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Increasing the Availability of Resources for Health

An Analysis of Madagascar's Planning and Budgeting Process

August 2024

The Local Health Systems Sustainability Project

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

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Acronyms

AWP	Annual Work Plan
BHC	Basic Health Center
CA-CSU	*Cellule d'Appui de la Couverture Sanitaire Universelle* (Universal Health Coverage Support Unit)
DAAF	*Direction des Affaires Administratives et Financières* (Department of Administrative and Financial Affairs)
DEPSI	*Direction des Etudes, de la Planification et du Système d'Information* (Department of Research, Planning, and Information Systems)
HSDP	Health Sector Development Plan
LHSS	Local Health System Sustainability Project
MEF	Ministry of Economy and Finance
MOPH	Ministry of Public Health
MTEF	Medium-Term Expenditure Framework
PPBME	Planning, Programming, Budgeting, and Monitoring and Evaluation
USAID	U.S. Agency for International Development

Executive Summary

With the aftermath of the COVID-19 pandemic, conflicting national priorities, and global economic challenges, it has become more and more difficult for governments to increase their revenues. It has also become more difficult to advocate for greater allocations of the government budget to health, as the health sector is often seen as a resource-intensive sector and not directly contributing to economic growth. At a crucial time when Madagascar needs to increase investment in health—particularly primary health care, financial protection for health and for increasing health system resilience—it will be difficult to increase domestic resources for health in the short term. The Ministry of Public Health (MOPH) must therefore ensure that existing public health resources are fully used and for the best health outcomes.

The MOPH needs more resources to accelerate progress toward universal health coverage. Traditional ways to increase domestic resources, such as increased government borrowing, macroeconomic growth, higher prioritization of health in the budget, and increased donor funding, either take many years to impact the health sector or are not feasible in the short term. Instead, one of the most sustainable strategies to increase resources for health in the short term is to improve the efficiency of health spending through better public financial management.

This report aims to raise awareness about how to improve the Planning, Programming, Budgeting, and Monitoring and Evaluation (PPBME) process to increase resources available for health. It identifies the challenges with each stage of the PPBME process and serves as a tool for continued collaboration within MOPH units to resolve these challenges.

Following a document review and stakeholders' interviews, the challenges identified at each stage of the PPBME process are summarized below:

Planning and Programming

- The inconsistent structures of the Health Sector Development Plan, the Medium-Term Expenditure Framework (MTEF), and the Finance Law prevent a complete analysis of health sector performance.
- Annual Work Plans are incomplete and do not allow the MOPH to budget for all planned activities.
- The MTEF's limited visibility on multi-year spending estimates means that health planning is on a shorter horizon.

Budgeting

- Lack of evidence in the development of MOPH budgets leads to reliance on historical budgets.
- High budget allocation to the central level undermines the integration of community needs and budget execution.
- Budget modifications during the financial year are often linked to political priorities instead of the MOPH's plans.
- Budget allocations lack flexibility to respond to changing MOPH needs.

Monitoring and Evaluation

- Budget monitoring reports do not facilitate the analysis of health sector performance for decision making.
- Lack of visibility on donor spending prevents the MOPH from accurately understanding the resources available.
- Lack of visibility on spending at the health care provider level complicates health sector planning and coordination.

Roundtable discussions involving the three MOPH units key to planning and budgeting helped develop the findings of this report. These discussions identified the challenges of the PPBME process and analyzed their underlying causes. The MOPH also held a roundtable with the Ministry of Economy and Finance and technical and financial partners to develop an action plan for improving the PPBME process, which was being finalized at the time of writing this report. Continued discussions among these stakeholders, led by the three MOPH units, are essential to implement the planned actions and improve the PPBME process.

Introduction

In 2022, the Ministry of Public Health (MOPH) developed a National Health Financing Strategy to accelerate progress toward universal health coverage in Madagascar. One of the objectives of the strategy is to increase per-capita health spending from $18 to $86 by 2030 with further analysis needed to identify the strategies to do this. Traditional sources of increasing revenues and spending for health include (1) additional government borrowing, (2) increased macroeconomic growth, (3) increased prioritization of health in the government budget, and (4) increased external funding (Heller 2005; Tandon and Cashin 2010).

