Motivation

Despite large efforts by the government and donors, little updated information was available on the effectiveness of spending in the public health sector.

Objectives

The objective of the second round of the study was to study if and when budgets, material and salaries arrived at the basic facility level based on primary data collected in a nation-wide survey. This information will help decision makers to improve their knowledge on the functioning of the sector and thus to address bottlenecks towards better service delivery.

Main findings

There is low financial capacity and accountability at the decentralized levels: (1) a large number of health centers do not receive the money or equipment they are entitled to; (2) there are reports of surpluses and leakages for all items investigated in the 2007 tracking survey; (3) bookkeeping at the decentralized levels is limited and capacity is low.

Leakage

Overall, there is 15% leakage of total amount of petroleum and registers sent. Averaging across survey rounds, 73% of the commune pharmacies report leakage in the drug supply chain from district to commune levels.

Other findings

-Extensive delays in the distribution of drugs from the central purchasing unit (SALAMA) to the facility-level pharmacies (PhaGeCom). The distribution takes on average one and a half months. There are big delays in payment of dispensers' salaries by communes: 60% of the health centers report irregular payments. Health centers where payments are irregular suffer more from the leakage of antibiotics. Inventory shortages at district and commune levels are mainly problematic for some specific drugs.

-Substantial leakages in the drug supply chain with large differences across drug types. The likelihood of leakages in the drug supply chain increases with drug price. Leakages of antibiotics are especially problematic: half of the basic health centers that ordered these drugs did not receive what they were supposed to receive. Health centers with a more educated director, with a locally-born director, which are of Type I, or are located in remote areas are more likely to suffer from leakages.

Sample

100 health centers

Sample design

Stratified random sample:

-For each the 6 biggest regions (out of 22), 2 districts were randomly selected, giving greater (less) weight to districts with more (less) public primary schools and health centers within the district.

-From selected districts, 3 communes were randomly selected giving greater weight to the communes with more schools.

-Two types of health centers provide basic health care in Madagascar i.e. CSB Type I and CSB Type II. In the selected communes, all public health centers of Type II were visited. If public health centers of type I were present in the commune, one was visited based on random selection.

Resources monitored

Current expenditures, non medical consumable, drugs

2 levels:

-district

-facility level

Implementation problems

The survey collected totals on budgets at SSD level, but there was often ambiguity as to whether this total corresponded to the actual total budget or the total of the line items investigated in the questionnaires. In several cases, the total reported in the questionnaire amounted to less than the total of the line items listed. This suggests considerable problems in the financial capacity at the decentralized levels (and in survey design). In addition, it proved impossible to track resources from MINESAN to SSD level with the available data.

Main report

(2007) "Madagascar Service Delivery in the Education and Health Sector: Results of the 2006/2007 Public Expenditure Tracking Survey," December 31.