Challenges to Ensuring Adequate and Timely Funding for MNCH Commodities:

Summary of Findings from Bangladesh, Kenya, Nepal, and Uganda

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ACRONYMS

LMIS	logistics management information system
MNCH	maternal, newborn, and child health
MoF	Ministry of Finance
MoH	Ministry of Health
NMS	National Medicines Store
RMNCH	reproductive, maternal, newborn, and child health
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
UNCoLSC	United Nations Commission on Life-Saving Commodities for Women and Children
USAID	US Agency for International Development

INTRODUCTION

As countries pursue the maternal, newborn, and child health (MNCH) targets established under Sustainable Development Goal 3, they will need to ensure the continuous availability of essential health commodities to prevent and treat the conditions that cause morbidity and mortality in those groups. Since the report of the United Nations Commission on Life-Saving Commodities for Women and Children (UNCoLSC) was published in 2012, much progress has been made to highlight the challenges countries face in ensuring access to essential commodities and to create resources to overcome these challenges.

A major issue yet to be adequately addressed is financing for these life-saving commodities. While they are procured with government funds in most settings, documented evidence is lacking on how governments make and execute these financing decisions. An understanding of the financial flows for MNCH commodities is critical to ensuring adequate and timely procurement of MNCH commodities as countries continue to decentralize and recognize a need to mobilize additional resources. This information on financial flows will also help the donor community make smarter investments.

The US Agency for International Development (USAID)-funded Systems for Improved Access to Pharmaceuticals and Services (SIAPS) Program mapped the budget allocation, approval, disbursement, and reporting processes in the public sector for essential MNCH commodities in four countries—Bangladesh, Kenya, Nepal, and Uganda—to inform the development of strategies and interventions that will improve access to these commodities. These assessments identified major bottlenecks that adversely affect financing and therefore access. While each country has individual challenges, we identified common bottlenecks that have implications for other countries and donors that are working to ensure access to essential MNCH commodities. These common bottlenecks include:

- Funds for health commodities are not allocated based on evidence, which leads to inadequate funding or budget allocations.
- Disbursed funds do not always match the allocated funds or budget.
- Delays in disbursement slow commodity procurement and distribution.
- Complex processes for budgeting and financial reporting delay auditing.
- MNCH commodity working groups, where they exist, fail to adequately monitor and do not use their power to influence or ensure sufficient financing for MNCH medicines.

METHODOLOGY

We reviewed budget documents and conducted in-depth interviews with stakeholders in donor agencies, the ministries of health (MoH) and finance (MoF), and other planning commissions at the national and subnational levels where relevant. We used standardized quantitative and qualitative data collection tools; however, for Kenya, we used budgeting and financing data collected separately as part of the subnational procurement assessment to inform the assessment. In some cases, we identified other stakeholders through our primary interviews. Table 1 lists the key stakeholders that we interviewed for data collection.

The data collection tools focused on six key aspects related to financing in the public sector:

- Budget development, approval, and allocation processes
- Timelines for the budgeting cycle
- Financial flows for MNCH commodities
- Expenditure tracking for MNCH commodities
- Gaps in funding or actual procurement of health commodities
- MNCH commodity security mechanisms

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

- Maternal health: oxytocin (10/5 IU)
- Neonatal health: injection gentamicin (20 mg/2 ml and 80 mg/2 ml)
- Child health: zinc (20 mg dispersible tablets) and oral rehydration solution (1 L sachets)

TABLE 1

Key Stakeholders Interviewed for Mapping Financial Flows of MNCH Commodities

MINISTRY OF HEALTH	MINISTRY OF FINANCE	DONORS	OTHER
▪ Finance director ▪ Director, MNCH department ▪ Director, procurement and supply planning department ▪ Head of central medical stores ▪ RMNCH commodity security working groups	▪ Director, budget department ▪ Director, public procurement department	USAID, UNFPA, UNICEF (health director, MNCH staff, finance staff, staff responsible for coordination with MoH- MNCH, procurement, and supply planning)	▪ Sector budget working groups ▪ Central medical stores or other procurement agencies ▪ Local government agencies that procure health commodities ▪ Planning Commission

OVERVIEW OF THE BUDGETING PROCESSES AND FINANCIAL FLOWS FOR MNCH COMMODITIES

A country's budgeting processes and financial flows for MNCH medicines vary based on whether budgeting and procurement occurs at the national (centralized system) or subnational (decentralized system) level or a mix of both systems. In some countries, local governments or health facilities procure health commodities.

