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PRACTICE SPOTLIGHT

PROMISING PRACTICES

LHSS Promising Practices Series

This series supports USAID's Vision for Health System Strengthening 2030 by documenting promising practices to address complex system health challenges. Defined as models, programs or activities holding potential, but not yet proven to be effective at scale, the promising practices explored in this series are grounded in first-hand experience. Further learning is needed to validate the enabling and inhibiting factors influencing the successful application of these promising practices in different contexts. This brief examines promising practices associated with delivering health care and social health protection to migrant populations through national health systems.

Advancing universal health coverage through better planning and budgeting at the subnational level

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Accelerating progress toward universal health coverage (UHC) is a policy priority for most low- and middle-income countries and an integral part of the global health equity agenda. Under USAID's Vision for Health System Strengthening 2030, efficient and transparent resource allocation and use can promote this agenda by expanding access to quality health services, particularly for underserved, socially excluded, and historically marginalized populations (USAID 2021).

A government's ability to allocate and use resources in a way that efficiently and equitably meets population needs is an element not only of strong public financial management (PFM) but also of strong health governance. Many countries have shifted the responsibility for making and executing decisions to lower levels of the health system to foster greater local accountability, transparency, and responsiveness to local needs. This decentralization has also given authority to government actors at these lower levels of the health system to carry out core PFM functions such as planning and budgeting their health programs. Such decentralization usually aims to bring decision-making power closer to the population being served. For example, decentralization may move decision-making power to subnational authorities, or in some countries, to health facilities that are better positioned to understand local needs and can address changing priorities more quickly. Such shifts also

recognize that subnational authorities are better positioned to engage lower-level stakeholders to act on local health needs (see Key Definitions box for examples of subnational authorities). Consequently, delegating decisions about the allocation and use of fiscal resources to the subnational level can increase the ability of governments to advance on two fronts: meeting dynamic local health needs while making progress on national health priorities. Such progress is possible when local needs and national health priorities are well aligned.

Decentralization can succeed in helping a country efficiently and equitably allocate and spend health sector resources only if subnational health sector actors can fulfill their increasingly varied and complex mandates (Ravishankar et al. 2024). They must have the capacity to mobilize funds and carry out decentralized health planning and budgeting. Budget and finance officers, health program planners, decision makers, and other subnational health managers must possess the skills, knowledge, and authority to effectively perform their day-to-day duties.

Yet, in many countries, staff from ministries of health (MOH) and other government bodies engaged in planning and budgeting for health at the subnational level do not receive the specialized instruction and knowledge that would equip them to carry out their responsibilities. This formidable barrier can be compounded by relationships between the national and subnational levels that do not have clearly defined roles and responsibilities, and national policies and mandated budget structures that are misaligned with reality on the ground. All told, these factors can make it difficult for subnational actors to perform their duties.

KEY DEFINITIONS

Health planning is the process of mapping out how policies will be implemented, identifying objectives, setting priorities, and determining targets and timelines for their achievement.

Health budgeting is the process of estimating available resources against those needed to achieve policy objectives, allocating those resources, and spending them in alignment with national health plans.

Subnational level actors are local government bodies, elected leaders and local health authorities at the local level who make decisions about health priorities, and how resources are allocated and spent to achieve national health objectives.

Resource optimization is the "sustainable resource mobilization and efficient, effective, and transparent allocation and use of resources" (USAID 2021).

The capabilities and systems needed to strengthen health planning and budgeting are widely known. These include the ability to develop and cost plans, knowledge of the public financial management guidelines relating to budget formulation and execution, and budgeting tools to support resource allocation.

However, less is understood about practical approaches to strengthen health planning and budgeting, especially at the subnational level where, in decentralized contexts, health managers often struggle to carry out their required functions related to planning and budgeting of limited health resources.

About this brief

This brief discusses promising practices identified by the USAID Local Health System Sustainability Project (LHSS), Abt Global, and other partners in working with government and non-government stakeholders to strengthen health planning and budgeting at the subnational level. The practices highlight why and how to put subnational level actors at the forefront of any reforms to improve health outcomes through resource optimization.

