Mapping the Financial Flow and Expenditures for Select MNCH Medicines in Bangladesh

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The goal of the Systems for Improved Access to Pharmaceuticals and Services (SIAPS) Program is to ensure the availability of quality pharmaceutical products and effective pharmaceutical services to achieve desired health outcomes. Toward this end, the SIAPS result areas include improving governance, building capacity for pharmaceutical management and services, addressing information needed for decision-making in the pharmaceutical sector, strengthening financing strategies and mechanisms to improve access to medicines, and increasing quality pharmaceutical services.

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ACRONYMS

CBHC	community-based health care program
CC	community clinic
CMSD	central medical stores depot
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DPA	direct project aid
ECNEC	Executive Committee of the National Economic Council
FMAU	Financial Management and Audit Unit
FP	family planning
GoB	Government of Bangladesh
HPNSDP	Health Population Nutrition Sector Development Plan
HPNSP	Health, Population and Nutrition Sector Plan
LD	line director
LMIS	logistics management information system
MCWC	Mother and Child Welfare Center
MDG	Millennium Development Goal
MNCH	maternal, newborn, and child health
MNCAH	maternal, newborn, child, and adolescent health
MCRAH	maternal, child, reproductive, and adolescent health
MoF	Ministry of Finance
MoHFW	Ministry of Health and Family Welfare
MoLGRDC	Ministry of Local Government Rural Development and Cooperatives
MTBF	medium-term budget framework
MSR	medical and surgical requisites
OP	operational plan
PC	Planning Commission
PIP	program implementation plan
PSSM-FP	Procurement Storage Supply and Management – Family Planning
PCP	project concept paper
RPA	reimbursable program aid
SDG	Sustainable Development Goal
SDP	service delivery point
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
SIP	strategic investment plan
UHC	upazila health complex
UNCoLSC	UN Commission on Life-saving Commodities
USAID	US Agency for International Development

BACKGROUND

As countries work to meet the targets for maternal, newborn, and child health (MNCH) established under Sustainable Development Goal (SDG) 3, they need to ensure the continuous availability of essential medicines and supplies to prevent and treat the conditions that cause morbidity and mortality in women and children.

Since the report of the United Nations Commission on Life-saving Commodities for Women and Children (UNCoLSC) was published in 2012, much has been done to highlight the challenges countries face in ensuring the availability of essential commodities and to create resources to assist countries in this endeavor. Procurement was identified as a major challenge by the UNCoLSC, and accurate forecasting was identified as a weak point. Despite the development of guidance on forecasting for the commodities prioritized by the UNCoLSC, in the absence of reliable data on morbidity or consumption, procurement is likely to remain an issue.

Another identified issue is financing these life-saving commodities. In most settings, these commodities are procured with government funds, but there is a lack of documented evidence as to how decisions regarding financing for these commodities are made and executed. An understanding of the financial flows for MNCH commodities is critical as countries pursue the goals of ending preventable child and maternal deaths and of universal health coverage and as many go through processes of decentralization. Understanding financial flows for MNCH commodities may also assist the donor community in making smarter investments and assisting countries in mobilizing additional resources. The US Agency for International Development (USAID) commissioned this study in Bangladesh, Nepal, Kenya, and Uganda.

Current MNCH Status in Bangladesh

In recent decades, Bangladesh has made substantial progress toward reducing maternal, neonatal, and child morbidity and mortality. The country has achieved the targets for Millennium Development Goal (MDG) 4 and is on track for belatedly achieving MDG 5. With the introduction of the new SDGs, Bangladesh, like many developing countries, is also committed to achieving SDG 3 and improving maternal, newborn, and child health. For Bangladesh to achieve SDG 3.1, the maternal mortality ratio has to be reduced from the current level of 176 per 100,000 live births[1] to 59 per 100,000 live births by 2030. Achieving the SDG target neonatal mortality rate of 12/1,000 live births by 2030 would require accelerating the annual rate of reduction from its current level of 3.4% to more than 4.6%.

The Government of Bangladesh (GoB) applies a sectorwide approach under the national Health, Population, and Nutrition Sector Plan (HPNSP) 2017–2022 to address the needs and gaps for accelerated progress in MNCH.

[1] WHO 2015, http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/

Health System Involved in MNCH Medicine

The Bangladesh Ministry of Health and Family Welfare (MoHFW) uses its infrastructure of primary-, secondary-, and tertiary-level facilities to deliver MNCH services. The supply of essential MNCH medicines falls under two major directorates—the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP)—from the national to the community level. Service provision is described in the HPNSP, which is developed and approved as a five-year sector program with annual projections, including budget and activities. The health sector program was first reformed as a sectorwide approach in the 1990s, and the fourth HPNSP is currently being developed to be implemented between 2017 and 2022.

MNCH service delivery uses several administrative tiers with the following levels of health facilities:

Primary health care:

- Community clinics: A community clinic is the lowest-level facility providing one-stop services for health, family planning (FP), and nutrition to the community. Community clinics serve between 7,000 and 10,000 people.

- Union health and family welfare centers: At the union level, there are union health and family welfare centers (under the DGFP) and union subcenters/rural dispensaries (under the DGHS) that serve approximately 30,000 people.

- Upazila health complex (UHC): UHCs are located at the upazila headquarters. This is the third layer to provide primary health care services. However, a few UHCs have been upgraded to provide additional emergency obstetric and neonatal care services.

Secondary health care:

- District hospitals, which are secondary-level hospitals with 100 to 250 beds, provide all MNCH care, including specialized care and referral services. This reduces the burden on tertiary-level hospitals. District hospitals also serve as referral centers for the UHC.