The health system structures in the assessment countries varied. For example, while Uganda has a centralized health system, Kenya's health services are completely devolved to county governments, with the MoH playing a leadership role for the counties and managing vertical health programs and national-level health services. Both Bangladesh and Nepal have components of centralized and decentralized systems, where commodity budgeting and procurement occurs at both the national and subnational levels.

BUDGET DEVELOPMENT, APPROVAL, AND ALLOCATION PROCESSES

The average timeline from initiating the annual budget development process to final approval and disbursement of funds is about nine months. With slight variations, countries have similar processes. The key stakeholders involved in the health budgeting process within the public sector are the MoF, development and economic planning commissions, the MoH, and the cabinet or parliament.

Kenya develops its health budgets at the county level with no input from the MoH, which only manages national-level health services and vertical programs. The primary role of the national level is to determine county budget ceilings. Otherwise, the county budget development and approval processes largely mimic the national-level processes in other countries.

FIGURE 1

General budget development, approval, and allocation processes for key stakeholders

MoF	■ Issues budget circulars (includes guidelines and deadlines) to initiate the budget development process ■ Determines the budget ceiling for the MoH or local governments that develop health budgets ■ Reviews budgets from various ministries, including the MoH ■ Ensures budget is within the ceiling and submit it to parliament/cabinet for approval ■ Disburses funds to the MoH or local government and monitors the use of the funds
Planning Commission	■ Sets national priorities and strategies and ensures that budgets are aligned to reflect this
MoH	■ Coordinates with relevant departments or health programs to agree on priorities, determine department budget ceilings, and develop a line item budget within the budget ceiling set by the MoF ■ Submits supporting documents, such as annual strategic plans or budget frameworks, to the MoF or parliament/cabinet for approval ■ Receives or disburses funds to lower levels of the health system
Parliament	■ Approves budget ceilings and line item budgets for the MoH

FINANCIAL FLOW FOR MNCH COMMODITIES

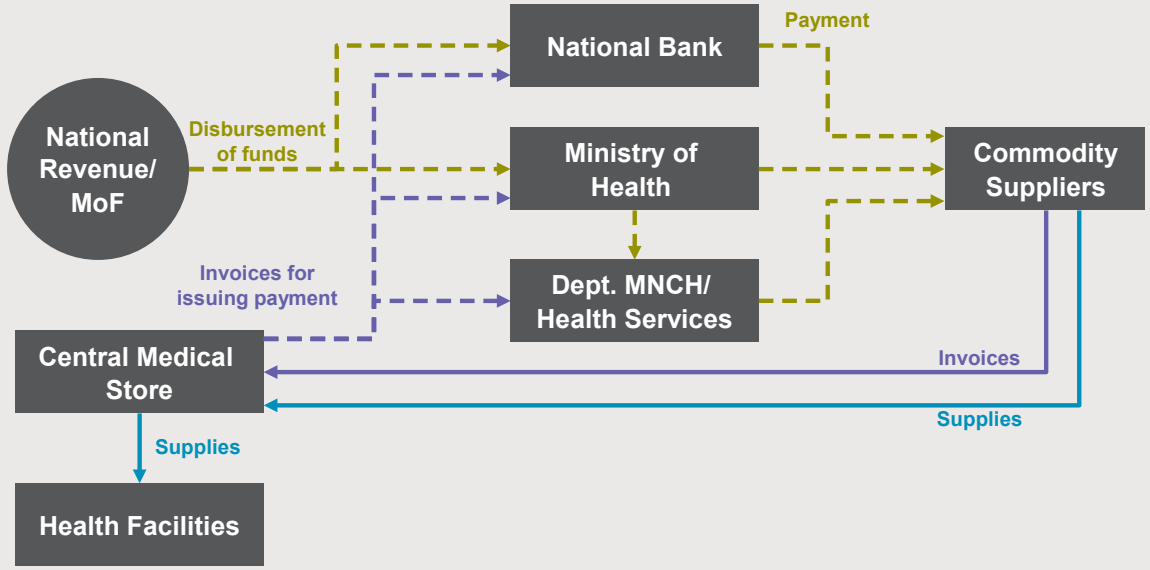
The pool of funds for MNCH commodities includes donor funds and government revenue (national and subnational levels, where relevant).

