year 1 as it may have come too late in the budget cycle, but at least, one can start initiating the dialogue with MOH and MOF to ensure there is funding behind IC priorities in the next budget cycle.

- Overall, to make this happen requires the recruitment of a PFM expert who works with the planning or/and fiduciary unit of the MOH on the preparation of the health budget, which also coordinates with the Ministry of Finance and decentralized entities and have a good understanding of MOH priorities, including IC priorities. This could be the same PFM consultant recruited under steps 2 and 3 or another one depending on the profile. This person can play a key role in the budget negotiation between MOH and MOF and ensuring funding is behind IC priorities. In Rwanda *"That the finance ministry's staffers worked with the health ministry at so many steps in the fiscal calendar reduced the conflict between the two ministries during budget negotiations"* (Simon, 2018).

- Develop a strategy to influence the budget process, this may include:
  - Strategic-issue paper advocating for more funding for IC as a tool that MOH can use in negotiations with MOF
  - Strategy for engaging with key influencers such as parliamentarians that approve the budget, e.g. through civil society engagements
  - This strategy can be developed in partnership with experts on health financing and advocacy. Civil Society input is recommended.

→**Deliverables/Milestones:** Shifts towards expenditure targets are seen in government budget, strategy for influencing the budget process

2.3. Phase 3: Monitoring the Implementation of the IC

Step 5. Tracking resources behind the IC priorities to monitor increased domestic resources

Objective: To monitor the implementation of the IC and ensure that resources behind IC priorities are growing, well-allocated and spent, it is fundamental to have fully operational domestic resources tracking tool(s).

As mentioned previously, most countries supported by the GFF have an IFMIS which is supposed to capture all budget and expenditures at all administrative and economic classification levels (Box 3). This can be a starting point to track whether IC is implemented. As part of step 1, you will have identified weaknesses and strengths of existing routine finance data systems for the MOH and whether setting up a BOOST will help better mapping IC priorities under programs or existing budget classification and tracking domestic resources behind the IC priorities.

- Following the activities described under steps 2 and 3, yearly analysis (if not more often) of BOOST or IFMIS data should be conducted to see how expenditures are evolving from the baseline (step 2) towards the expenditure targets defined in (step 3). This can be done by the same PFM/HF consultant you hired under step 2.

- Design TA to ensure this system is working at various levels. This could be part of a broader exercise of setting up a BOOST at country level or just updating it (Box 2). In Ethiopia, for instance the health team is re-energizing the BOOST in the health sector to better track

domestic expenditures behind the National Health Strategy over time at different levels. The BOOST consultant is not only updating the BOOST with most recent data at decentralized level but also providing capacity at MOF and MOH to better use those data for expenditure analysis and in the case of the MOH, to better track domestic resources behind HSTP priorities. The consultant is also updating the BOOST for all sectors.

- Note that BOOST has been used in a few countries but not all countries will find BOOST relevant to better track domestic resource behind the IC/NHS. Some may have strong routine financial management data g systems, or some countries may require help to strengthen the automation of IFMIS at decentralized level instead or to set up other tracking resources. This means that we are not advising to develop BOOST in all countries to better monitor the implementation of the IC. This will depend on the context of each GFF country and whether BOOST can address a government need beyond the GFF one (aligning IC priorities to MOH budget

- Note that these tools tracking domestic resources can be combined with the overall resource mapping and tracking of the IC/NHS which also tracks external resources. However, very often there is a separate exercise to track donor funding and another one to track domestic resources. In some countries, the MOH is aiming at creating interoperability between these tools. A mid-term goal in Ethiopia is to populate the resource tracking tool of donors with data coming from the BOOST so that both external and domestic budget and expenditure data are captured.

→**Deliverables/Milestones:** Yearly analysis of BOOST data or IFMIS data to track how expenditures are evolving from the baseline (step 2) towards the expenditure targets defined in (step 3) and fine-tuned (Step 4).

3. Annexes: Tools

3.1. Road Map to Secure domestic funding behind IC priorities

See Folder “securing domestic funding under IC”

3.2. TOR of PFM consultant in FR and EN to align IC priority to Budget Process

See Folder “securing domestic funding under IC”

3.3. List of ST PFM/Governance consultants

See CV under Folder "securing domestic funding under IC" if you are interested in getting their contact details. Consultants are either part of the WB Governance GP or STC hired by the WB/GFF at country level.

Table 3. List of PFM consultants and their qualification

Name	Country	Task	Language
Aminata Nana **PFM consultant from Burkina-Faso, involved with program budgeting reforms in Burkina-Faso and Cote d'Ivoire.**	DRC	Supporting MOH aligning PNDS priorities with program budget structure; TA to implement program budgeting in DRC and strengthen PFM unit within MOH.	French and English
Hirut Wolde	Ethiopia	Leading update of BOOST and mapping the HSTP priorities in the MOH budget	English and Amharic
Ibrahima	Senegal	Hired to align IC Priorities with MOH program budgeting classification. Will use BOOST.	French, English, Wolof
To be completed.			

3.4. List of WB BOOST team members in GFF countries

Table 4. List of WB Governance team members working on BOOST GFF countries

Name	BOOST_Status	Country Lead
Afghanistan	In Progress	Kirk Schmidt
Angola	Delivered	Massimo Mastruzzi
Bangladesh	Discussions	Massimo Mastruzzi
Benin	Delivered	Yem Tougma
Burkina Faso	Delivered	Yem Tougma
Cameroon	Delivered	Yem Tougma
Cote d'Ivoire	Discussions	Yem Tougma
Democratic Republic of the Congo	Discussions	Yem Tougma
Ethiopia	Delivered	Hirut Wolde
Ghana	In Progress	Hirut Wolde
Guatemala	Delivered	Eduardo Estrada
Guinea	Delivered	Yem Tougma

Haiti	Delivered	Ibrahim El Ghandour
Honduras	Discussions	Eduardo Estrada
Kenya	Delivered	Kirk Schmidt
Kyrgyzstan	Delivered	Irina Capita
Liberia	In Progress	Hirut Wolde
Mali	Delivered	Yem Tougma
Mozambique	Delivered	Kirk Schmidt
Myanmar	In Progress	Massimo Mastruzzi
Nigeria	Discussions	
Senegal	Delivered	Yem Tougma
Sierra Leone	In Progress	Hirut Wolde
Tajikistan	Delivered	Irina Capita
Tanzania	Delivered	Massimo Mastruzzi
Uganda	Delivered	Kirk Schmidt
To be completed/updated		

3.5. Status-Quo of GFF countries on IC priorities and MOH Budget alignment

Table 5. Status-Quo of GFF countries on IC priorities and MOH budget alignment

		Phase 1: Inception Phase		**Phase 2: Development of the IC/NHS**		**Phase 3: Monitoring the IC/NHS**
	Hired PFM TA for this	**Budget process, classification and tracking assessed**	**Assessment on how domestics expenditure is allocated to health (mini-PER)**	**IC priorities mapped and reflected in the MOH budget through**	**IC priorities have secured more domestic funding**	**IC priorities tracked in IFMIS or BOOST or other system**
DRC	Yes		Yes – 2016 PER and PNDS analysis but may be incomplete	Under process through the revision of the PNDS	Yes and No, Priority 5 (PBF) has but in Kinshasa only	Not yet but TA planned to build BOOST
Ethiopia	**Yes**	**Under process**	**Yes**	**Under process**	**Under process**	**Under process**
Senegal	**Under Process**	**To start in Dec 2018**	**To start in Dec 2018**	**To start in Dec 2018**	**To start in Dec 2018**	**To start in Dec 2018**
To be completed						