These promising practices also address the gap in knowledge about practical approaches to help subnational actors become able stewards of resource allocation and use processes. Implemented together, these practices can improve planning and budgeting, while paving the way for longer-term reforms aimed at optimizing resources for health at the subnational level.

Examples from Bangladesh, Tanzania, and Timor-Leste describe how these countries implemented one or more of the promising practices and hold potential for replication and scale in other parts of the world.

Implemented together, these promising practices can improve planning and budgeting, while paving the way for longer-term reforms aimed at optimizing resources for health at the subnational level.

Resource optimization challenges at the subnational level

In countries pursuing decentralization, subnational actors are being given increased responsibility not only for delivering health services, but also for planning, financing, and managing those services. This may include developing health plans and targets, collecting revenues from local sources to cover costs, formulating and executing their own budgets, and borrowing money to finance capital investments in new and upgraded facilities (UNICEF 2020). Local health authorities are also tasked with managing complex health financing flows from different government and donor funding streams, each with their own set of financial management procedures and reporting requirements.

Moreover, budget structures established by national governments can either facilitate or greatly complicate health planning and budgeting at the subnational level, depending on whether those structures align with the legal mandates of subnational units. For example, if local-level actors are required to follow nationally mandated spending and reporting procedures, they may not have the authority to make spending decisions in response to changing local needs. Similarly, reforms related to planning and budgeting may be designed at the national level but not fully implemented, requiring subnational level actors to simultaneously manage old and new systems. For example, incomplete implementation of program-based budgeting can mean that subnational actors must formulate budgets based on delivering outputs, yet still report expenditures on inputs.

PROMISING PRACTICE

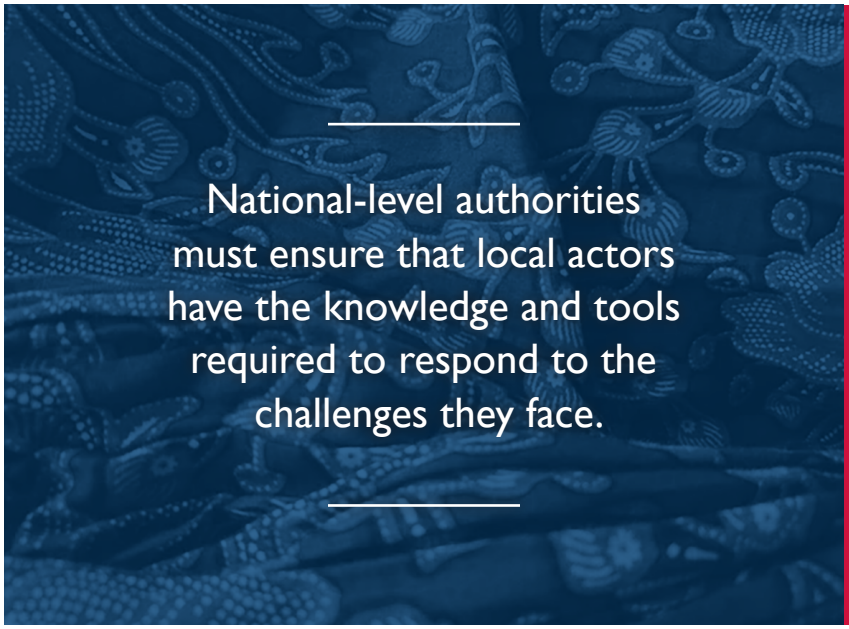
Strengthen partnership between national and subnational actors to support alignment of PFM systems with health sector needs.

Establish a common understanding of the roles, responsibilities, and respective needs of national and subnational health actors. Establish systems, policies, and procedures that meet those needs and facilitate the ability of actors to fulfill their roles and responsibilities. Ensure an effective and continuous loop of information sharing and feedback.

In decentralized systems, national and subnational actors share responsibility for implementing planning and budget reforms. National authorities such as MOH officials must convey their sustained commitment to support subnational actors in carrying out their health planning activities and budgeting decisions at the local level. The clearest demonstration of this resolve is for national authorities to facilitate and enable local actors to carry out their planning and budgeting functions.

National-level authorities must ensure that local actors have the knowledge and tools required to respond to the challenges they face. National authorities may also need to remove chokepoints, confer greater authority, ensure timely disbursements, and simplify reporting requirements.