However, several of these sources for increasing resources for health pose challenges for Madagascar. Madagascar's "moderate" risk of debt burden, following recent shocks such as COVID, limits the extent of borrowing that the government has access to (World Bank 2017, 2024). Even with a decent average GDP growth of 4.5% since 2021, relying on macroeconomic growth to increase resources for health takes time and is a process on which the MOPH has little influence. Allocations of the government budget to health, an indicator of the government's prioritization of health, have fluctuated since 2021 and averaged 6.3 percent of the state budget, well below the 15 percent commitment of the Abuja Declaration. Finally, external funding is a volatile source of funding to rely on for essential health services.

More recently, strengthening public financial management is being globally recognized as a more feasible strategy for increasing resources for health (Barroy and Gupta 2021; Cashin et al. 2017). While this strategy does not raise new revenues for health, it increases the resources *available* for the sector. That is, it ensures that government resources already allocated to the health sector are fully used in a way that maximizes health outcomes. By strengthening public financial management through its planning and budgeting processes, the MOPH in Madagascar can not only make full use of its resources, but it will also be able to negotiate a stronger case for more resources to the Ministry of Economy and Finance (MEF).

Strengthening the MOPH's planning and budgeting process is an initiative that puts the control back with the MOPH, rather than waiting for macroeconomic growth to trickle down to the health sector, or to rely on external funding. Strengthening public financial management to improve the use of resources is also in line with the National Health Financing Strategy, which aims to "improve efficiency in the use of resources" (MOPH 2022). Increasing the efficiency of the existing resources already allocated to the health sector presents an opportunity to quickly make more resources available to the health sector and/or to achieve more with those resources.

The objective of this report is to raise awareness among MOPH and other stakeholders about how the Planning, Programming, Budgeting, and Monitoring and Evaluation (PPBME) process could be improved to increase resources available for health. Specifically, the report seeks to identify and document the areas of improvement in the MOPH's application of the PPBME process. The PPBME process is defined by the MEF, and all line ministries and government agencies must use it. However, the MOPH faces specific challenges in its application of the process, and this is the first effort by the MOPH to document the challenges, as a tool for advocating for improvements. The report also serves as the basis of an effective three-way dialogue among the *Direction des Affaires Administratives et Financières* (DAAF, Department of Administrative and Financial Affairs), *Direction des Etudes, de la Planification et du Système*

d'Information (DEPSI, Department of Research, Planning, and Information Systems), and *Cellule d'Appui de la Couverture Sanitaire Universelle* (CA-CSU, Universal Health Coverage Support Unit). The purpose of this dialogue is to continue to analyze these challenges in depth and identify the ways forward. These three entities are key MOPH units involved in ensuring sufficient resources for the health sector and are therefore best placed to steer these efforts. The process of creating this report involved roundtables among these three units, which are necessary to improve the PPBME process for the MOPH.