Centralized System

In a centralized system, the national-level government holds funds and pays suppliers for commodities. In Uganda, for example, the MoH budgets for and the National Medicines Store (NMS) procures and manages health commodities. The MoF pools and manages donor and national funds and makes quarterly disbursements to the Bank of Uganda. The Bank of Uganda holds the funds and pays suppliers directly once the NMS submits supplier invoices and the MoF issues payment approval. In other centralized systems, the funds may be disbursed by the MoF to the MoH or to a department within the MoH that procures commodities. Payments to suppliers are made directly by the MoH or specific departments within the MoH once the supplies have been received by the central medical stores.

Figure 2 illustrates options for financial flow in a completely centralized health system.

FIGURE 2 **Example of MNCH financial flow for a centralized system (adapted from Uganda)**



Decentralized System

In Kenya, once the MoF disburses funds to the counties, the County Treasuries combine these national funds (government revenue and donor funds) with county revenue and make payments directly to the suppliers. Health facilities, particularly county hospitals, in some counties receive extra funds for emergency procurement, while some facilities generate revenue to use for procurement.

FIGURE 3

Example of MNCH financial flow for a decentralized system (adapted from Kenya)

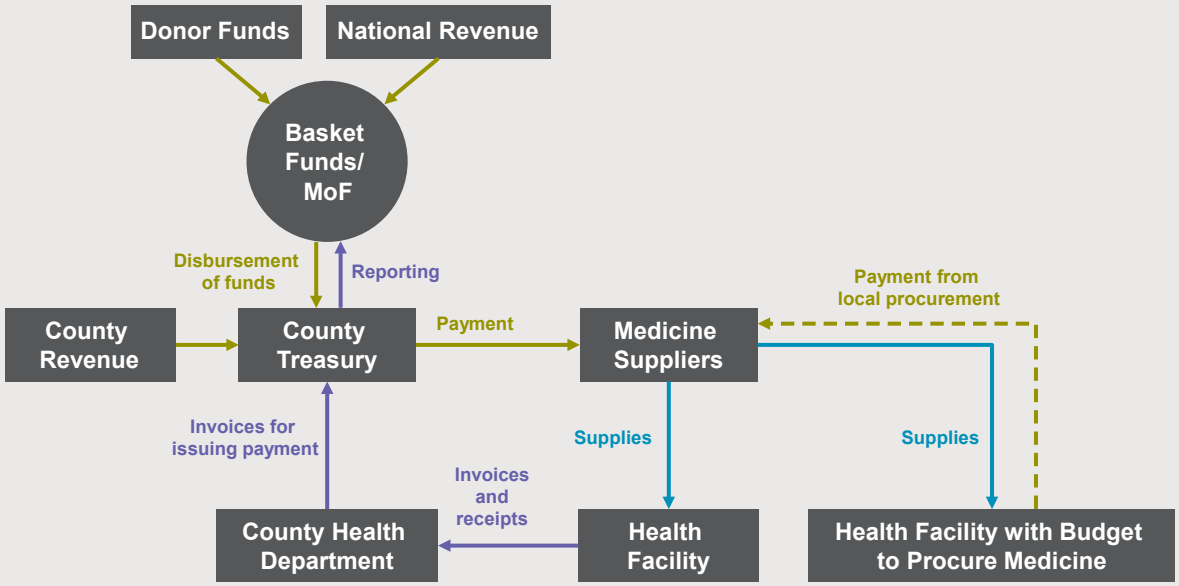


Figure 3 illustrates the financial flow in a decentralized health system.

While a decentralized system may appear to have more flexibility or greater efficiency, both centralized and decentralized systems have challenges, and some countries have even made adaptations to have a mixed system, adapting the centralized system by adding some local autonomy.

In Nepal and Bangladesh, for example, the system is mostly centralized but there is some component of a decentralized system. According to national policy, the Ministries of Health allocate a small percentage of the health commodity procurement budget for local procurement at the regional and district levels to help ensure the availability of buffer stock and to provide a mechanism for emergency procurement.