For example, national actors can deliberately structure PFM systems with sufficient flexibility to enable subnational actors to carry out their health planning and budgeting responsibilities.



Foster willing partnerships

Well-functioning health systems depend on the willingness of both national and subnational actors to create and maintain a mutually advantageous partnership, grounded in shared trust. Ideally, there should be accountability on both sides, as well as with local communities, with each actor depending on, and benefiting from, the commitment and capacity of the other to fulfill their obligations.

This national-subnational relationship can be built through ongoing communication and regular exchange of feedback. Ultimately, this relationship must recognize that being on the frontline gives subnational actors the advantage of knowing how and when health resources need to be allocated.

This axiom underscores the importance of establishing open communication channels for subnational actors to provide feedback to the national level. Establishing pathways for the national level to closely observe and better understand the needs of subnational actors is equally vital. Cultivating this active partnership and two-way communication also creates space for subnational actors to showcase how they are adapting to meet local needs and innovating to improve performance and quality.

In this framing, national authorities must regard themselves as allies of – and co-responsible with – their subnational counterparts for optimizing the allocation and use of resources at each level of the health system. This means national authorities must demonstrate openness to learning where national systems, policies, and processes impede health planning and budgeting processes at lower levels.

The national authorities must work alongside subnational counterparts to understand their baseline capacity, and take steps to strengthen their ability to plan, budget, and spend within existing PFM parameters. In turn, subnational actors can provide feedback on central-level systems and structures that inhibit their ability to carry out their duties. National actors then need to use that feedback to make changes to facilitate decentralization.

An official from the President's Office, Regional Administration and Local Government (R) receives a demonstration of the Zanzibar Planning, Budgeting, and Reporting System. Zanzibar, Tanzania 2023 / *Photo: USAID PS3+*

Empowering subnational actors to succeed

PFM systems set at the national level can determine how effectively subnational actors are able to fulfill their mandates. Factors such as budget structures, how expenditures are monitored, the number of funding streams, and payment mechanisms all influence how efficiently resources are allocated and used at the lower levels.

For example, when national regulations result in rigid budget structures that do not yield to contextual variations, it is extremely difficult for subnational actors to perform their day-to-day responsibilities or meet local needs. Conversely, budget structures that allow subnational autonomy and flexibility while maintaining strong national level oversight can enable local authorities to make independent judgments about health planning and spending, while remaining accountable to the central government.

Multiple funding streams from numerous national sources introduce complexity and limit the ability of subnational actors to predict and manage their spending resources (ThinkWell and WHO 2022). Each source comes with its own disbursement cycle and procedures for assessing, spending, and reporting on the funds (Insanally, Bhuwanee and Watson 2022). Disparate funding streams may also have different payment mechanisms that can result in unpredictable revenue amounts and timing. In such cases, national actors can intervene by streamlining how multiple funding streams are managed at the subnational level.

The Tanzania case study highlights how the government rolled out a new health policy for direct facility financing and provided the systems and capacity strengthening that empowered the subnational level actors to successfully implement the policy.

Supporting subnational planning and budgeting in Tanzania

In 2017, the Government of Tanzania introduced a new policy for direct facility financing (DFF), enabling health facilities to directly receive and independently spend government funds. As part of Tanzania's decentralization strategy, this shift aimed to increase the autonomy of subnational actors in health planning and budgeting.

The design of this initiative shows how the national level can support subnational actors in implementing and achieving the expected benefits of the policy. The DFF policy, together with support provided by the central government, has helped to strengthen planning and budgeting by regional secretariats, local government authorities, health facilities, and villages. It has also produced tangible improvements in health facilities' infrastructure and service delivery (Kihanga et al. 2024, Ruhago et al. 2023). By channeling development partner funding through DFF, the national government has also helped to reduce fragmented funding flows that were complex for health facilities to manage.

Operationalizing direct facility financing

At the national level, the MOH, Ministry of Finance, and the President's Office, Regional Administration and Local Government (PORALG) demonstrated full commitment to this reform. Together they have supported the local government and health facilities in operationalizing DFF in three important ways.