Methodology

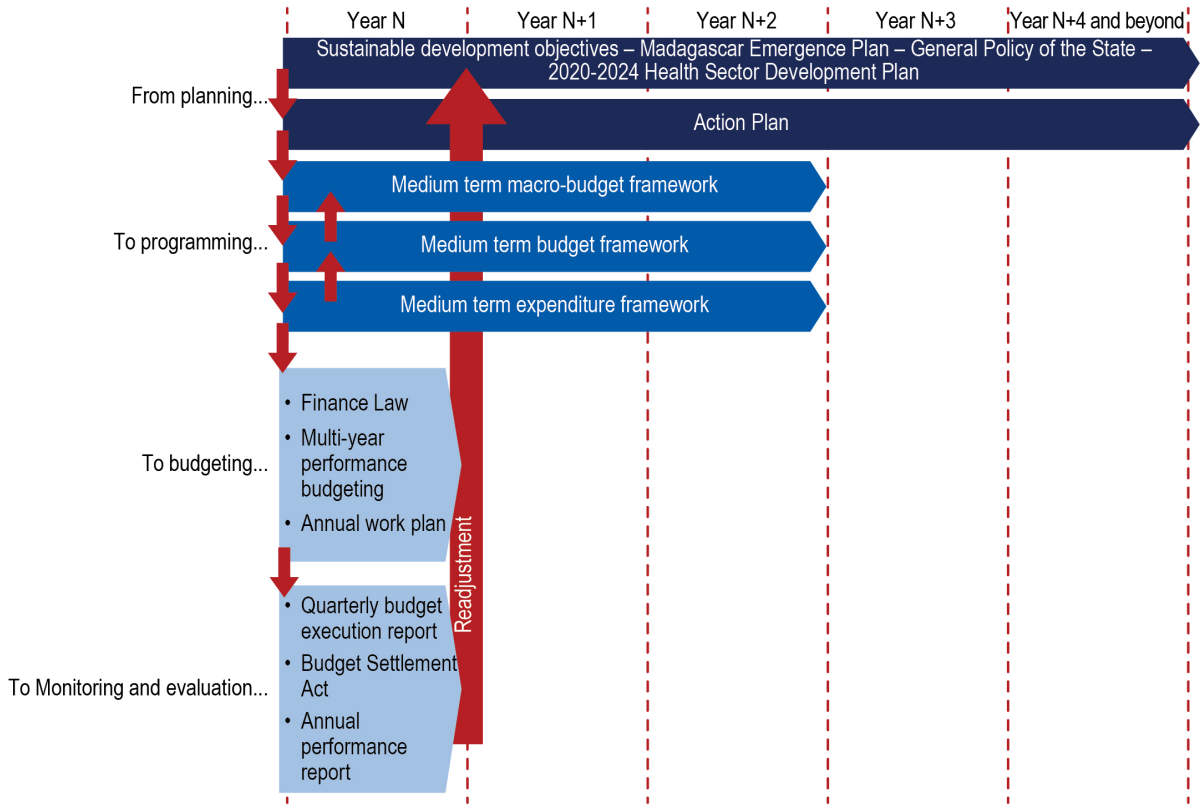
The DAAF, with the technical support of the U.S. Agency for International Development's (USAID's) Local Health System Sustainability (LHSS) Project, conducted a review of key documents related to the PPBME process (see References). The DAAF also conducted interviews with stakeholders at the central and district levels (Appendix A), and two roundtable discussions with the MOPH departments and services most involved in programming and budgeting. These are the DAAF; the DEPSI; and the Resource Mobilization team of the CA-CSU. Discussions have helped identify the challenges of the PPBME process and analyze the underlying causes of the challenges.

Summary of the Planning, Programming, Budgeting, and Monitoring and Evaluation Process

The MEF is responsible for defining the PPBME process and ensuring that all entities receiving government funding apply this process. It is accompanied by several guidelines covering themes such as the development of the MTEF, how to plan and monitor the government budget, and for developing annual work plans (MEF 2018a, 2018b). The PPBME process has four components, some of which are implemented annually and others on a multi-year basis (Figure 1).

1. During the **planning** stage, the government, both at the Presidential and MOPH level, defines its objectives over the long term, which includes strategies each will explore and refine.
2. In the **programming** stage, the MEF sets medium-term frameworks for estimated resources available over three to four years and sets high-level ceilings for spending for line ministries. At the same time, each line ministry defines how its objectives will be operationalized with high-level estimation of resources to achieve them, based on the budgetary constraints set by the MEF.
3. During the **budgeting** stage, the MEF uses the estimations from step 2 and updates these estimates before announcing annual budget ceilings to the MOPH and other line ministries. The MOPH will use this ceiling as a parameter to predict its expenses and revenues for the upcoming fiscal year.
4. The **monitoring and evaluation** phase requires the MEF to produce financial reports throughout the fiscal year on the government's budget performance, and the MOPH to produce programmatic reports. These reports are designed to identify where the MOPH can improve its budget and program performance to help meet its goals.

Figure 1. Summary of the Planning, Programming, Budgeting, and Monitoring and Evaluation Process of the Ministry of Public Health

