Budget Advocacy Network

Save the Children UK

&

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Health Budget Tracking Report

Health Budget Tracking: Sierra Leone

INTRODUCTION

This study uses a health budget tracking tool designed by Save the Children UK. It has two objectives;

1) To track the health budget at both national level and down to district level. Within this we look at how the budget is created as well as how it is then distributed, differences between budget allocations and actual expenditures, growth rates, and the challenges within the process.
2) To test the application of the tool at district level, with the intention to roll out the tracking tool nationwide in 2012.

It is important to note the limitations of this report. The study was carried out on a small scale with the main objective being to test the application of the budget tracking tool in order to learn the best way to apply the tool more broadly in 2012. It is not intended to be an exhaustive analysis of the health budget, particularly at District level.

The report tracks the budget from 2007 to 2012. By adjusting figures according to inflation over that time period it allows us to get an overview of expenditure in real terms for the last five years so we can highlight trends in both the budget and the actual expenditure and monitor the growth rate.

The data collected during the study was both qualitative and quantitative. The qualitative data was collected from health facilities and councils in Bombali District during November 2011, and the quantitative data was collected from the Budget Bureau in the Ministry of Finance and Economic Development, Sierra Leone. All statistical data is from the annual Government Budget and Statement of Economic and Financial Policies, and from the annual Local Government Equitable Grants Distribution Formulae and Annual Allocation publications.

The report is divided in to the following sections:

1. **Executive Summary**

2. **National Data**

    a) % of National Budget Allocated to Health
    b) Allocations and Actual Expenditure
    c) Programme Allocation

3. **Bombali District**

    a) The budgeting process
    b) Funds direct to Peripheral Health Units (PHUs)
    c) Drugs and Medical Supplies
    d) Personnel
    e) Budget analysis

4. **Conclusion**
5. **Recommendations**

1. EXECUTIVE SUMMARY

Although there has been a gradual increase in the Ministry of Health and Sanitation (MoHS) Budget for Sierra Leone from 2008 to 2011, the recent budget statement for 2012 has outlined a significant fall in allocations. This study has tracked the health budget from 2007 to 2012, and in real terms for 2007 prices there will be a decline of 17.5% in 2012.

The Abuja Declaration, which the Government of Sierra Leone committed itself to in 2001, called for 15% of a nations expenditure to be allocated towards health. However, the average allocation from 2007-2012 remains at 8.4%, with 2012 expected to be only 7.4%.

On a more positive note, the actual expenditure for health has gradually increased from 2007-2010, although there were still significant cuts in vital programme areas.

At a district level, Bombali and Makeni Councils' and health facilities within the district have all reported issues with delayed funds and there appears to be some confusion as to what funds they should be receiving. Bombali District is due to experience a substantial fall in funding in 2012 will have to have severe consequences for the level of health care in the district.

Key Recommendations:

- In order to meet the Abuja target of 15%, the Government must consider revising the 7.4% currently allocated to health in 2012, and outline a clear plan as to how it will achieve 15% by 2015.

- Actual expenditures for recurrent costs need to be far closer to the allocated budget to avoid cuts in crucial programme areas. Considering the high fatality rate from malaria, the programme for malaria prevention and control critically requires this funding.

- Communication to District and City Councils must be improved. Specifically councils need to be informed immediately that the 1 million Leone grant they received for each PHU was a one off pilot initiative and when they should expect to begin receiving the PBF. Equally, councils then need to share this information with Peripheral Health Units (PHUs).

- Quarterly allocations need to be distributed on time and the Government needs to look at new methods to ensure this i.e. instead of having to wait for returns from ALL sectors in ALL districts until funds can be disbursed, each sector could instead only have to wait for returns from within each respective sector.

2. ANALYSIS OF NATIONAL HEALTH BUDGET

a) % of National Budget Allocated to Health

For this study the national budget and the health budget was calculated to include the following areas:

Total National:

Non-salary, non-interest, recurrent expenditure
Wages and salaries
Domestically funded development expenditure

Total Health:

Recurrent
Domestically funded development
Transfers to local councils
Wages and salaries

Table 1. % of National Government Budget allocated to Health

Year	National Total Budget (Le'm)	Total Health Budget (Le'm)	% of National Budget
2007	744,239	68,939	9.3
2008	854,568	65,213	7.6
2009	941,174	74,721	7.9
2010	113,834	84,691	7.4
2011	1,371,167	150,988	11.0
2012	1,867,831	138,011	7.4
		Average	8.4