First, the Ministry of Finance made every health facility visible in the national PFM system by assigning a unique budget code for each facility receiving DFF. This meant that each facility became eligible to receive and spend government funds, with legally binding rights and responsibilities (WHO 2022).

Second, PORALG invested its own resources to roll out planning (PlanREP) and financial management (FFARS) systems to health facilities. This enabled health facilities to have real-time digitized financial data to plan their revenues, understand their spending to date, and forecast future spending.

Digitalization of planning and budgeting processes has given health facilities ready access to their own health budgeting data and spending trends. This information enabled facilities to make flexible, data-driven decisions on resource allocation and use in response to local needs. It has also enabled national authorities to hold subnational actors accountable by providing access to real-time data for fiscal oversight of health spending.

PORALG has also supported efforts to make PlanRep and FFARS interoperable with health-specific systems such as Tanzania's integrated health information architecture, known as DHIS2. This interoperability further enables health facilities to make the link between how resources are being used and progress toward health sector objectives, and to reallocate resources when needed.

Finally, PORALG was responsible for ensuring that subnational actors understand and have the resources, tools, and information to implement DFF and spend government funds judiciously. For example, it supported regional secretariats and local government authorities in strengthening the capacity of health facilities through training, mentoring, and the rollout of a helpdesk. These initiatives enhanced health facilities' ability to plan for and manage the sound allocation and use of health resources.

New planning and financing management systems yield results

The percentage of health facilities with improved budget execution rates rose from 58 percent in 2021 to 82 percent in 2023. With increased ability to spend more of the resources allocated to them, these facilities were able to hire additional health workers, improve infrastructure, and strengthen supply chain management to increase the availability of medications. Since 2021, PORALG has also rolled out planning and financial management systems to the village level, with approximately 24 percent of villages' plans and budgets now incorporated into the government's systems. Villages and health facilities with access to PlanRep and FFARS help coordinate the management of health resources at the local level and avoid duplication.

Rolling out DFF required significant investments, both by donors and the Government of Tanzania, and an unwavering commitment by the latter. The government not only hired new staff, such as accountants, to enable sound financial management at the subnational level, but is implementing a long-term vision for DFF. For example, undergraduate and graduate university curricula now include courses on financial management, including use of the PlanRep and FFARS systems (WHO 2022). Tanzania's work to strengthen capacity and scale new health planning and budgeting systems is a long-term effort that continues to this day.

PROMISING PRACTICE

Tailor capacity strengthening to the day-to-day duties of subnational actors to support alignment of planning and budgeting with health needs.

Minimize broad, "nice to have" training and maximize tailored skills transfer that helps subnational actors effectively execute their routine planning and budgeting functions. This means keeping the end user in mind and customizing capacity strengthening initiatives to reflect what health managers need to know.

Capacity strengthening needs at the subnational level in health planning and budgeting should not be underestimated in countries operationalizing their decentralization policies. Staff responsible for setting targets, developing budgets, executing spending decisions, and monitoring resources may have received training on broad PFM principles and processes that apply across government agencies in all sectors. However, such training would give subnational actors only a basic understanding of planning and budgeting cycles.

To ensure that MOH officials can effectively plan and budget in alignment with health needs, capacity-strengthening should be carefully tailored to the health sector and the specialized needs of subnational actors.

A one-size-fits-all approach to strengthening subnational capacity in health planning and budgeting will never suffice because 1) lower-level roles are highly diverse and often contextualized, and 2) the individuals in these jobs have different baseline capacities and training needs.

Customize according to roles and mandates

Capacity strengthening efforts must focus on the mandated role of each type of subnational actor and their respective daily tasks, while properly defining and measuring actors' performance. For example, capacity strengthening can be more effective when it distinguishes between the administrative and policy functions of subnational health planning and budgeting. Administrative functions include the routine management of plans, budgets, and processes such as applying PFM rules to request and spend health budgets. Policy functions encompass the use of planning and budgeting information to make strategic decisions, such as assessing spending against health indicators to decide when and how health resources should be reapportioned.

To ensure subnational actors are equipped to do their jobs, national and subnational level actors must first collaborate to delineate clear expectations about mandated roles at the lower level and map precise divisions of responsibility. This exercise

should include open dialogue about how decision-making authority delegated to lower levels dovetails with health planning and budgeting decisions made centrally.