Tertiary health care:

- This top layer consists of government and private medical colleges with 100 affiliated public hospitals located at district and divisional headquarters and in major urban areas. There are also some postgraduate teaching hospitals and specialized hospitals offering tertiary care services.

The MoHFW is responsible for implementing, managing, coordinating, and regulating the national MNCH program, including all other health, FP, and nutrition policies, programs, and activities. The MoHFW organizational structure (figure 1) comprises the secretariat[2] responsible for policy and administration of eight functional wings/units and executing agencies through

[2] In 2017, the MoHFW divided its functions under two divisions with a secretary for each. One wing contains most of the health service delivery and directorates, while the other includes medical education/institutes and FP.

which the MoHFW implements its policies, which include nine directorates/units/institutes. The DGHS and DGFP have separate management and delivery structures from the national to the field level and generally deliver MNCH services in the public sector with support from other directorates and departments within the ministry. The DGHS and DGFP have line directors (LDs) who are responsible for division (e.g., MNCH, central medical store) program planning and implementation. Under the DGHS, the LD for maternal, newborn, child, and adolescent health (MNCAH) services and the LD for hospital services are mostly responsible for MNCH activities, while the DGFP delivers maternal, child, reproductive, and adolescent health (MCRAH) under one LD.

The DGHS and DGFP have an administrative and structural presence at the divisional, district, and upazila levels that contributes to planning and budgeting program activities that form a basis for developing the MNCH annual operation plans and budget.

Under the MoHFW, the DGFP is primarily responsible for managing and ensuring FP services in collaboration with other directorates and departments, particularly the DGHS.

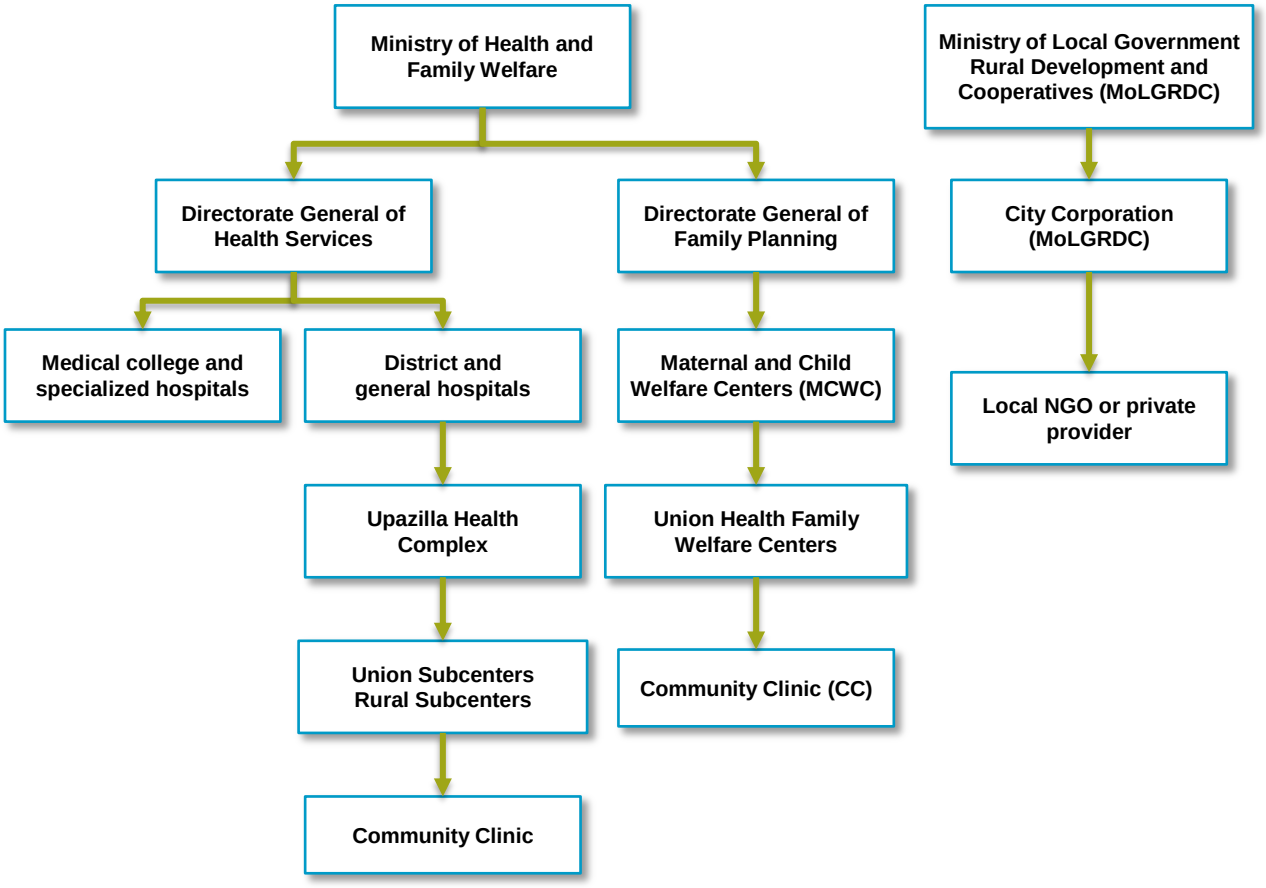

Figure 1: Health service delivery organizational structure in Bangladesh[3]

[3] Ahmed SM, Alam BB, Anwar I, Begum T, Huque R, Khan JAM, Nababan H, Osman FA. Bangladesh Health System Review, 5(3):2015, p. 31.