The Government's commitment to the Abuja Declaration calls for 15% of the national budget to be allocated to health. As Table 1 clearly shows, not only is the Government failing to meet this target, but apart from a rise in 2011, the percentage of the budget directed to health has steadily decreased over the last few years and is going to significantly decrease in 2012 from 11% to 7.4%.

b) Health Budget: Allocations and Actual Expenditure

Table 2. Health budget allocations and growth 2007-2012[1]

Year	GDP deflator	Budget Allocation (Le'm)	Real terms Allocation (Le'm) in 2007 prices	Real terms Growth Rate (%)
2007	3,718	68,939	68,939	
2008	4,134	65,213	58,651	-14.9
2009	4,351	74,721.10	63,850	8.9
2010	4,976	84,691.40	63,280	-0.9
2011	5,956	150,988	94,253	48.9
2012	6,599	138,011	77,758	-17.5
			Average medium term growth (2008-2012)	4.9

Table 2 looks at the growth rate of the health budget in real terms for 2007 prices. As this table highlights, although there was an encouraging increase in the health budget in 2011 which brought the average growth over the past 5 years up to 4.9%, annually, the health budget has generally reduced with a significant decrease of 17.5% due to occur in 2012. This could have a drastically

[1] 2011 and 2012 deflator rates estimated using inflation figures given from the MoFED: 2011: 19.7, 2012: 10.6.

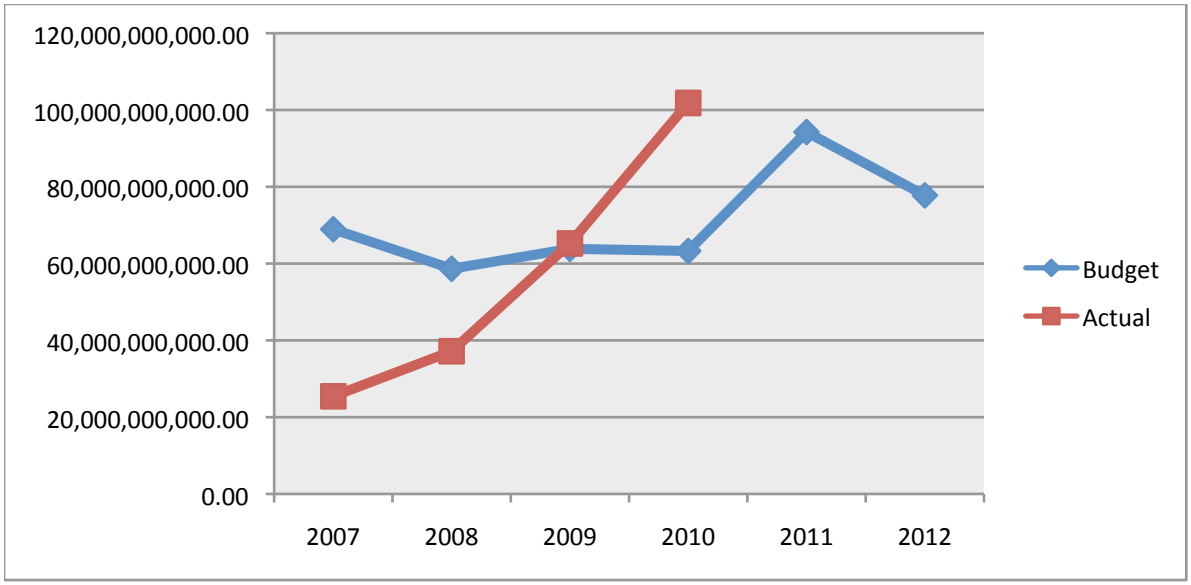
negative impact on health care within Sierra Leone, particularly with the pressure of sustaining the Free Health Care Initiative (FHCI), and goes directly against the commitment to the Abuja Declaration.

Table 3. Health: Actual expenditure and growth 2007-2010

Year	GDP deflator	Expenditure (Le'm)	Real terms expenditure (Le'm) in 2007 prices	Real terms Growth Rate (%)
2007	3,718	25,429	25,429	
2008	4,134	41,328	37,169	46.2
2009	4,351	76,345	65,239	75.5
2010	4,976	136,284	101,830	56.1
Average medium term growth (2008-2010)				59.3

Encouragingly, as table 3 shows, the actual expenditure for health care has been increasing at an average rate of 59.3% since 2007 and in fact, as Figure 1 below shows, the actual expenditure in 2010 far surpassed the budgeted allocation.