KEY FINANCING AND DISBURSEMENT BOTTLENECKS

As noted, despite countries' differences in health system structures, they share common bottlenecks in financial management—from developing the budget, managing approval processes, and allocating funds to disbursement and reporting on the use of funds—that result in insufficient funding for health commodities and potential stock-outs.

The key bottlenecks identified were:

1. Funds for health commodities are not allocated based on evidence, which leads to inadequate funding or budget allocations
2. Disbursed funds do not always match the allocated funds or budget
3. Delays in disbursement slow commodity procurement and distribution
4. Complex processes for budgeting and financial reporting delay auditing
5. MNCH commodity working groups, where they exist, fail to adequately monitor and do not use their power to influence or ensure sufficient financing for MNCH medicines

1. FUNDS FOR HEALTH COMMODITIES ARE NOT ALLOCATED BASED ON EVIDENCE, WHICH LEADS TO INADEQUATE FUNDING OR BUDGET ALLOCATIONS

Budget allocations are often not sufficient to meet commodity procurement needs, which may lead to stock-outs. While limited financial resources may affect funding allocations, other factors that can cause inadequate funding allocations for health commodities include:

- A weak logistics management information system (LMIS) that does not capture crucial data to inform budgeting and procurement
- Limited capacity, particularly at decentralized levels, to forecast health commodity needs
- Lack of evidence-based methods or standard procedures to determine health facility budgets for commodities

A Weak LMIS That Does Not Capture Crucial Data to Inform Budgeting and Procurement

A strong LMIS provides data on the availability and use of health commodities that are needed to conduct accurate quantification and procurement planning, inform budgeting and resource mobilization, and strengthen overall financial management. All of the countries lacked adequate LMIS data, particularly for MNCH commodities and at subnational levels of the health system in decentralized settings. MNCH commodity data are rarely monitored at both the national and county levels. For example, Kenya has no requirement for health facilities to submit data on the availability and use of commodities to county health departments. Even when the data were collected, it was unclear how the national level used them to inform county health budgets, including for commodities and facilities. Similarly, although Bangladesh has a well-established eLMIS for family planning commodities, the information system for MNCH commodities is limited. Therefore, LMIS systems need to focus more on MNCH commodities.

Limited Capacity, Particularly at Decentralized Levels, to Forecast Health Commodity Needs

Countries often have limited capacity to accurately forecast quantities of health commodities due to a lack of standardized guidelines, standard operating procedures, and quantification tools and LMISs. The quantification for MNCH commodities is often based on previous year needs, even though this information is out of date. At the subnational level in Kenya and Bangladesh, each county and district calculates its forecasts differently based on past consumption or distribution or on the previous year's expenditure on medicines with a standard percentage increase. These estimates, which are based on out-of-date historic information, feed into the national quantification, further compounding the inadequacies in the peripheral forecast.

In addition, there are no guidelines or standard procedures or tools tailored to quantifying health commodity needs at the local government or health facility levels.

Improving the methods to estimate health commodity needs is a priority for many countries. Under the UNCoLSC, generic guidance documents were developed at the global level, but these need to be adapted and applied by country teams to quantify correctly. Both Bangladesh and Uganda conduct national-level forecasting workshops, and in Uganda, a Quantification and Procurement Planning Unit within the MoH was formed to improve quantification of essential medicines and commodities used in vertical programs.

Despite the existence of national-level forecasts, they are not always used to budget for health commodities because the needs are significantly higher than the available budget.

Budget exercises are based on forecasting and therefore, the budget for health commodities will only be accurate if the forecast is done correctly.

Lack of Evidence-based Methods or Standard Procedures to Determine Health Facility Budgets for Commodities

Regardless of facility needs, budget allocations to health facilities focus on ensuring that the budget ceiling is not exceeded for the facility, for medicines, or for the health budget overall.

For example, the Uganda NMS divides the total allocation for each health facility level evenly across all facilities, regardless of their requirements or patient catchment area (box 1).