MoHFW's Role in Financial Management

Good financial management and planning is key to achieving the overall objectives of the health sector programs (e.g., HPNSP 2017–2022). The Financial Management and Audit Unit (FMAU) oversees and harmonizes all financial functions for both the revenue and development budget under the Joint Secretary of Finance. The MoHFW is in the process of outsourcing critically needed financial management and audit staff on a temporary basis to support the FMAU and LDs.

The Ministry of Finance (MoF) provides training, instruction, and guidelines in the form of a circular on financial management and auditing, which has greatly improved overall financial management and reduced financial irregularities and audit objections.[4] The quality and timeliness of financial management reporting has improved, facilitating on-time reimbursement by development partners.

The budget for commodities is prepared based on multiyear operational plan (OPs). The LDs take into account periodic requests/demand notes for commodities from the field level (users/ facilities) during preparation of OPs based on the approved program implementation plan (PIP) and its budget allocations in addition to allocations based on consumption data. MNCH medicines are included under the major LDs (MNCAH, hospital services, and community-based health care (CBHC) programs) of the DGHS and one LD of the DGFP (MCRAH). At the national level, the DGHS and DGFP, through their LDs, develop and finalize the required plan, budget, and procurement for essential medicines, while the planning LDs play a key role in coordinating within the directorate. The coordination mechanism (figure 2) among various units within the directorates is important for timely program planning and budgeting.

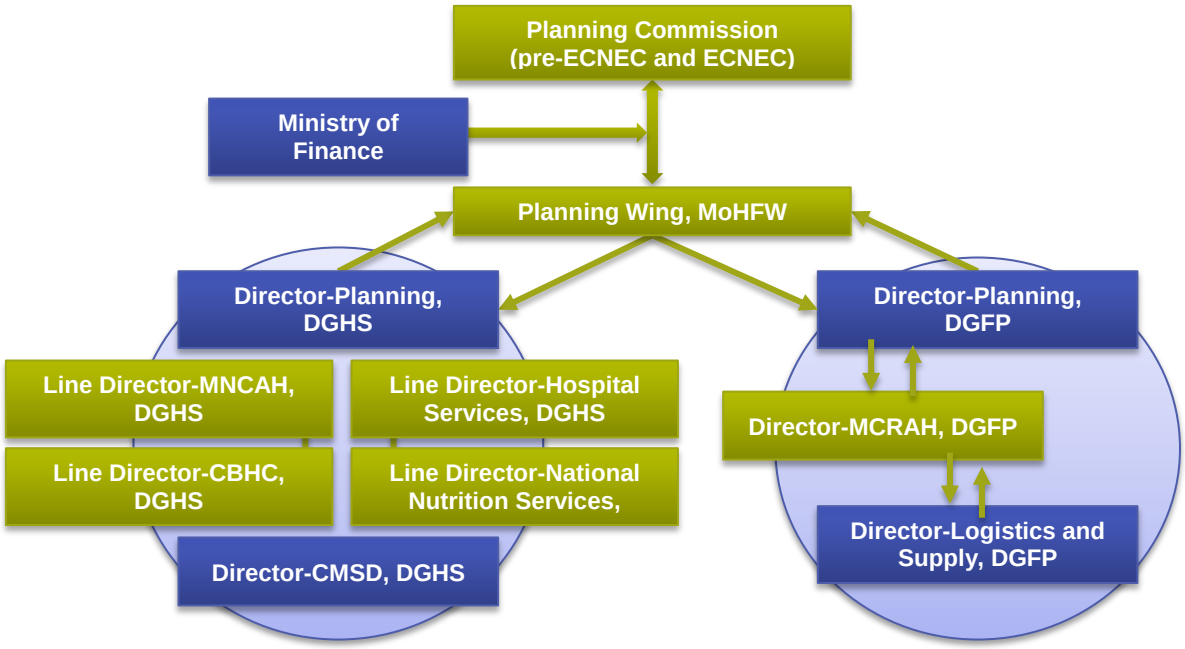

Figure 2. Coordination mechanism for program planning and budgeting

[4] Annual Programme Implementation Report 2016. Available at: www.mohfw.gov.bd/index.php?option=com_docman&task=doc_download&gid=10298&lang=en

The two directorates, which have separate administrative and infrastructure mechanisms, function differently in planning, procurement, and disbursement of commodities, as outlined below.

Directorate General of Health Services

The budget planning is coordinated at the DGHS by the planning LD in collaboration with other concerned LDs (MNCAH, hospital services, CBHC, national nutrition services, and central medical stores depot (CMSD) (figures 2 and 3). The CMSD plays an important role in ensuring the procurement of instruments, medicines, insecticides, and office equipment for health institutions under the DGHS in Bangladesh. It is one of the specialized procuring entities for the DGHS and the MoHFW and is responsible for supply planning, including procurement, storage, and distribution of commodities according to requisitions from the respective LDs.

Directorate General of Family Planning

The DGFP implements MCRAH activities through its facilities at the national, district, upazila, and union levels and community MCRAH services through field staff. The LD-MCRAH, DGFP, and its allied departments (figures 2 and 4) participate in planning, activity implementation, procurement, and financial management through a separate OP under the MoHFW's five-year sector program. The LD-MCRAH prepares projections for its target of service delivery. For commodities to be procured, the LD takes into consideration current stock balance, quantity in the pipeline, quantity to be procured, and buffer stock. At the request of the LD-MCRAH, the LD-Procurement Storage Supply and Management-Family Planning (PSSM-FP) in the DGFP accomplishes the bidding process either nationally or internationally following applicable government rules. Additional approval from the World Bank is required for procurements using the reimbursable program aid (RPA) budget.