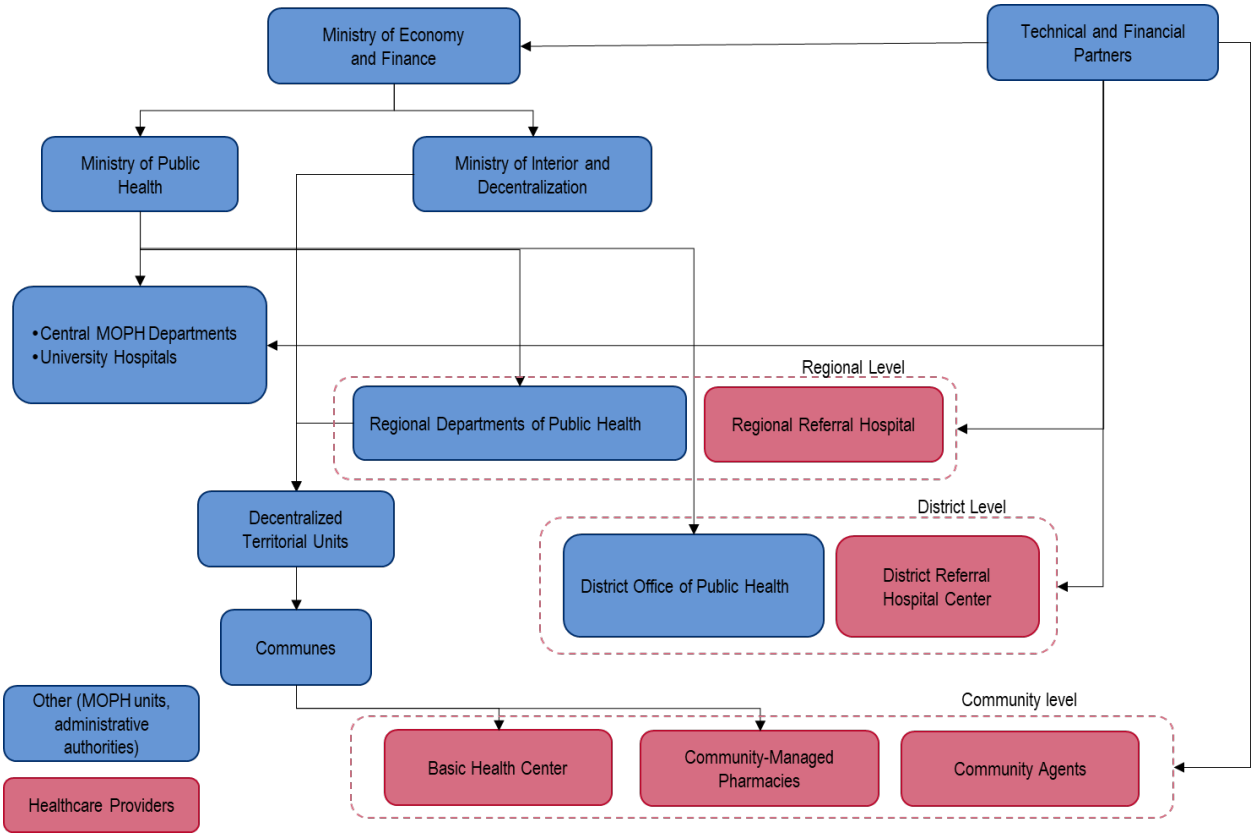


Source: MEF 2017.

Regarding the flow of funds in the health sector (Figure 2), the MOPH allocates funds to its departments and services at the central, regional, and district levels and to general hospitals. The Ministry of Interior and Decentralization transfers lump sum budgets to Decentralized Territorial Communities, which have financial and management autonomy and decide how to allocate these funds to health and other sectors.

The MOPH's basic structures (Basic Health Centers, or BHCs) therefore receive funds from the MOPH (via the Regional Departments of Public Health) and the Ministry of Interior and Decentralization through the Decentralized Territorial Communities and local governments (known as communes). The communes are responsible for managing the budgets of the BHCs and the community-managed pharmacies, under the supervision of a health committee. The technical and financial partners support the health structures through the government budget or assist the health structures directly at the regional, district, and community levels.

Figure 2. Flow of Funds in the Health Sector



Key Challenges in MOPH's application of the PPBME Process

Table 1 presents the objectives, responsible entity, and outputs of each stage of the PPBME process.

Table 1. The Objectives, Key Actors Involved, and Outputs of the Planning, Programming, Budgeting, and Monitoring and Evaluation Process