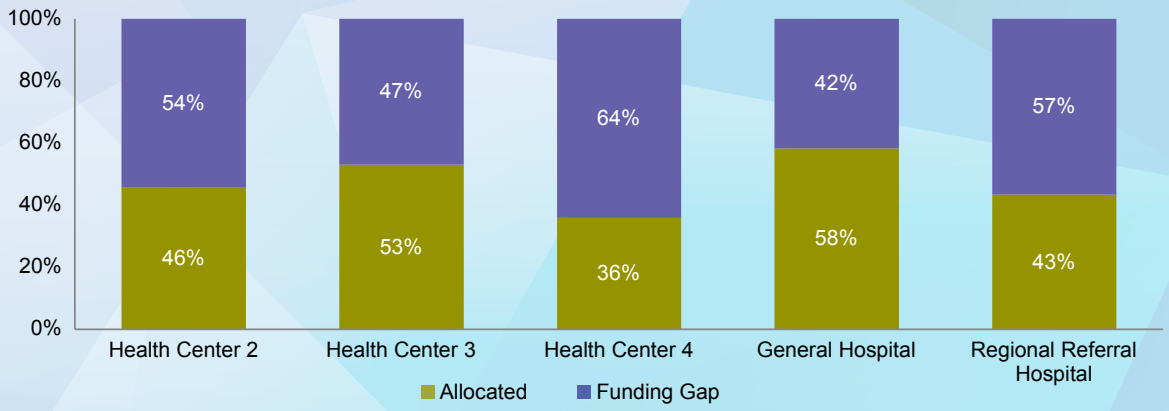
BOX 1

BOTTLENECK EXAMPLE FROM UGANDA

The NMS budget has not increased in the last three years. As a result, despite NMS conducting an essential medicines needs assessment at the health facility level to develop needs-based procurement plans, health facilities receive medicines based on the pre-approved budget allocation and not on the NMS needs assessment.

In addition, the total budget allocated to health facilities is based not on quantifications but on the budget ceiling for each level that the Ministry of Finance, Planning and Economic Development sets. The NMS divides the total amount allocated per level by the total number of health facilities at that level. As a result, the mean funding gap in Uganda was 51%. Each health facility receives the same funds (credit) for commodities, regardless of the number of patients it serves.

Percent of required funding for essential medicines at health facilities in Uganda



In Kenya, county pharmacists determine the commodities budget for each health facility; however, they have no standard procedures for this process and methods vary among counties. The county pharmacist may divide the total budget equally among all health facilities or consider individual facility needs. County governments do anticipate over-expenditures, especially for health commodities, and have set up a supplemental budget process to manage over-expenditures when pharmaceutical expenses exceed the allocation. The supplemental process starts nine months into the fiscal year and involves

reallocating approved funds from under-budget line items to over-spent line items, such as "medical drugs" that need additional financial resources (box 2). Despite this process, the overall county budget cap leads to stock-outs of essential MNCH commodities.

While this is a coping mechanism to manage over-expenditure, it demands additional resources and does not solve the problem because historic budgets are used to develop the new budgets. The only definitive solution is to increase the overall budget cap.

BOX 2

SUPPLEMENTAL BUDGETS COMPENSATE FOR OVER-EXPENDITURES IN HEALTH COMMODITIES PROCUREMENT: ELGEYO-MARAKWET, KENYA

Nine months into the fiscal year, the county reviews current expenditures and can reallocate funds among departments or budget line items based on under- or over-expenditures. A supplemental budget is developed around April of the current fiscal year and submitted to the County Assembly for review. While the approved funds are being reallocated, the overall budget must remain within the county ceiling. In addition, counties are not allowed to transfer funds between approved development and recurrent allocations. Our discussions with county health departments and county pharmacists indicated that over-expenditures are fairly common for health commodities and that the supplemental budget compensates for the over-expenditure.

County budget for "medical drugs" for Elgeyo-Marakwet, FY 2014–2015

	AMOUNT (KES)	PERCENT (%)
Total County Budget	2,995,655,205	
Amount disbursed by national level	2,845,235,405	95% of total budget
Amount of county revenue	132,000,000	4.4% of total
Grants	18,420,000	0.6% of total
Amount requested by County Health Department	895,293,662	
Amount approved for County Health Department	895,293,662	100% of requested
Amount requested for "medical drugs"	100,000,000	
Amount approved for "medical drugs"	70,000,000	70% of requested
Total expenditure for "medical drugs"	106,000,000	153% of approved
Supplemental or revised budget for "medical drugs"	106,000,000*	Increased by 36,000,000 KES to compensate for over-expenditure

* Note that this is the revised budget that includes the initial allocated amount and the additional amount that was reallocated from other budget line items.