In sum, these variables will guide how capacity strengthening can be customized according to the knowledge, skills, and tools subnational actors must master to plan, budget, and spend within existing PFM parameters. Well-designed tailoring must be rooted in adult learning methods that incorporate lived experiences of trainees and build on their existing capabilities.

Tailor to local needs

Tailoring should also align with local needs, including the objectives of subnational actors. For example, plans for local management of resources to implement primary health care or other health programs should be tailored to advance national public health priorities. This process can begin with a self-assessment of the skills and abilities subnational actors need for day-to-day health management tasks. In some instances, self-assessment may need to be facilitated, as subnational actors may not be able to pinpoint their capacity gaps or specify the training they need to plan and budget.

Facilitated user input into the scope of subnational training ensures that the curriculum reflects actors' needs, inspires them to participate in the training, and creates a greater sense of local ownership. The effects of capacity strengthening also become long-lasting when the design process is driven by the users.

Structure durable support

For tailored capacity strengthening to be durable, it must last beyond a one-time support initiative. It is incumbent upon national entities to create a locally sustainable mechanism to build, expand upon, and continuously refresh health planning and budgeting capacity among existing and future subnational cohorts.

Capacity strengthening initiatives should be managed and delivered by in-country institutions to promote localization and sustainability. This would entail strengthening capacity among various entities to conduct training in health planning and budgeting. Ideally, the training would be offered by ministries such as health and finance, local governments, public and private sector training institutions, and partners in academia.

This promising practice is illustrated in the Bangladesh case study, which describes how standard planning and budgeting guidelines were supplemented with training curricula and peer learning approaches tailored to the day-to-day tasks of staff in municipalities and city corporations.

Health visit, Habiganj, Bangladesh 2022 / *Photo: Shrabanti Debnath, USAID LHSS*

Local governments begin managing urban primary health care in Bangladesh

Urban primary health care (PHC) in Bangladesh has traditionally been funded by development partners, and managed and delivered by local NGOs using health facilities owned by municipalities or rented by donors. In recent years, development partners have been less willing to continue supporting this patchwork approach, resulting in a significant reduction of accessible PHC services for urban lower-income populations.

To address this gap, municipalities and city corporations, known collectively as local government institutions, or LGIs, have been given new responsibilities and autonomy to manage urban PHC. LGIs now receive a block grant from the national Ministry of Local Government, and need to know how to plan, track, and spend their grant to meet local PHC needs. In short, they are responsible for determining where and how to expand urban PHC services, allocate resources, and spend budgets. LGIs are also responsible for policy planning for urban PHC.

In the past, guidelines for LGIs to carry out these functions did not exist and capacity strengthening efforts by the national level MOH provided only a broad overview of PFM. The training curriculum did not cover the skills LGI managers needed to interpret budget performance data and make decisions about how to plan and deliver PHC services. Nor did it address the need for municipal finance teams to understand the intricacies of government budgeting procedures so they could formulate PHC budgets, make sure funds were available when needed, and spend according to plans and in compliance with PFM rules. There was a clear mismatch between the subnational actors' operational and analytic capacity and the specialized skills they needed to carry out tasks related to PHC programming.

Strengthening capacity in line with diverse roles

In response, local MOH departments, in collaboration with LHSS, began providing tailored training directly to officials in 14 city corporations. Under this new approach, the training curriculum covered planning, budgeting, stakeholder engagement, resource mobilization, and implementation and monitoring of PHC service delivery plans. The new strategy also included adult learning approaches, including storytelling and role plays, to encourage behavior change. This training was topped off with peer learning meetings among the city corporations where participants shared how they developed and implemented their PHC plans, their challenges, and lessons they were learning. Interestingly, due to positive peer pressure, friendly competition emerged among municipalities around the amount of funding each budgeted for health.

> Local government institutions are responsible for determining where and how to expand urban primary health care services, allocate resources, and spend budgets.

Planning and budgeting reflect local needs

Local actors such as the mayor's office, the local Office of the Civil Surgeon, and the MOH's Directorate General of Family Planning came together in Health Standing Committees charged with convening stakeholders to provide input on municipal health sector decisions.