	PPBME Stated Objective	Level	Responsible Entity	Output
PLANNING (multi-year)	Show the trajectory of the socio-economic development of the nation	National	• General Department of Economy and Planning, MEF	• Madagascar Emergence Plan • General Policy of the State
	Show the trajectory of the development of the sector	Sectorial	• MOPH	• Health Sector Development Plan
PROGRAMMING (multi-year)	Show the allocation of resources in accordance with medium-term priorities	National	• MEF	• Medium-Term Macro-Budget Framework • Medium-Term Budget Framework
	Show the allocation of resources in accordance with medium-term priorities	Sectorial	• MOPH	• Medium-Term Expenditure Framework
BUDGETING (annual)	Show the allocation and execution of resources of the Finance Law	National	• Budget Directorate, MEF	• Finance Law • Multi-year performance preparation
	Show the effective allocation and execution of resources of the Finance Law	Sectorial	• Department of Administrative and Financial Affairs, MOPH • Department of Research, Planning, and Information Systems, MOPH	• Annual Work Plan • Budget • Quarterly budgetary execution report
MONITORING AND EVALUATION (annual)	Show the programmatic results of the country and their impact on the population	National	• General Directorate of the National Institute of Statistics, MEF • Budget Directorate, MEF	• Directory of statistics of the health sector of Madagascar • Quarterly budgetary execution report • Annual Work Plans and monitoring • Settlement Law
	Show the programmatic results of the sector and their impact on the population	Sectorial	• DAAF • DEPSI	• Quarterly budgetary execution report • Annual Work Plans and monitoring • Settlement Law • Annual Performance Report

Planning

Planning spans a long-term horizon (i.e., five to six years). The Madagascar Emergence Plan for 2019-2023 and the General Policy of the State consider health as a key sector (Republic of Madagascar 2019). The Madagascar Emergence Plan for 2019-2023 targets health for all through the following programs: (1) universal health coverage, (2) improvement of the quality of health care for all, and (3) the national community nutrition program (Republic of Madagascar 2022). The General Policy of the State focuses on improving human capital to contribute to sustainable economic growth. The health component of this Policy focuses on building 30 referral hospitals, improving specialized services in Regional and District Hospitals and *Hôpitaux Manarapenitra* (modern, standardized hospitals), scaling up BHCs, and providing specialized services through medical trailers and mobile clinics.

At the sector level, the 2020-2024 Health Sector Development Plan (HSDP) that the MOPH developed translates the government's health sector priorities into more specific objectives.

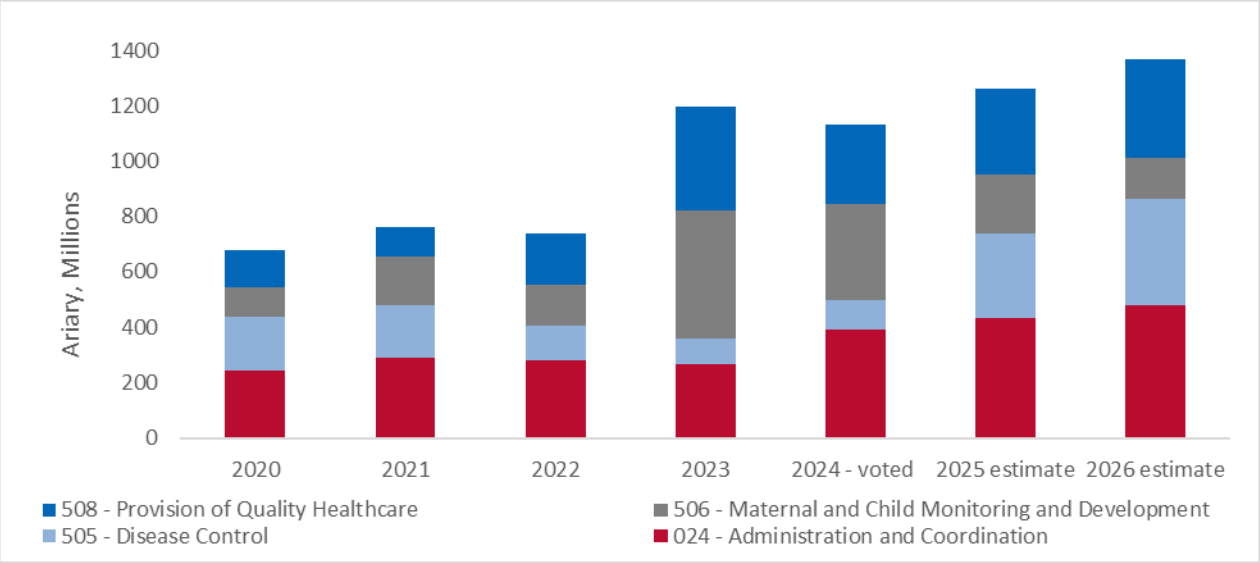
The challenge identified for the Planning stage is closely linked to the Programming stage and is described in the next section.