There are also funds for local procurement of emergency and essential medicines, including other medical and surgical requisites (MSRs) for emergency obstetric care and delivery services at service centers. The DGFP allocates funds to district FP managers and to MCWCs for local procurement following procurement guidelines.

PURPOSE OF THE STUDY

The purpose of this study was to map the process of budgeting and the flow of funding, disbursements, and expenditures for select essential MNCH medicines and supplies in the public sector in four countries to inform the development of strategies and interventions to improve the availability of these medicines.

To gather information on the financial flow for selected medicines, four tracer medicines that have been on most countries' essential medicines lists for five years or more were selected.

Table 1. List of Tracer Medicines in Bangladesh

	Medicines	**Responsibility for planning, budgeting, procurement, and distribution**
Maternal Health	Oxytocin (10/5 IU)	DGHS: • LD-MNCAH (primary health care from upazila to community level) • LD-Hospital Services (secondary and tertiary hospitals) • LD-CBHC (community clinics) DGFP: • LD-MCRAH (e.g., union health and family welfare center, upazila/district MCWCs, Maternal and Child Health Training Institute)
Neonatal Health	Injection gentamicin (20 mg/2 ml and 80 mg/2 ml)	
Child Health	Zinc (20 mg dispersible tablets) ORS (1 L sachets)	

STUDY METHODOLOGY

The situation analysis employed qualitative and quantitative data collection methods. The USAID-funded Systems for Improved Access to Pharmaceuticals and Services (SIAPS) Program developed tools for the collection of data. The following methods were used:

- In-depth interviews with key personnel at the national level responsible for planning, approval, expenditure, and expense reporting of budgets for commodities, the procurement planning department, and donors
- Document and record review

A SIAPS consultant, along with SIAPS headquarters staff, conducted data collection between December 2016 and February 2017 using in-depth interview with identified stakeholders in Dhaka. The list of stakeholders interviewed is as follows:

Public sector:

- Mr. Nazrul Islam, Additional Secretary, Finance and Monitoring Unit, MoHFW
- Dr. Altaf Hossain, Program Manager, Neonatal Health and IMCI, DGHS
- Dr. Pobitra Kumar, Program Manager, Maternal Health, DGHS
- Deputy Director, Planning and Research, DGHS
- Dr. Khaled Reza, Deputy Director, CMSD, DGHS
- Dr. Mohammed Sharif, Director, MCH Services and LD-MCRAH
- Dr. Fahmida Akhter, Deputy Director, MCH Services, DGFP

Donors and Implementing partners:

- Dr. Shehlina Ahmed, Health and Population Adviser, Department for International Development, Dhaka
- Dr. Busra Binte Alam, Senior Health Specialist, Health, Nutrition, and Population Global Practice, World Bank, Dhaka
- Dr. Sajm Musa, Advisor to UNFPA Representative, UNFPA Bangladesh, and former LD-MNCAH, DGHS
- Dr. Riad Ahmed, Health Specialist, Health and Nutrition Section, UNICEF Bangladesh
- Mr. Zahedul Islam, Country Project Director, Management Science for Health, Bangladesh

FINDINGS

The study revealed the following aspects of health system functioning and information relevant to the financial flow for MNCH commodities, which could be of future use in improving management of MNCH commodities in Bangladesh.

Since the major part of the budget contribution for MNCH medicines is in government funds (84% of funding in the current HPNSP), procurement, distribution, and financial management are mostly guided by provisions in the five-year health sector plan.

Budgeting Process

The GoB introduced the strategy of developing a five-year sector plan to cover health activities in the 1990s.

Development of Plans and Budget for the Sector Program

Most instructions to guide the process are in the form of a circular rather than formal training. The plan and budget for the five-year sector program, which are the two integral components, usually take two to three years to develop and get approved. The process for a new program starts during the middle of the existing program.

Table 2 shows activities undertaken for developing the five-year sector plan.

Table 2. Key Activities Accomplished for the Five-year Sector Plan

Activity	Description
Project Concept Paper	The project concept paper (PCP) reflects national goals and targets, such as Vision 2020, 2030, SDGs, and maternal and neonatal health strategies. A PCP on the health sector was developed by the Planning Commission (PC) in consultation with various sector-program stakeholders.
Medium-term Budget Framework	The medium-term budget framework (MTBF) is an estimate and projection of a budget prepared by the MoF, PC, and MoHFW. The MTBF helps the MoHFW instruct its directorates, divisions, and institutions to prepare budget estimates and projections through consultations as per ministerial guidelines.
Strategic Investment Plan	A strategic investment plan (SIP) is a five-year strategic plan that covers all strategic directions and includes an indicative budget for the respective sector program to meet national goals and priorities. The SIP serves as the basis for preparation of a PIP and future OPs for five financial years.
Program Implementation Plan	A PIP includes detailed activities and budgets by different annual OPs (each OP has one LD to operationalize) of the sector program and the projected budget on a yearly basis for five years. The PIP is developed by the MoHFW in consultation with LDs, implementing partners, and donor agencies. The PIP is approved by the Executive Committee of the National Economic Council (ECNEC), which is chaired by the Prime Minister of Bangladesh. It serves as a master document and is used to develop the annual OP by each LD.