Figure 1. National Health Budget: Allocation and Actual Expenditure in Real Terms[2]



In 2007 (the last election year) only 44% of the budget was actually spent, within this, none of the funds allocated for domestic development were disbursed. It is highly likely that this underspend is a direct result of the elections, with the focus being on election issues and possibly a significant withdrawal of expected funds from donors due to investment instability. With the 2012 elections fast approaching it is critical, especially with the increased funds needed to sustain the FHCI, that underspending on this level does not occur again.

In 2008, only 72% of the planned budget was actually spent, significant progress was made on this in 2009 as 95% of the allocated budget was spent, however as shown in section 1.III (Programme Allocation), this still led to drastic cuts in many areas.

[2] Figure 1 uses real term figures in 2007 prices.

A more in-depth look at the actual expenditure however gives us a slightly different perspective on spending patterns. The 2009 budget actually shows an increase in personnel and domestic development between the budget allocation and the actual expenditure, this means the recurrent allocation was more significantly reduced than the 92% suggests; recurrent only received 83% of the original budget allocation:

Table 3: 2009 Health Budget

	Budget 2009	Actual 2009	Variance	% of Budget Spent
	(In Le'm)			
Personnel	18,591.10	19,691.00	-1,099.90	106
Recurrent	**39,809.50**	**33,219**	**6,590.50**	**83**
Dom Dev	880	3,288.50	-2,408.50	374
Total	59,280.60	54,816.00	4,464.60	92

Similarly, in 2010, despite a substantial increase from the allocated budget to the actual expenditure, recurrent costs were still cut:

Table 4. 2010 Health Budget

	Budget 2010	Actual 2010	Variance	% of Budget Spent
	(In Le'm)			
Personnel	18,591.10	63,372.00	-44,780.90	341
Recurrent	**43,525.70**	**28,980.60**	**14,545.10**	**67**
Dom Dev	6,856.00	12,517.28	-5,661.28	183
Total	68,972.50	104,869.88	-35,897.38	152

As a result of this, vital programme areas experienced significant fundings cuts from the 2010 allocated budget:

Table 5. 2010 Primary Health Care: Programme Breakdown

	Budget 2010	Actual 2010	Variance	% of Budget Spent
	(In Le'm)			
Maternal and Child Health/EPI	2994.5	5	2989.5	0.17
School Health Programme	1312.5	46	1266.5	3.50
Malaria Prevention & Control	1674.8	15	1659.8	0.90
STI/HIV/AIDS Prevention & Control	1184.4	58	1126.4	4.90

These cuts to recurrent expenditures will have considerable negative effects on primary, secondary and tertiary health care throughout the whole country leaving facilities unable to provide daily basic care to patients or run preventative programmes to actively reduce morbidity levels. Funds directed to reducing morbidity would clearly ease the pressure on facilities in the long run as less people would require their services.

c) Programme Allocation

This section looks at the distribution of funds within primary health care; programme allocations, how much they actually receive, and how much each respective programme area receives in relation to other programmes.

As mentioned in the above section, primary health care programmes experienced drastic cuts from their allocated budgets in 2010, with none of the programmes receiving over 5% of their allocated budgets. As the figures 2-4 show this has been a common trend over other years as well. 2009 did see an increase in actual expenditure but even this increase left massive shortfalls in many critical areas.

Figure 2. Maternal and Child Health/EPI: Budget allocation and actual expenditure in real terms[3]