Reconstituted, these committees now include a cross section of national and subnational representatives from relevant ministries, local government leaders, NGOs, and private sector entities. Collaborating for the first time, these broad stakeholder groups are sharing responsibility for planning and budgeting PHC services for poor urban dwellers.

City corporations in Rajshahi and Sylhet, two municipalities with large urban populations, reflected that greater collaboration among stakeholders has "expedited the decision-making process, improved regular coordination, and resulted in quick identification and mobilization of resources" (LHSS 2022b). Working together, Health Standing Committee members can monitor PHC services more closely and conduct joint supportive supervision visits in government and private health facilities.

Celebrating the opening of a new primary healthcare center. Bogura, Bangladesh 2023 / *Photo: T.A. Robin, USAID LHSS*

Learning to manage PHC

National-level representatives from the Ministry of Local Government attended municipal peer-learning events and observed the positive results of tailored capacity strengthening. Impressed, these representatives are preparing to roll out a similar capacity strengthening model to city corporations across the country.

In the past, the size of the municipal block grants for health was not determined by information about service delivery needs or trends. Now, with six city corporations using such data to plan and budget how block grants will support PHC services, the Ministry of Local Government has begun asking other city corporations to collect the same information to determine the size of their block grant awards.

Generating local results

The new capacity to conduct data driven planning and budgeting has enabled six city corporations and LGIs in Sylhet and Rajshahi Districts to reopen at least eight previously shuttered urban PHC facilities. Seeing how peer municipalities are increasing their budgets for PHC, these city corporations and LGIs have also increased their collective allocation to health from approximately $44,600 in 2022-23 to nearly $202,260 in 2023-24 using internally generated revenue. They have also intensified public health awareness activities, including school health programs, dengue prevention campaigns, and vitamin A supplementation campaigns, often in partnership with national-level campaigns and programs.

PROMISING PRACTICE

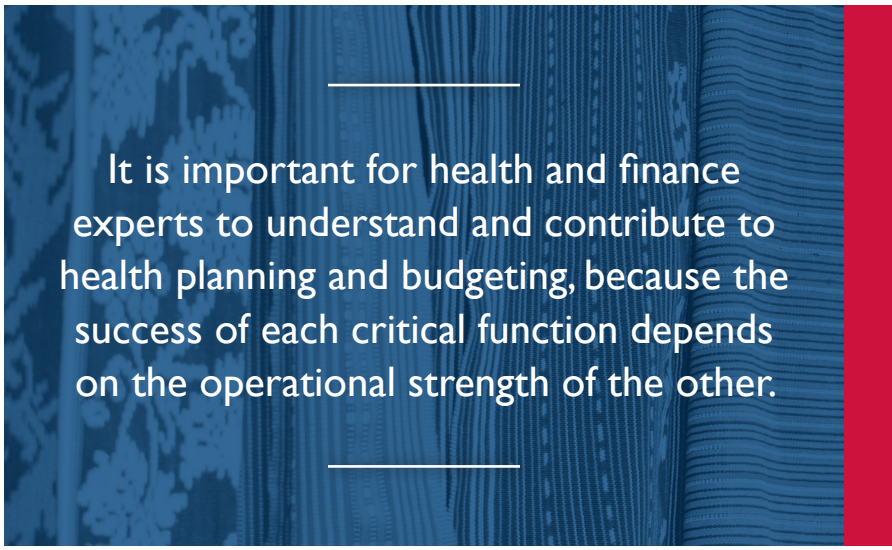
Support stakeholder engagement at the subnational level for locally driven planning and budgeting.

Create a culture of shared responsibility to meet local health priorities among subnational stakeholders, beginning with strong health planning and budgeting. Ensure that subnational stakeholder outreach and participation mechanisms are functional, effective, and representative. Nurture meaningful participation of civil society organizations (CSOs) and communities in decision-making for health planning, resource allocation, and spending.

Health planning is often seen as the sole responsibility of experts in ministries of health, while allocating and executing budgets is considered the responsibility of experts in ministries of finance or local government. In fact, health experts and budget experts are all frontline stakeholders.