Activity	Description
Operation Plan	An OP is prepared on yearly basis. MNCH services are generally delivered under three major OPs of the DGHS (LD-MNCAH, LD-Hospital Services, and LD-CBHC) and one OP of the DGFP (LD-MCRAH). The LDs and their teams prepare the OP activities and budget, taking into consideration the approved PIP and its budget allocations. The development partners work closely with the LDs to finalize the OP. The OPs should be reviewed annually for both physical and financial achievement and formulation and revision of the next year's OP.

Key information used in developing the sector program PCP, SIP, PIP, and subsequent OP

The following areas and priorities were considered during development of PCP, SIP, and PIP of the fourth health sector program:

- The SIP, PIP, and OP of previous five-year sector programs; national health policy; national population policy; national nutrition and food related policy; national drug policy; national strategies on maternal, neonatal, and infant health; Integrated Management of Childhood Illness, Behavior Change Communication, and OP 2009; Annual Plan Implementation Report 2008; Mid-term Review 2008; and Vision 2021
- National targets and estimates under national and SDGs (previous MDGs)
- Previous five-year budget with yearly allocations and previous sector estimates
- Local demand from user levels (e.g., cost centers, field work, districts, institute)
- Performance-based reports on budget, expenditures, and gaps, including national survey reports (e.g., BMMS, BDHS, BBS), MIS, and other relevant published and unpublished documents

Technical Support for the Development Process of the PIP/OP and Budget

A Project Management and Monitoring Unit supports the MoHFW and its departments in developing the SIP, PIP, and OP. The development partners also provide technical assistance to the development process and the unit.

Timelines for Budget Development Process

Since the start of the health sector plans in 1998, there have been four plans. Table 3 shows the duration of each plan.

Table 3. Health Sector Plans in Bangladesh (1998–2022)

Sector Plan	Duration
1. Health Population Sector Plan	July 1998–June 2003
2. Health Nutrition and Population Sector Plan	July 2003–June 2011
3. Health Population Nutrition Sector Development Plan (HPNSDP)	July 2011–June 2016 (no-cost extension through December 2016)
4. HPNSP	January 2017–June 2022

Timelines in the fourth sector program: The next sector plan, including activities from the PCP to developing the OP, must be developed and approved during the last year of the previous sector plan (i.e., July 2015–June 2016).

A recent policy shift from input-based financing to a program for results and the use of disbursement-linked indicators for financing and monitoring has created some challenges for all stakeholders to develop plans and budgets in the time available in addition to other factors, such as administrative process; lack of qualified personnel with expertise in financial procedures to work with LD; and coordination among the field, directorates, the ministry, donors, and stakeholders. The development and approval of the current sector program and its SIP and PIP took longer than expected, resulting in a six-month delay. The delay was because of the introduction of a new program for a results-based financing system instead of input-based financing and the consultation to develop and approve the disbursement-linked indicators among the MoHFW, World Bank, and implementing partners.

Fourth Sector Plan (2017–2022)

The PCP, SIP, and PIP of the current fourth sector plan (HPNSP) with its indicated yearly budget for five years were approved in 2017.

- The development of the SIP process was initiated in 2015 and the Minister of the MoHFW approved it with the indicated budget in April 2016.

- The PCP and its associated budget guided the development of the SIP and budget, which guided the MoHFW in developing the PIP. The PIP and its budget was finalized through a series of consultations and review meetings at the MoHFW and submitted to the ECNEC for approval.

- The ECNEC, which is chaired by the Prime Minister, approved the PIP in March 2017.

- The PIP guided the development of the OPs. In April and May 2017, the OPs for 2017–2018 with activities and budget detail under various LDs were prepared and submitted for approval by the MoHFW. The MoHFW, including the health and FP directorates and their LDs, the MoF, and development partners participate in the budget development process.

The budget framework is developed every five years. It has been observed that there is a gap of more than six months between two sector programs (i.e., from July to December 2016 between the third and fourth sector programs). The actual end date for the previous program was July 2016, but a no-cost extension was given through December 2016. The no-cost extension period was used for preparation of the upcoming fourth sector program (2017–2022). It was also expected that the SIP/PIP/OPs would be ready to initiate program implementation in January 2017; however, there was a delay in the start of the next SIP.

The annual review of the results for reimbursement in the disbursement-linked indicator financing in the fourth sector plan may require annual revisions of at least some of the OPs to respond to the

review results and make necessary adjustments.[5] However, during the previous HPNSDP, the OPs were only updated twice during the five-year implementation period.

Financing Pattern in Two Recent Health Sector Programs

An MTBF is prepared jointly by the MoF; PC; and all ministries, including the MoHFW. The MTBF covers the first three years of the five-year plan—the actual budget for the first year and projections for the two subsequent years.[6] The MoHFW prepares its nondevelopment budget using GoB revenue funds, development budget using funds from donors, and expenditure limits by divisions and directorates. It helps in preparing the estimate/projection of development funds, including direct project aid (DPA) (funds given in advance for planned program activities) or RPA (funds given as a reimbursement to the GoB after the activity report and budgets are submitted). Finally, based on the budget framework and guidelines, the divisions/directorates of the MoHFW prepare yearly budget plans for the five-year PIP.

The current HPNSP covers financial years 2017–2022. The budget for 2017–2018 is actual, and for 2018–2022, it is total estimates projected based on an annual increase of approximately 15% over the FY 2017–2018 budget.

Table 4 shows a comparison between the budgets for the past five-year PIP and the current PIP. While the total budget has doubled from the last plan, the percentage contribution from the GoB has increased slightly and donor contributions have decreased slightly.