2. DISBURSED FUNDS DO NOT ALWAYS MATCH THE ALLOCATED FUNDS OR BUDGET

Often what is needed is not what is allocated for commodities, and in some cases, the obligated budget may be sufficient but not fully disbursed. Inadequate disbursement restricts the procurement of health commodities (box 3), which may limit the availability of MNCH commodities. In Nepal, reasons cited for the discrepancies/delays in fund disbursements[1] include:

- Lack of trained staff and physical facilities lead to inefficient reporting and reimbursement procedures, including for donors
- Nonstandardization on financial record keeping and reporting tools and forms (for different donors)
- Delays in timely approval of development programs
- Nonrelease of donor commitments

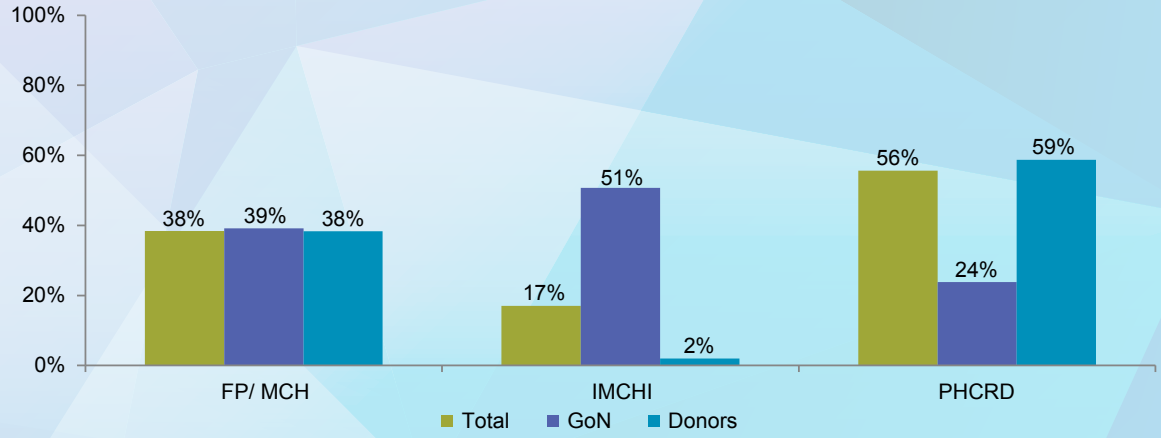
[1] Department of Health Services annual report Fiscal Year 2071/72; dohs.gov.np/wp-content/uploads/2016/06/Annual_Report_FY_2071_72.pdf

BOX 3

DISCREPANCIES AMONG APPROVED, ALLOCATED, AND DISBURSED FUNDS BY THE GOVERNMENT AND DONORS TO MNCH PROGRAMS IN NEPAL

Our analysis of the Department of Health Services annual report shows that the funds disbursed to each division are less than what was approved and allocated—ranging from 24% to 51% for government funds and 2% to 59% for donor funds, depending on the health program. For example, during FY 2014–2015, only 17% of the total allocated budget for the Integrated Management of Childhood Illness program was actually disbursed; 51% of the government allocation was released; and 2% of the donor commitment was disbursed.

Percentage of allocated government of Nepal and donor funds disbursed to MNCH programs, FY 2014–2015



IMCHI: Integrated Management of Childhood Illness
PHCRD: Primary Health Care and Revitalization Division

3. DELAYS IN DISBURSEMENT OF FUNDS SLOW PROCUREMENT AND DISTRIBUTION OF HEALTH COMMODITIES

Delayed disbursements from the national level to lower levels, either county governments or entities within the MoH responsible for making payments, result in longer procurement lead times. In Nepal, where the average procurement lead time is nine months, delays in disbursements could be due in part to challenges associated with expenditure tracking and clearing of expenses that delay the release of funds, and, during the first quarter, is also because of delays in the transfer of signatory authority among the MoF, the MoH, the Department of Health Services, and ultimately the health divisions. In Kenya, county pharmacists indicated that national-level delays in fund disbursements have caused some counties to have outstanding balances with the Kenya Medical Supplies Authority, which slows the procurement process. In Uganda, to reduce payment delays and increase efficiency, the National Bank of Uganda pays suppliers directly to reduce the number of channels through which funds are disbursed, thereby decreasing disbursement delays.