Greater collaboration between government health and finance experts strengthens working relationships and reveals shared interests. These partnerships can optimize resources by producing more rational health plans and budgets. For example, involving finance staff in the health planning process can produce a more accurate understanding and costing of health care needs. Meanwhile, greater involvement of health staff in the budgeting process can contribute to budgets and spending that are better aligned with national health targets.

Furthermore, to foster greater autonomy in decision-making and more effective localized action, stakeholder engagement must go beyond strengthening connections between government entities. It is essential for subnational actors to directly engage a broad range of stakeholders, within and outside the public health sector. The purpose of these alliances is to promote full and systematic collaboration in planning and prioritization, budget execution, and performance monitoring at lower levels of the system.



Promote alliances within and outside the health sector

Stakeholder alliances should be formed in two spheres: with internal stakeholders, and with external stakeholders. Internal stakeholders are public sector health workers and managers, and budget experts work in ministries of finance and local governments. These internal stakeholders typically work on parallel tracks, instead of together, on all aspects of subnational resource allocation, use, monitoring and reporting. External stakeholders are actors outside the public health sector who can influence or complement government health programs. These may include elected officials, CSOs, and private sector entities.

Active partnerships with internal and external stakeholders at the subnational level help governments ensure that community needs are well met, local authorities are held to account for how resources are allocated and spent, and expenditures are in alignment with health plans. While creating such partnerships can be challenging, they are an indispensable ingredient for optimizing limited resources in the context of decentralization.

Coalesce around shared goals

Central ministries (including health, finance, and local government) can create an enabling environment by conducting broad stakeholder engagement at the national level, and by supporting subnational health sector actors in leading their own internal and external stakeholder engagement initiatives. National actors can also strengthen subnational capacity to ground this engagement in political economy analysis, which will help government actors understand the interests, needs, spheres of influence, and decision-making authority of stakeholders.

Meanwhile, greater involvement of all key stakeholders, including communities, involved in budget preparation, execution, and accountability at strategic points in the planning process and throughout the budget cycle can contribute to budgets and spending that are better aligned with local priorities and advance national health targets. Subnational actors can convene stakeholder networks and create opportunities to coalesce around shared goals. This work can be sustained when stakeholders view their engagement with health planners and budgeters as necessary and advantageous to achieving their own goals.

Similarly, creating pathways to engage stakeholders outside the public health sector, such as elected officials, civil society representatives, and private sector actors, can ensure that planning and budgeting decisions at the subnational level are more responsive to local needs.

With their deep understanding of and close ties to communities, CSOs are well positioned to identify local health priorities, support decisions about how to allocate health resources, and help monitor whether resources are spent in line with priorities. These stakeholders can also play a role in advocating for and more quickly mobilizing fiscal, human, and in-kind resources.

The Bangladesh and Timor-Leste case studies illustrate how this promising practice has been applied in different settings. In Bangladesh, Health Standing Committees with broad representation provide an institutionalized mechanism for health and finance experts to work together and have achieved fast, coordinated decision-making. In Timor-Leste, organizing and empowering CSOs has helped ensure that decisions about health resource allocations reflect local health needs.

Suco Carabau, Timor-Leste 2022 / *Photo: Emilio dos Santos/LHSS*

Strengthening PFM for health through civic engagement in Timor-Leste

The Government of Timor-Leste has faced challenges with systemically weak PFM systems and other central and decentralized health governance processes. Over time, these weaknesses have contributed to low budget execution, misalignment of budget allocations with health priorities, and inefficient use of health resources (LHSS 2023a). The challenges have been compounded by a lack of accountability among national and municipal government bodies involved in the health system.

In the past, limited engagement between government entities and CSOs due to a historic lack of trust (Nash 2022) impeded participation of CSOs and communities in decision-making for health planning, resource allocation, and spending. As a result, government leaders lacked a clear understanding of community health priorities. Such challenges disproportionately affected underserved and vulnerable populations (LHSS 2023c).

Building shared accountability

While mechanisms for exchanges between the MOH and CSOs existed at the national level, there were few such mechanisms at the subnational level. To nurture meaningful engagement and build shared accountability between the local MOH units and CSOs, LHSS in 2022 supported the creation of an umbrella organization of CSOs working in priority health areas. Known as Rede Ba Saúde Timor-Leste, or REBAS-TL, this civil society network of 43 organizations set out to partner with the government to better meet the health needs of Timorese communities, and to create local solutions to health financing and governance challenges (LHSS 2023c).