Programming

Programming envisages a medium-term horizon (i.e., approximately every three years). Programming takes a top-down approach, starting with the MEF, which evaluates the macroeconomic situation and its constraints. The MEF creates the Medium-Term Macro-Budget Framework and the Medium-Term Budget Framework and uses them to set expenditure ceilings for ministries organized around economic programs. The Medium-Term Expenditure Framework (MTEF) is a multi (three) year program of rolling expenses, which reflects how many resources are needed to achieve the high-level strategy of the government, the health sector strategy of the MOPH, and the strategies of all line ministries. It allows "the Ministries to improve the predictability of their budgets and serves as a document for analyzing the future budgetary impact of current policies" (MEF 2018c, 9).

The MOPH contributes to the health section of the MTEF by estimating its needs for the 2020-2024 HSDP. To do this effectively, the MOPH needs to be able to map the sector-specific programs in the HSDP with the economic programs in the MTEF. Figure 3 summarizes the evolution of the MOPH's projected expenditures, as they are defined in the MTEF.

Figure 3. Approved MOPH Budgets of the Finance Law (2020-2024) and Estimated Budgets from the Medium-Term Expenditure Framework



Source: MEF 2024b. Integrated Finance Management Information System; Volume 3: Medium-Term Framework Annexed to Finance Law n°2023-021.

The inconsistent structures of the HSDP, the MTEF, and the Finance Law prevent a complete analysis of health sector performance.

The HSDP on the one hand and the Finance Law and the MTEF on the other are organized by different programs. The Finance Law, explained in more detail in the Budgeting section, is the budget that the National Assembly enacts for the following fiscal year. The HSDP is organized around four health-oriented strategic objectives, broken down into eight strategic orientations and further broken down into many products. The budget for the HSDP, however, is presented by health system pillars and, separately, by health programs (e.g., vaccination, maternal health, child health). By contrast, the Finance Law and MTEF are organized around four economic programs (Table 2).

Without mapping these program groups to each other, the MOPH is challenged to compare the achievement of its HSDP objectives against spending. Being able to compare HSDP program achievements against MOPH spending for those programs would enable the MOPH to understand how effective its spending has been and whether it should reallocate resources. The lack of alignment also makes it difficult for the Health Commission of the National Assembly, which plays a crucial role in advocating for health budgets, to understand how the budget proposed by the MOPH will help achieve the objectives of the HSDP.

In 2023, the MOPH – supported by the LHSS Project – initiated a process to harmonize the programs of the HSDP and Finance Law, to establish a common framework for the objectives, results, activities, and outputs. Until this exercise is fully applied to all the MOPH units, it will remain difficult to compare the budget allocated by MEF with the achievement of the HSDP programs.

Table 2. Programs of the HSDP and Finance Law

HSDP Programs	Programs in the HSDP costing	MTEF and Finance Law Programs
• Strengthen actions on the main determinants of health and an effective response to health emergencies and disasters • Improve the availability and use of quality health care • Ensure the availability and efficient, effective management of resources • Strengthen the institutional framework, leadership, and governance for mutual accountability at all levels	• Human resources infrastructure • Logistics • Financing • Health information system • Governance	• 024 Administration and Coordination • 505 Disease Control • 506 Monitoring and Development of Mother and Child • 508 Provision of Quality Health Care

Source: LHSS 2024.

Annual Work Plans are incomplete and do not allow the MOPH to budget for all planned activities.

The *Annual Work Plan Preparation Guide* (MEF 2018a) describes the purpose of the annual work plan and the template to be used. The MOPH applies this Guide and requests Annual Work Plans (AWPs) of MOPH units from the most decentralized level, the BHCs. At the decentralized level, the AWPs are expected to identify priorities that address the needs of the local community and that align with the HSDP objectives. The AWPs at the BHC level are subsequently compiled at the District Office of Public Health, then at the Regional Department of Public Health, and finally at the MOPH at central level.

However, the absence of an implementation plan for the HSDP means that the MOPH units, or cost centers, at the subnational level prepare their AWPs without a guidance document from the central level that explains how to operationalize the HSDP. The MOPH has been conducting the AWP development exercise since 2006, but a low percentage of MOPH units actually prepare their AWPs. Consequently, in the budgeting phase the central MOPH lacks a complete vision of the activities of all its units. Thus, the MOPH cannot assess how the compiled AWPs will result in the achievement of the HSDP objectives, and therefore which activities in AWPs should be prioritized for the budget.