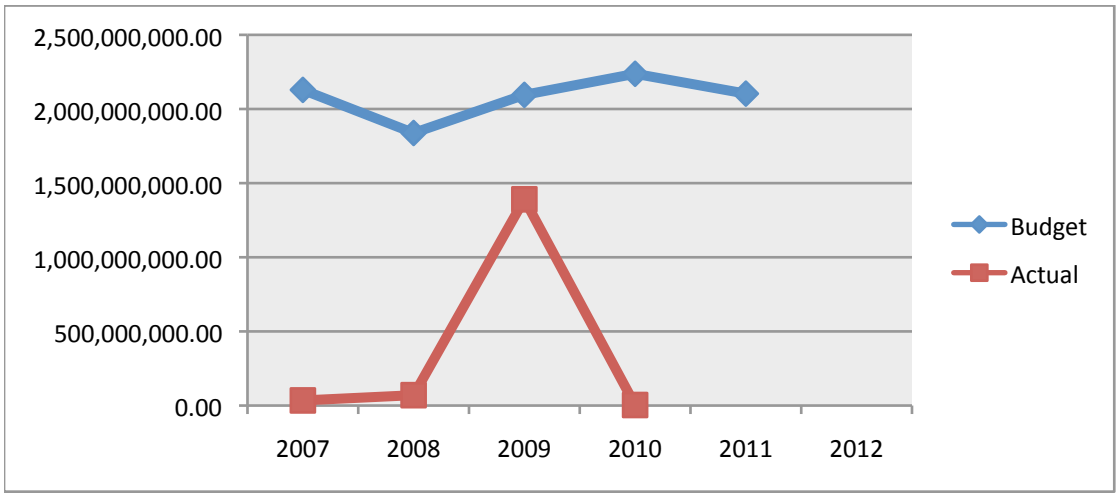
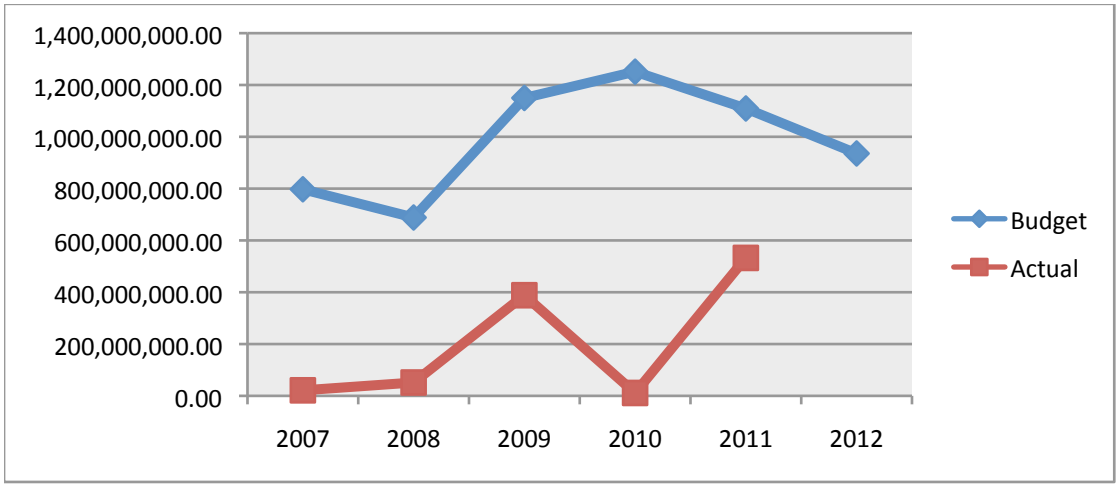


Figure 3. Malaria Prevention and Control: Budget allocation against and expenditure in real terms[4]



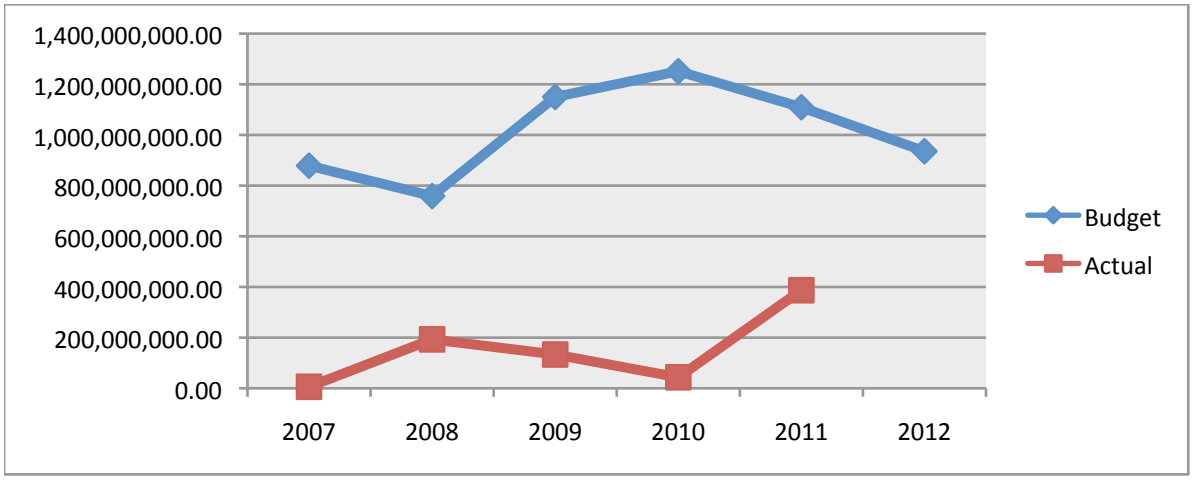
As Figure 3 shows, the allocated funds to the programme for malaria prevention and control have significantly decreased since 2010. On top of this, the actual expenditure for the programme over the last few years has been minimal and although there was an increase in actual expenditure in 2009, the programme still took a large cut as they received only 33.8% of their expected budget. Yet malaria continues to be one of the biggest health risks in Sierra Leone. In 2009 there were 646,808