Together, the MOH and REBAS-TL created a positive space where CSOs could meet with influential MOH officials to explore issues of mutual interest, such as how CSOs could convey and represent communities' needs (LHSS 2023a).

Translating local feedback into advocacy

Over the following two years, REBAS-TL members greatly increased their capacity to engage effectively with

Community Health Worker in Dili, Timor-Leste 2023 / *Photo: Emilio dos Santos/LHSS*

government counterparts at the national and local levels, and to advocate persuasively using evidence. CSOs also received training in how the MOH conducts health planning and budgeting at the national and municipal levels (LHSS 2023c).

At the subnational level, REBAS-TL members are advocating with local government health directors for municipality-specific health needs. For example, in Manatuto, a CSO advocated for better nutrition support and medical supplies. In Covalima, another CSO raised awareness about high malnutrition, infant mortality, and the absence of doctors at some health posts. And in Oecusse, CSOs trained in social accountability and community-based monitoring advocated for resources to support village health assemblies.

In the Special Administrative Region of Oecusse-Ambeno, community leaders can discuss health issues with the Regional Secretary for Health, thanks to an advocacy forum set up by local CSOs. This forum is helping to increase collective ownership between the community, CSOs, and the government to respond to local health needs (LHSS 2023b).

budgets and participating in health sector evaluations. Further, the MOH is orienting CSOs on the government's national health priorities and strategic plans.

REBAS-TL continues to strengthen the capacity of local CSOs to effectively engage with health authorities at regional and municipality levels, and to institutionalize this engagement. It is also advocating for community health resources with a parliamentary committee responsible for MOH budget allocation and functioning.

Bridging the gap between communities and the health system

Empowered through their partnership with the MOH, REBAS-TL members are bridging the gap between communities and the health system at the national and subnational levels. As a result, health CSOs have a better understanding of the health system and the root causes of challenges that affect the delivery of care to Timorese communities. As their capacity grows in the coming years, these organizations will continue offering local support and advocate for policies that reduce health disparities across Timor-Leste.

Empowered through their partnership with the MOH, REBAS-TL members are bridging the gap between communities and the health system at the national and subnational levels.

At the national level, CSOs are translating constituent feedback into evidence-based advocacy with the MOH for better health planning and budgeting. REBAS-TL members are also providing input into the ministry's annual plans and

Community youth in Suco Carabau, Timor-Leste 2022 2022 / *Photo: Emilio dos Santos/LHSS*

Looking Forward

As more countries trend toward decentralization, subnational actors will continue to play an increasingly prominent role in the management and delivery of health services. Responsiveness to local health priorities depends in large part on the capacity of front-line health officials to plan, budget, and demonstrate accountability for spending health resources. Their success also relies on the willingness and ability of national actors to facilitate systems, policies, and partnerships that allow decisions about how health resources are allocated and expended to be made closer to communities being served.

This brief highlights why and how subnational actors should be placed at the center of capacity strengthening efforts to meet the complex demands of planning and budgeting at the subnational level.

Increased collaboration between national and sub national actors will offer entry points for the latter to contribute their experiences towards improving financial management processes that can help them meet their health policy implementation objectives.

Through such closer working relationships, the national level can create an enabling environment where subnational actors have the technical capacity, systems, and infrastructure required to carry out their responsibilities.

Subnational actors should also seek opportunities to advance engagement with civil society beyond advocacy and accountability, to strategic participation in planning and budgeting processes that incorporate community needs and priorities.

Building on experiences from Tanzania, Bangladesh, and Timor-Leste, the promising practices described are just that: promising. Further learning and testing are needed, accompanied by qualitative or quantitative indicators of progress, to demonstrate the tangible benefits of applying these practices, and to progress from promising to proven approaches.

Signs are that these practices have a role to play in ensuring that decentralization meets its goal of increasing system responsiveness by moving financial decision making closer to the frontline.

About LHSS

The Local Health System Sustainability Project (LHSS) under the United States Agency for International Development (USAID) Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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