Table 4. Budget Pattern in Five-year HPNSPs by Source of Fund and Proportions

	HPNSDP 2011–2016		HPNSP 2017–2022	
Financing pattern in two successive health sector programs	**Amount (billion Taka)**	**% of grand total**	**Amount (billion Taka)**	**% of grand total**
1. GoB Nondevelopment (Revenue)	348.2	61	720.0	61.8
2. GoB Development	86.0	15	146.0	21.3
3. Subtotal of GoB (1+2)	**434.2**	**76**	**966.0**	**83.6**
4. RPA/Pool fund	86.9	15	11,6	10.1
5. DPA	48.7	9	71.7	6.2
6. Subtotal of RPA and DPA (4+5)	135.7	24	188.7	16.3
7. Total of development (2+6)	**221.7**	**39**	**434.8**	**37.6**
8. Grand total (1+7)	569.9	100	1,164.7	100

Financial Flow

Budget Disbursements

After approval of the sector program PIP and budget, the OPs with budgets are submitted to the MoHFW Steering Committee, chaired by the Minister of the MoHFW, for approval. The Joint

[5] PIP, fourth HPNSP (January 2017–June 2022)
[6] Budget Circular-2, Memo no-MoF: Finance Division: 07.101.020.014.2015-232 Dated: 24-04-2016

Secretary (Project Implementation) of the MoHFW approves and disburses first-, second-, and third-quarter funds under the OPs, while fourth-quarter funds are approved by the MoF.

During the process of procurement, LDs prepare and submit procurement requests to the CMSD (DGHS) and LD-PSSM-FP (DGFP), where the units prepare their procurement plans with budgets and submit them to the MoHFW for administrative approval; they receive additional approval from the World Bank for RPA funds. All steps for procurement are processed and completed according to GoB rules. Funds are made available to the CMSD or PSSM-FP. An amount for local purchase of MSRs, including medicines, is also sent to the local level based on allocation guided by OPs and approval of the MoHFW. For DPA, the fund release follows the agreed-upon procedure through the respective LDs.

Procurement and Distribution of MNCH Commodities

Supply Chain Management Portal

The MoHFW has introduced a web-based portal that is accessible to all users and stakeholders. This portal is used for procurement, planning of goods and services, package development, tracking of procurement packages, and linkages with drug registration databases.

The logistics management information system (LMIS) monitors national- and regional-level logistics data. The DGHS has introduced the LMIS in 10 districts. Data are entered at the local level and consolidated into reports available in a dashboard. The DGFP has national and full subnational coverage, with the LMIS effectively supporting similar functions. The web portal enables online submissions, approval and tracking of procurement, distribution, and monitoring of commodities.

The 2017–2022 PIP has a total budget allocation of 550 million Taka (approximately USD 7 million) for both national and subnational level procurement of consumable stores, MSRs, medicine, and instruments for MNCAH for five years.

Procurement and Distribution under the DGHS

In 2012, the MoHFW, with support from SIAPS, introduced the web-based Supply Chain Management Portal (www.scmpbd.org) for online monitoring of the DGHS procurement and logistics management system in 10 districts and in all districts for the DGFP.

The portal provides reports of procurement status in different templates. It also records delays in procurement for individual packages, including the reasons for the delay. e-Procurement would help simplify and expedite the procurement process.

The procurement process followed by the DGHS is shown in figure 3.

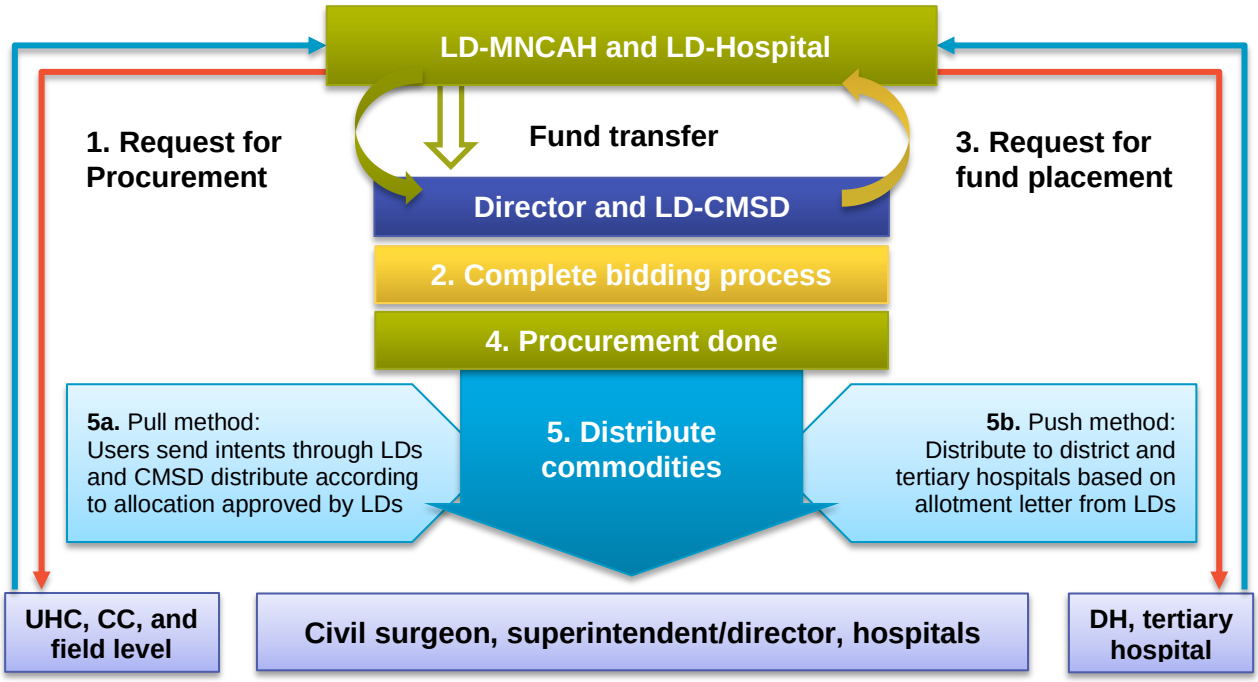

Figure 3. Budget, procurement, and distribution in the DGHS

The lead time for procurement is three months, but the process may take longer depending on whether the CMSD opts for a national or international bidding process. Because most funding comes from government funds (70% in HPNSDP 2011–2016; 84% in HPNSP 2017–2022), the process follows government SOPs. However, procurement using funds from development partners follows donor requirements.