[3] Figure 2 uses real term figures in 2007 prices. 2011 actual expenditure is an estimate from the 2012 budget.
[4] Figure 3 uses real term figures in 2007 prices

total reported cases of malaria and it was the cause of 29% of deaths among children under 5, thus making malaria the leading cause of death for children under 5 in Sierra Leone.[5]

Figure's 3 and 4 do show a promising estimated increase in actual expenditure for both the malaria and STI/HIV/AIDS prevention programmes. Even if this estimate is achieved however it still leaves a significant shortfall with malaria only receiving 48% the budgeted amount and STI/HIV/AIDS receiving 35%.

Figure 4. STI/HIV/AIDS Prevention and Control: Budget allocations against actual expenditure in real terms[6]



3. ANALYSIS OF DISTRICT HEALTH BUDGET – BOMBALI

a) The Budgeting Process

The budgeting process is comprised from the following procedures:

A budget ceiling is made available to each council; this is decided at national level through use of a formula. The formula takes into account variables such as population, topography, number of PHUs etc. For example, 20 million may be allocated to the MoHS, and then 15 million of this may go to the local councils. Makeni for example may get 3 billion of this and it will be split between primary (e.g. 1 billion) and secondary health care (e.g. 2 billion). (The split between primary and secondary is decided at national level).

A circular is then sent out to the Chief Superintendent in the hospitals and the DMO in the DHMT, asking them to draw up an activity plan and indicative figures using the Budget Ceiling. They use a standard template, which is then sent back to the Council once completed. The Council then looks to see if the activity plan is in line with statutory instruments, government priorities, and the health sector strategic plan, and also that costs are reasonable. Once it is approved at Council level it is sent to the MoHS, the Budget and Finance Committee of the Ministry of Finance (MoFED) approves it and then it has to be passed by Parliament. The final budget will then be announced at a public hearing at district level.

[5] http://apps.who.int/ghodata/?vid=17800&theme=country
[6] Figure 4 uses real term figures in 2007 prices. 2011 actual expenditure is an estimate from the 2012 budget

The budget is divided into quarterly allocations. For example, each quarter the DMO will be told that the funds are available and that they must spend according to the activity plan. In line with this, all DMOs and chief superintendents in hospitals have been trained in financial management. Each district must then send back returns for each quarter to account for the money spent and ensure it is consistent with the activity plan.

Key Challenges reported during conversations with facilities/councils visited:

i) **Inadequate allocations;** all facilities visited reported inadequate funds, the DHMT particularly highlighted the lack of excess funds for emergency activities (Indeed the 2011 Annual Plan for Bombali District only budgeted Le7,031,000 for emergency preparedness.) and the hospital reported that the budget ceiling they received was only 55% of the budget they required.

ii) **Delays in receiving funds;** all facilities reported delays in receiving the quarterly instalments. When the study was carried out we had entered the 4th quarter yet they were still waiting to receive the instalment for the 3rd quarter. The District Council highlighted a key factor contributing to this being that the MoFED has to wait for returns from ALL districts and ALL sectors (not just health) before the next quarter can be released.

iii) **Planning constraints;** sometimes, after the budget activity plan is approved at Council level it can end up being altered by decisions that are made on a national level. E.g. It was decided at a national level that the whole 2nd quarter of Reproductive and Child Health Project (RCHP) funds had to go towards upgrading the Basic Emergency Obstetric and Neonatal Care (BeMONC) centres this year. The DHMT was therefore forced to cancel any activities to which where this money had been allocated. Not only does this affect the ability of districts to accomplish their targets, it may be extremely de-motivating for staff to have their activity plans cancelled.

b) Funds Directed to Peripheral Health Units

The Government is currently introducing a system of Performance Based Financing (PBF), this is extra money given directly to a PHU based on the numbers accessing the facility. For example, for treating children under 5 they get Le300 per patient, for a new patient they receive Le1,000, and for a full immunisation they receive Le6,000. The money is given to the PHU, and staff there may spend it as needed on items such as fuel, stationary, and volunteer stipends.