Interviewed stakeholders mentioned several factors contributing to the incompleteness of AWPs, including a lack of appreciation by the cost centers of the importance or role of AWPs, a lack of capacity of the cost centers to complete the AWPs, and the lack of monitoring and support from the District Offices of Public Health and the Regional Departments of Public Health. The tendency toward centralized decision making (see Budgeting section) has also left cost centers viewing the AWP development process as futile.

Moreover, the ongoing initiative to digitize AWPs (e-AWP) to better centralize them in real time has not yet been fully completed. UNICEF supported the MOPH in 2023 to launch the e-AWP entry tool and trained some (1) monitoring and evaluation teams and (2) financial and administrative teams at the regional and district levels. DEPSI has already organized additional training at the central, regional, and district levels, and the e-AWP has been tested in some districts but not yet in the BHCs. A lack of resources has slowed down the MOPH initiative to operationalize the e-AWPs. So, while the tool is functional and some cost centers have used it for the 2025 planning exercise, many still do not have access to the e-AWP tool.

The MTEF's limited visibility on multi-year spending estimates means that health planning is on a shorter horizon.

Every year, the MOPH must update its estimates of the resources it will need over the next three to four years, which feeds into the MTEF. This ensures that rolling updated three-year estimates are available every year. The MEF usually adjusts these estimates to be compatible with the macroeconomic conditions and with the government's budgetary objectives.

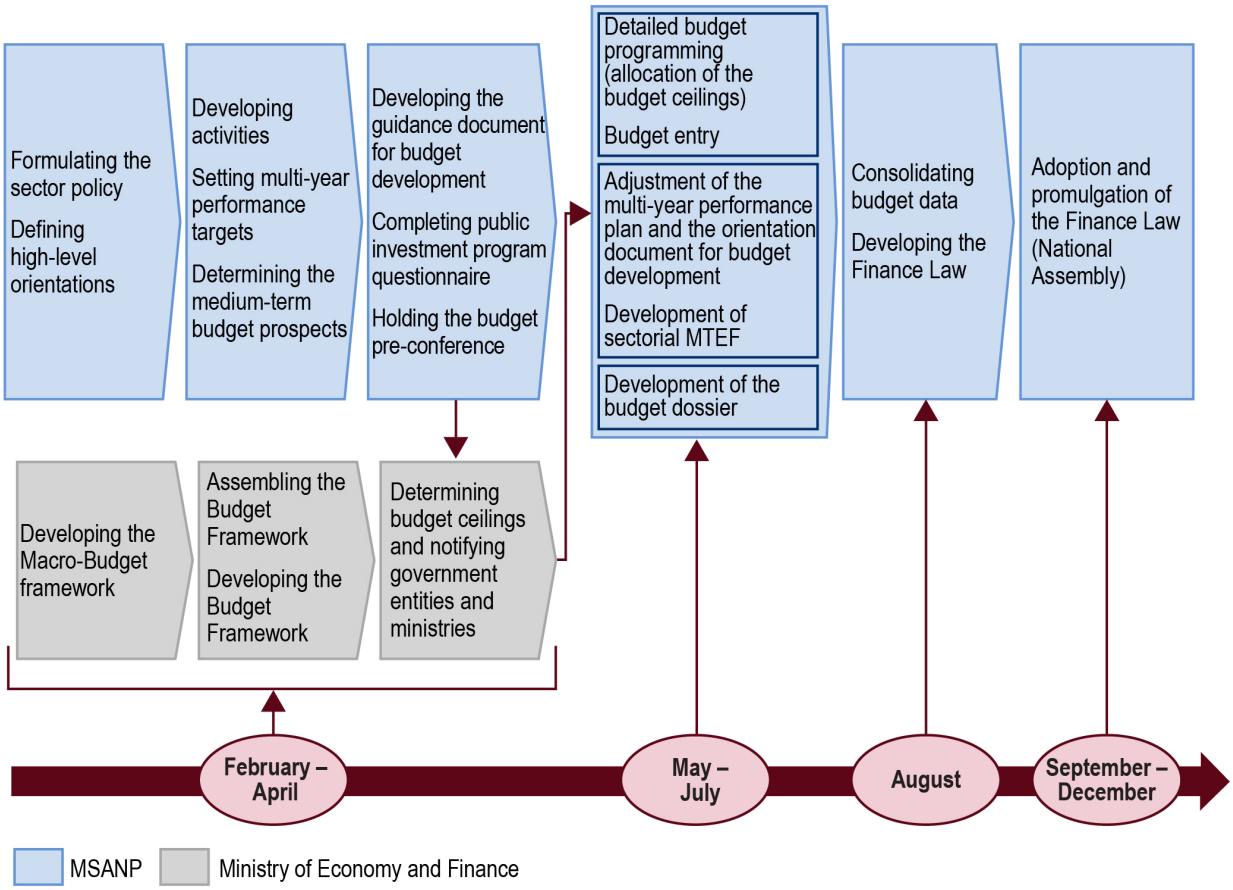
Each year the MEF must provide its revised MTEF to line ministries. The updated MTEF indicates to line ministries how many resources the government estimates will be available and, therefore, a fairly accurate indication of the line ministries' budget ceilings for the following three years (Figure 4). However, at the time of updating the Medium-Term Budget Framework and MTEF each year, the MOPH only has access to the ceilings for the next year and not for the subsequent years. Consequently, the MOPH develops its estimates of health sector needs over the medium term only with the information on the next year's budget ceiling, but without transparency on the MEF's estimated trajectory of the MOPH budget ceiling over three to four years. This means that the MOPH prepares its annual budget without full visibility, potentially leading to producing unrealistic estimations of its needs, which must subsequently be revised downward in the future.