4. COMPLEX PROCESSES FOR BUDGETING AND FINANCIAL REPORTING DELAY AUDITING

All countries met the deadline for final budget approval; however, delays occurred between the approval and disbursement of funds and in the submission of key documents during the budgeting process itself. Despite the timely approval of the budget in Nepal, after delays in disbursement of funds, there were further hold ups in clearing expenditures to release funds for the next quarter, which delayed activities because the health department did not receive all allocated funds (box 4). Amounts that clear the audit are confirmed as expenditures, and questionable costs are marked as "irregular expenses" and do not appear in the final expenditure report unless a clarification is provided to the auditor general's office. The amount can be cleared or denied, and the MoH may be asked to return the funds. This process takes an average of three months, and the next scheduled payment from the pooled fund to the MoH is not made in full until all expenses are cleared.

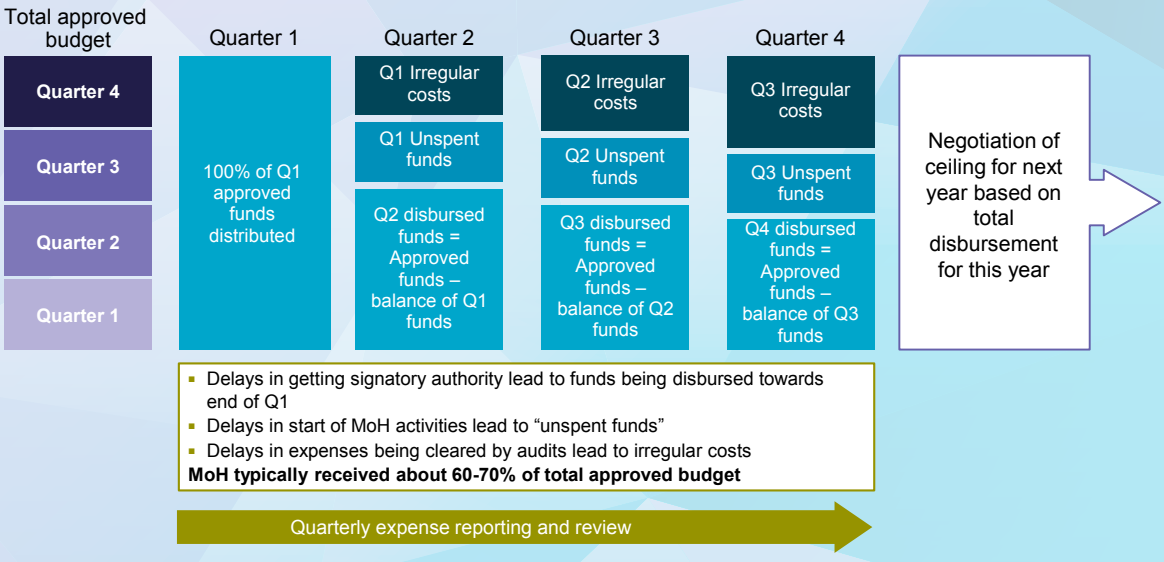
Bangladesh experienced delays in the development of the annual operational plan, which includes an itemized budget with a line item for health commodities. To meet the budget deadline, the country used the five-year program implementation plan that had been previously developed and approved but did not include the most recent commodity forecasts or activity updates.

BOX 4

DELAYS DUE TO REPORTING PROCEDURES ADVERSELY AFFECT THE DISBURSEMENT OF FUNDS FOR THE NEXT QUARTER IN NEPAL

Due to challenges in tracking expenditures and clearing expenses through Nepal's Auditor General, quarterly disbursements are either delayed or not fully received by the MoH. This delay plus the slow release of funds from donors causes funding gaps that can interrupt field-level activities. The figure below illustrates the problem: Every year, 100% of funds are disbursed to each entity in the first quarter; however, in subsequent quarters, the amount disbursed depends on factors such as unused funds from the previous quarter and questionable costs. As a result, the disbursements in the last three quarters of the year are always less than 100% of the allocations.