As a pilot test for this initiative Le1,000,000 was given to each PHU in the country, the PHUs had to account for this money and submit returns for it. A critical issue discovered in Bombali District was a complete lack of communication surrounding this initiative. Both the PHU and Community Health Clinic (CHC), as well as the DHMT and the District Council, were under the impression that this Le1,000,000 allocation was a continuing initiative on top of the PBF and all complained that they had only received this once and were still expecting it to arrive every quarter. This has an enormous effect on their planning, and may have drastic implications for voluntary staff who are expecting to receive small stipends from this money. As many of the clinics rely hugely on volunteers, to lose any of them through this lack of money would have substantial consequences on the service the clinics provide and put even further strain on the budget.

Key challenges:

- Communication between national and district level regarding financial initiatives needs to be much clearer to avoid false expectations.

- Insufficient allocations - the PHU and CHC visited, plus the District Council and DMO, all stated that this money was far too small to cover all the costs it is allocated for – volunteer stipends, fuel, small maintenance issues etc.
- Clear timeframe as to when funds can be expected - now the Le1,000,000 pilot initiative has been completed, clinics need to know exactly when they can expect to receive the PBF and this needs to be delivered on time every quarter.

c) Drugs and Medical Supplies

All facilities and council's visited reported an extreme lack of drugs including basic drugs such as Paracetamol or ACT (for the treatment of malaria). Equally, they all reported problems with the drug distribution system - a 'pull' system should now be in place to ensure facilities are getting the drugs they need, however it appears that most drugs are still distributed on a 'push' system – facilities receive whatever drugs are available.

The following two tables give a brief overview of the severity of the situation in Bombali District:

Table 6. Supplies of Critical Drugs at 3 Health Facilities

DRUG	DATE RECEIVED	QUANTITY	CURRENT STOCK/DATE SUPPLY FINISHED	COMMENTS
PHU (Catchment population: 3,664)				
Amoxycillin	22.09.11	89 syrups	-	Only for children, none for pregnant women
ACT (Malaria Treatment)	22.09.11	42 sachets	Finished: 12.10.11	
Paracetamol	22.09.11	1,000 tabs	End of Oct: 220 left	Only for adults, no syrup received for babies or young children
CHC (Catchment population: 4,173)				
ACT (under 5's)	28.09.11	42 sachets	Finished: 11.10.11	
ACT (adolescents)		21 sachets	Finished: 11.10.11	
Paracetamol	None in stock (for adults or children) since January 2011			
Makeni Government Hospital				
Paracetamol	13.09.11	6,000 tabs	10.10.11: 1,000 left	Only for adults, no syrup for children
ACT	13.09.11	1025 sachets	10.10.11: 325 sachets left	

Table 7. Sample of Bombali Drug Store Inventory as of 02.11.11 (for primary health care)

ITEM	QUANTITY OF STOCK ON HAND	MINIMUM QUANTITY OF STOCK TO HAVE ON HAND
Amoxycillin 250mg caps	0	294,000
Artesunate 50mg + Amodiaquine (for treatment of malaria)	0	95,640
Ciprofloxacin 250mg tabs	0	134,001
Gloves, exam, latex, disposable (all sizes)	0	441,000
Jadell	3,300	60
Ibuprofen 200mg tabs	0	294,000
Oral Rehydration Sachets	0	134,100
Metronidazol 200mg/5ml, Syrup (for	0	26,199

treatment of tetanus for children)		
Paracetamol 125mg/5ml Syrup	0	77,196
Paracetamol 500mg	0	57,000
Phenoxylmethel tabs (penicillin)	0	294,000
Folic acid 5mg tabs	0	92,001

Table 7 shows the vast gap between the required levels of stock and the actual stock they currently have, which is zero for nearly all essential drugs such as those to treat malaria, rehydration treatment for illnesses such as diarrhoea, fevers and measles, basic antibiotics, simple painkillers, folic acid (an essential vitamin for good health during pregnancy) and even disposable gloves to prevent infection. This table also shows how some funds are wasted on supplies such as Jadell where stocks have built up to 3,300 yet they only require a stock of 60. Staff at the drugs store explained that this was a contraceptive implant that no personnel in the district were trained to use.