The DGHS also approves subnational procurement of commodities and other MSRs at the local (e.g., upazila, district, divisional, facility/institution) level. Local-level managers and secondary and tertiary facilities receive an annual fund allocation of 5% of the overall commodities budget, from which they are allowed to purchase certain items, including essential medicines, following government guidelines (Public Procurement Act 2006 and Public Procurement Rules 2008). An illustrative fund allocation[7] for MSR, including medicines, is shown in table 5.

Table 5. Budget for Local Procurement of MSRs by Level (2015–2016)

Level	Amount (Taka/USD)	Comments
Through civil surgeons (64 districts)	1,900 million/24 million	This fund is for all UHCs, rural dispensaries, TB clinics, school health clinics, and urban dispensaries
78 district hospitals	1,550 million/19.8 million	For district hospitals. Distribution was made at the DGHS level considering total beds (100–250), patient bed occupancy, and individual institutional requirement
Medical college hospitals and specialized institutes	N/A	Fund is decided based on number of beds (500–2,000) and local requirements

[7] Collected from DGHS records.

LDs are responsible for ensuring that MNCH medicines are procured and distributed to various tiers of MNCH service delivery under the DGHS through central-level quantification and procurement:

- LD-MNCAH: Plans, procures, and distributes for UHCs and field-level service delivery
- LD-Hospital Services: Plans, procures, and distributes for district hospitals and above (all tertiary-level facilities, such as medical college hospitals and specialized hospitals)
- LD-CBHC: Plans, procures, and distributes for community clinic-based services

Procurement and Disbursement under the DGFP

The PSSM-FP of the DGFP's Logistics and Supply Unit is responsible for procuring and supplying quality contraceptives and reproductive health commodities to service delivery points (SDPs) throughout the country. The DGFP delivers commodities from the central warehouse to users through a chain of 21 regional warehouses, 483 upazila family planning stores, and SDPs.

The DGFP procures medicines in bulk as part of kits or packages as follows:

- ***Drug, dietary, and supplement kits***: Required medicines in the form of kits
- ***Delivery kit with packages***
- ***Procurement of loose medicine:*** Medicines for normal delivery and emergency obstetric care services to service centers (e.g., injectable oxytocin, anesthetics, related medicines).

The procurement process followed by the DGFP is shown in figure 4.

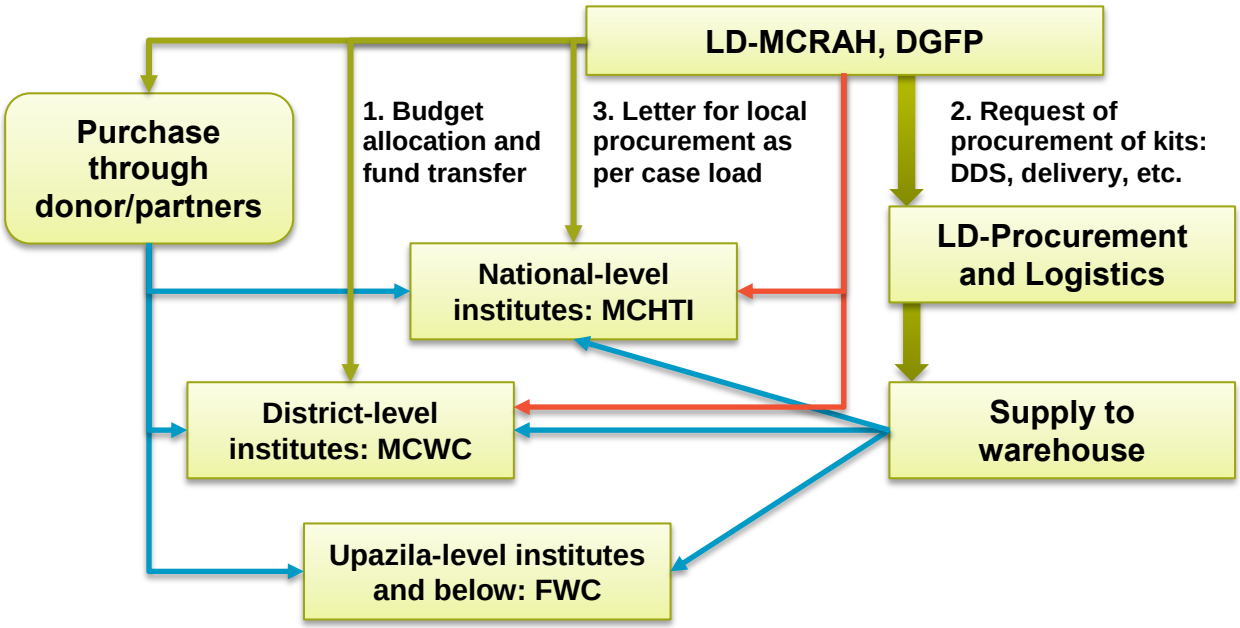

Figure 4. Procument and fund disburment process in the DGFP

During the interviews, stakeholders mentioned that the automation of the supply management system through two software programs (the Warehouse Inventory Management System and the Upazila Inventory Management System) has been very useful to make procurement decisions based on real-time data. To monitor the status of DGFP procurement packages, a web-based tool called "Procurement Tracker" was used. Similarly, the LMIS was used to monitor DGFP national- and regional-level logistics data. Both tools were found to be very useful in stock-out/overstock situations. The DGFP has been working to support the availability of essential commodities at all levels under the general five-year sector program by:

- Creating a Forecasting Working Group under the DGFP to prepare short- and long-term procurement plans and develop a forecasting, quantification, and supply planning system
- Organizing quarterly meetings of the Logistic Coordination Forum to review progress of the implementation of procurement plans and the optimal functioning of the supply chain
- Introducing e-Government Procurement and strengthening the e-LMIS in the DGFP

The Supply Chain Management wing of the PSSM-FP is currently using the Warehouse Inventory Management System, LMIS, and the Upazila Inventory Management System.

To ensure accountability, physical inventories are conducted in all warehouses twice a year, and a commodity audit is carried out by a third party (contract out) every two years.

Funds are allocated and transferred to health facilities for local purchase using the procurement guidelines of the DGFP. The LD-MCRAH approves local procurement as per the guidelines.

Expenditure Tracking

Financial monitoring is done through monthly meetings coordinated by the Joint Chief of Planning, MoHFW, and chaired by the MoHFW Secretary or Minister. All LDs have to submit physical progress reports with a statement of expenditure.

For financial reporting, LDs use reporting formats to submit monthly, quarterly, and annual financial statements to the MoHFW.

An annual financial audit is conducted in the following fiscal year. Any objections/queries raised are resolved, and there is no effect on funding for subsequent procurements. If there is any questionable cost, the respective department is requested to submit clarification; however, this does not affect the approval or rejection of the GoB budget.

Any unspent funds in the GoB budget lapse at the end of fiscal year, but unspent money from the development fund may be carried forward to the next year for implementing planned activities after consultation and approval by respective donors.

A scarcity in adequate support staff proficient in program management, finance, and auditing can cause delays in expenditure tracking. This may affect the fund disbursements, as may frequent transfers and retirements of experienced personnel in directorates/divisions.

SUMMARY OF KEY FINDINGS

Bangladesh has significantly improved its MNCH indicators. The five-year sector plan based on national health priorities guides the development of the PIP and yearly OPs. Most of the funding for health comes from GoB funding (approximately 61% under the current sector plan). The sector plan includes activities as well as the five-year budgeting plan. The development of sector plans (SIP, PIP, and OP) and budgets requires a multifaceted process, and stakeholders include the PC; ministries (MoF, MoHFW); directorates (DGHS, DGFP); and development partners.

Although planning, budgeting, procurement, and financial management in the health sector have improved over past few decades, there are often delays in the plan implementation. It was highlighted during the stakeholder interviews that there were delays in the development of the annual OP, which includes an itemized budget with a line item for medicines. To meet the budget deadline, the annual budget was based on the five-year program implementation plan previously developed and approved; it did not take into consideration the most recent estimate for medicine needs or any changes to the activities detailed in the five-year plan. In addition, the annual OPs are not always updated to reflect recent changes. An evaluation of the sector program in 2015–2016 showed that a delay in fund release posed a challenge to a significant number of LDs in financing, procurement, and implementation.[8]

Another area highlighted in effective management of the financial flow was the lack of a trained workforce for planning and finance/budgeting in all directorates and divisions. It was mentioned during stakeholder interviews that training should include mid-level program managers in the field and at the directorates to ease the process of planning and accountability in implementation and monitoring.

Due to the division of MNCH services and supplies between the DGHS and DGFP, as well as the combination of internally generated and donor funds, it is difficult to track spending on commodities and supplies;[9] an improved logistics management or inventory system would help consolidate available information and enable better decision making at the higher level. This also calls for harmonizing directorates, providers, and the public and other sectors to estimate and distribute MNCH commodities. The projection for MNCH commodities in the annual OP is an estimate, and the commodities are distributed based on general estimates using the number of beds, patient occupancy, and previous expenditure per facility; they are not needs based.[10] Any shortage of medicines at the facility level is managed by local procurement or patient participation. Local purchases can be expensive because of the quantity being procured and the limited sources of availability. Therefore, when local purchases are made, the market price often changes between estimation and actual purchasing, which can lead to fewer supplies being procured and available at the service level. Distribution of commodities to user facilities is done at the national level using distribution data rather than morbidity or incidence data, which might affect the availability of medicines.

[8] MoHFW, Annual Programme Implementation Report December 2016, p. 40.
[9] Maternal Health Supplies in Bangladesh; p. 26. Available at: https://pai.org/wp-content/uploads/2011/12/maternal-health-bangladesh.pdf
[10] Annual Program Review Bangladesh HPNSDP 2012, p. 7

Delays in the administrative response and the release of funds also delay procurement. Efficiency and coordination within and between departments is essential to expedite procurement.

The Supply Chain Management Portal has made the procurement process more efficient by allowing LDs to submit requests online through the CMSD (DGHS) or Logistics and Supply Unit (DGFP); prepare procurement plans and bids; complete the online bidding process; and monitor procurement and the MoHFW's logistics management system. The MoHFW and LDs can see the status of procurement of their products or packages online.