Delays in expenditure tracking lead to delayed or incomplete release of funds in Nepal



5. MNCH COMMODITY WORKING GROUPS, WHERE THEY EXIST, FAIL TO ADEQUATELY MONITOR AND DO NOT USE THEIR POWER TO INFLUENCE OR ENSURE SUFFICIENT FINANCING FOR MNCH MEDICINES

MNCH commodities have recently become a focus of both local and international scrutiny under the UNCoLSC. Unlike family planning commodities, which have benefited from commodity security working groups for some time, MNCH commodity security working groups are in the early phases of being established and are limited in their advocacy for funding allocation through national and donor funds.

A critical role of MNCH commodity security working groups is to ensure that adequate financial resources are allocated for MNCH commodities, and groups typically include important stakeholders responsible for ensuring access to health commodities, such as MNCH program managers, pharmacists, donors, and nongovernmental organizations. The main objective of an MNCH commodity security working group is to ensure long-term availability of MNCH medicines through timely resource mobilization, including national, donor, and implementing partners and a tentative five-year forecast. Committee functions include monitoring MNCH stock status, reviewing budget allocations and expenditures, and addressing supply chain challenges. The group can coordinate with other stakeholders to standardize processes, guidelines, and information systems to strengthen MNCH commodity quantification, budgeting, and allocated funds, particularly in decentralized systems.

Often, however, countries either lack an MNCH commodity security working group or the MNCH commodities fall under the larger reproductive health umbrella, where they may not be a priority, as is the case in Nepal and Uganda. The MNCH commodity security working group in Kenya is new and not fully established, but its objective is to advocate for additional resources at the national level and to strengthen the capacity of county health departments to budget for, procure, and manage MNCH commodities.

CONCLUSION

One of the most common reasons cited for poor availability of essential health commodities is the lack of financial resources for either allocations or disbursements. In the case of MNCH commodities, the situation is more complicated because countries rarely have commodity security working groups focused on MNCH, as these commodities have not received the attention that family planning and other commodities have. However, the last five years have seen increased attention on improving access to MNCH commodities through the work of the UNCoLSC and, more recently, the Global Financing Facility. The result of more attention to MNCH commodities has been the identification of financing as a major concern; however, little documentation exists on the key bottlenecks in the budgeting process from development and allocation to the disbursement of funds and expenditure tracking.

In our assessments of the budgeting process and financial flows for MNCH commodities in four countries with diverse health systems and structures, we found common challenges that need to be addressed because they potentially limit access to essential MNCH commodities in other countries as well:

- Quantification and forecasting of MNCH health commodities is often not based on evidence. This is a particular issue when

budgeting and procurement occurs at subnational levels. Commodity forecasts from lower levels are often not considered in the budget development process. In addition, quantified needs are frequently much greater than the available budget, and adhering to budget ceilings takes precedence in allocations.

- The allocated budget (both national and donor allocations) may not always be fully disbursed. While the reasons for these discrepancies are unclear, more accountability at the national and donor levels is needed to ensure that programs receive their committed funds.
- National-level disbursements are slow for various reasons, including complex financial processes. Often these financial processes are duplicative and delay payments to suppliers. A more streamlined financial process could reduce delays in procurements and payments.

In conclusion, the root cause of MNCH commodity stock-outs remains the lack of available funding to ensure adequate procurement. Resolving the complex financial processes that add extra time to the disbursement of commodity funds and other bottlenecks in the flow of finances for MNCH commodities may help to facilitate adequate and timely procurement, thereby improving the availability of MNCH commodities in the absence of increased funding.

Similarly, a heightened awareness of the problems caused by reduced allocations and disbursements could lead to greater advocacy and mobilization of additional local and international resources and smarter donor investments.

Resources

Mapping the Financial Flow and Expenditures for Select MNCH Medicines in Bangladesh, 2017

Mapping the Financial Flow and Expenditures for Select MNCH Medicines in Kenya, 2017

Mapping the Financial Flow and Expenditures for Select MNCH Medicines in Nepal, 2017

Mapping the Financial Flow and Expenditures for Select MNCH Medicines in Uganda, 2017