Key challenges affecting the budget:

- Lack of drugs puts extra pressure on the already inadequate and irregular money that facilities receive as they sometimes have to buy more drugs/supplies from this.
- Extra costs equated with getting rid of expired or unwanted drugs.
- Money wasted on drugs facilities do not use or do not use in such large quantities.
- Inadequate drugs and supplies may lead to exacerbated illness in patients leading to extra financial pressure on facilities.

d) Budget Analysis

Figure 5. Bombali District: Budget and Actual Expenditure[7]

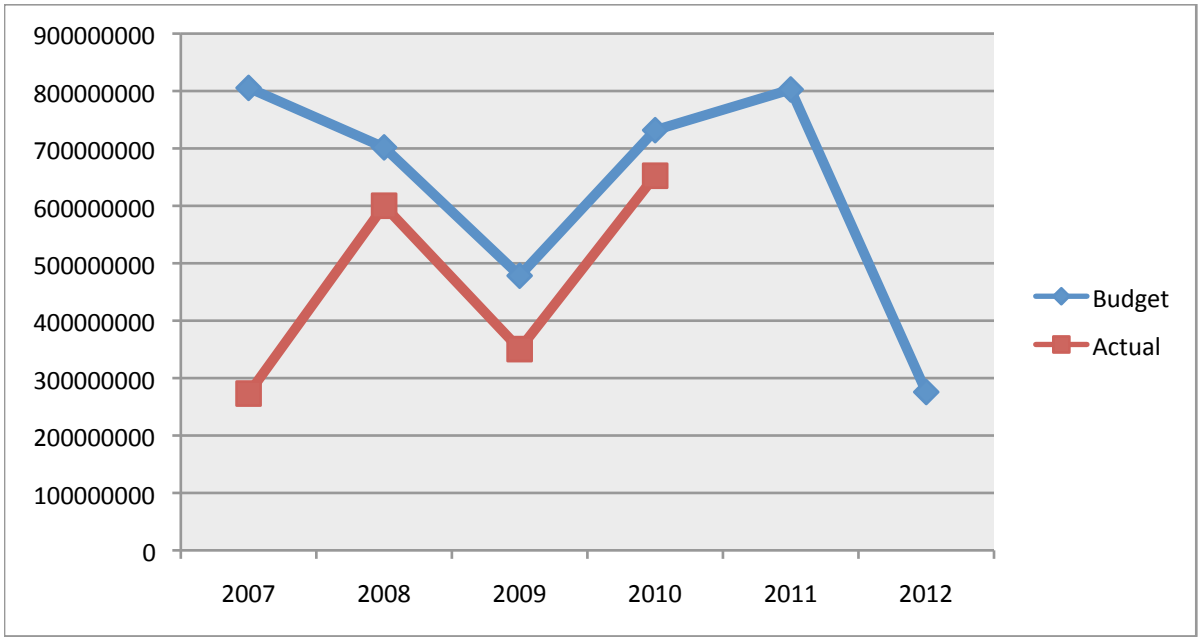


Figure 5 reflects the national underspend in health for 2007. The following three years show a steady trend in terms of allocation against actual expenditure where Bombali District received an average of 83% of the allocated budget with a high in 2010 of 89%. The budget allocation however does not follow a general trend with allocations dropping in 2008 and 2009 and a substantial cut in allocations expected in 2012.

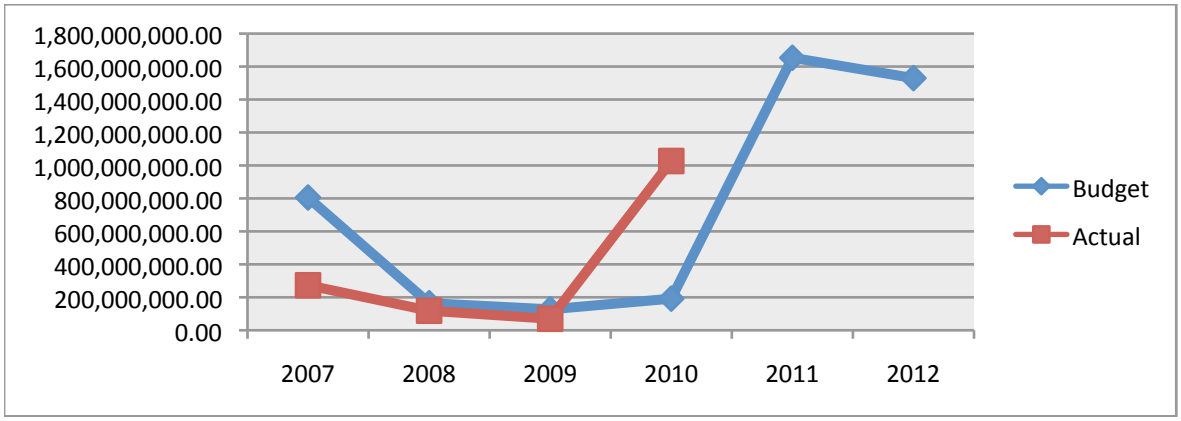
[7] Figure 5 uses real term figures in 2007 prices

Table 8. Bombali District Health Budget: Growth Rate

Year	GDP deflator	Budget Allocation (Le'm)	Real terms Allocation (Le'm) in 2007 prices	Real terms Growth Rate (%)
2007	3,718	805.45	805.45	
2008	4,134	780.38	701.85	-12.86
2009	4,351	559.75	478.31	-31.85
2010	4,976	979.42	731.81	53.00
2011	5,956	1285.88	802.70	9.69
2012	6,599	489.42	275.75	-65.65
Average medium term growth (%)				-9.53

As table 8 shows the growth rate for Bombali District health budget is extremely negative with an average real term growth of -9.53% since 2007 and a highly worrying expected growth of -65.65% in 2012.

Figure 6. Makeni City: Budget against Actual Expenditure[8]



Most significantly for Makeni City, in terms of actual expenditure as reflected in the national health budget, is the vast overspending in 2010; a considerable 535% of the allocated budget. The budget increased substantially in 2011 but, as in line with the national health budget, is due to experience a decline in 2012 in real terms.

Table 9. Makeni City Health Budget: Growth Rate in real terms

Year	GDP deflator	Budget Allocation (Le'm)	Real terms Allocation (Le'm) in 2007 prices	Real terms Growth Rate (%)
2007	3,718	252.77	805.45	
2008	4,134	182.83	164.43	-79.58
2009	4,351	148.67	127.04	-22.74
2010	4,976	256.79	191.87	51.028
2011	5,956	2,648.58	1,653.36	761.72
2012	6,599	2,715.24	1,529.81	-7.47
Average medium term growth (%)				140.59

[8] Figure 6 uses real term figures in 2007 prices

The average medium term growth for Makeni City is slightly deceptive as the budget allocation increased reasonably in 2010 and substantially in 2011, up until this point the budget had shown a steady decline.

4. CONCLUSION

Over the past five years the health budget has repeatedly fallen short of the 15% target allocation the Government of Sierra Leone committed to through the Abuja Declaration. Although there was a reasonable growth of the health budget in 2011, the projected figures suggest there will be a significant decrease in 2012. The actual expenditure however has shown a steady increase between 2007 and 2010 at an average growth rate of 59.3%.

Recurrent expenditure consistently experiences the most severe cuts from the budgeted allocation leaving facilities unable to perform their duties in providing health care and carrying out programmes to prevent disease and reduce morbidity rates.

At district level, Bombali and Makeni are both due to receive a reduced amount of funds in 2012, Bombali District especially will experience a huge reduction from last year and there appears to be no consistent trend in the funding they receive as it rises one year and falls the next. Having such inconsistent funding will make future planning highly difficult.

There is also a worrying level of confusion within the district as to when and how much funds facilities will directly receive.

Following the completion of this study, Save the Children UK intends to continue the budget tracking across the entire country allowing us to look at trends within each district, compare districts to one another, see were the most severe shortfalls occur, and how these challenges can be addressed.

RECOMMENDATIONS

- In order to meet the Abuja target of 15% of the national budget allocated to health, the health budget must increase significantly from the 7.4% allocated in 2012.

- Actual expenditures for recurrent costs need to be far closer to the allocated budget to avoid cuts in crucial programme areas. Considering the high fatality rate from malaria, the programme for malaria prevention and control critically requires this funding.

- Clearer communication to District and City Councils to improve knowledge sharing. Specifically councils need to be informed immediately that the 1 million Leone grant they received for each PHU was a one off pilot initiative and when they should expect to begin receiving the PBF. Equally, councils then need to share this information with PHUs.

- Quarterly allocations need to be distributed on time; need to look at new methods to ensure this i.e. instead of having to wait for returns from ALL sectors in ALL districts until funds can be disbursed, each sector could instead only have to wait for returns from within each respective sector.