The MOPH also encounters challenges in including the multi-year maintenance costs for major investment projects because the latter are often not considered in the revised MTEF. Consequently, though there is a lot of support for investments, either the initial capital costs are not sufficiently funded or the necessary maintenance costs are not funded.

Budgeting

Figure 4 summarizes the annual budgeting cycle, which is conducted between February and July of each year, and the roles of line ministries and the MEF.

Figure 4. Summary of the Budget Development Process



Source: MEF 2015.

The annual budget preparation process begins in February each year. It is triggered by the announcement of the budget ceilings for each ministry by MEF. At the MOPH, the DAAF is responsible for coordinating and compiling inputs from various units within the MOPH for the preparation and submission of the budget dossier to the MEF, in close collaboration with the ministry's leadership, DEPSI, CA-CSU, and other departments.

Around May, the MOPH updates its programming documents, such as the MTEF and HSDP. It uses the updated MTEF and HSDP, the compiled AWPs available, and performance reports of the previous year to define needs for the following year, through a consultative process. The MEF produces a high-level quarterly Budget Execution Report, which the MOPH can also use during its budget preparation.

The DAAF facilitates internal arbitration within the MOPH to comply with the budget ceiling allocated by the MEF. After the MOPH submits its budget to the MEF, the MEF makes adjustments to adhere to the overall budget framework and notifies sector ministries of the budgets that will be presented to the National Assembly.

Lack of evidence in the development of MOPH budgets leads to reliance on historical budgets.

The MOPH develops its MTEF based on documents such as the General Policy of the State and the HSDP, and each year the MOPH aligns its budget estimates on these documents. To develop the annual budget, the MOPH requires information such as a detailed analysis of the budget performance for the previous year and the progress made with programmatic achievements. However, the MOPH only has access to limited budget execution data when preparing the annual budget proposal.

Additionally, the MOPH's technical performance reports from the previous year, such as the Annual Performance Report, are not ready on time. For example, at the time of preparing this analysis in July 2024, the 2022 Annual Performance Report had not yet been validated. Consequently, the budget is drafted without validated information on what was achieved with the previous year's budget, and the budget is established by default, mainly based on historical data.

The budget calendar has also been cited as another challenge in the budget preparation process. Ideally, the schedule for the preparation of the Finance Law should allow for the exchanges between the MEF and the line ministries and for internal MOPH discussions. A "budget schedule is defined each year, but it is not systemically respected. In particular, no budget circular was issued by the MEF during the health crisis of 2020, and all the decisions related to the budget development were made directly in consultation with ministers. Between the time when the initial MTEF is developed and when budget negotiations take place, the MEF has not notified the ministries and institutions of any spending ceilings" (MEF 2021). Though the height of the COVID-19 pandemic required extraordinary procedures, even in normal times the timeframe given to the MOPH does not allow for a collaborative process for a realistic budget formulation. For example, in 2023, after the announcement of budget ceilings, the deadline granted to line ministries for their 2024 budget submission was five days. This deadline is not sufficient for ensuring the adjustments and internal decisions required within the MOPH, even if it begins its preparatory work in advance.

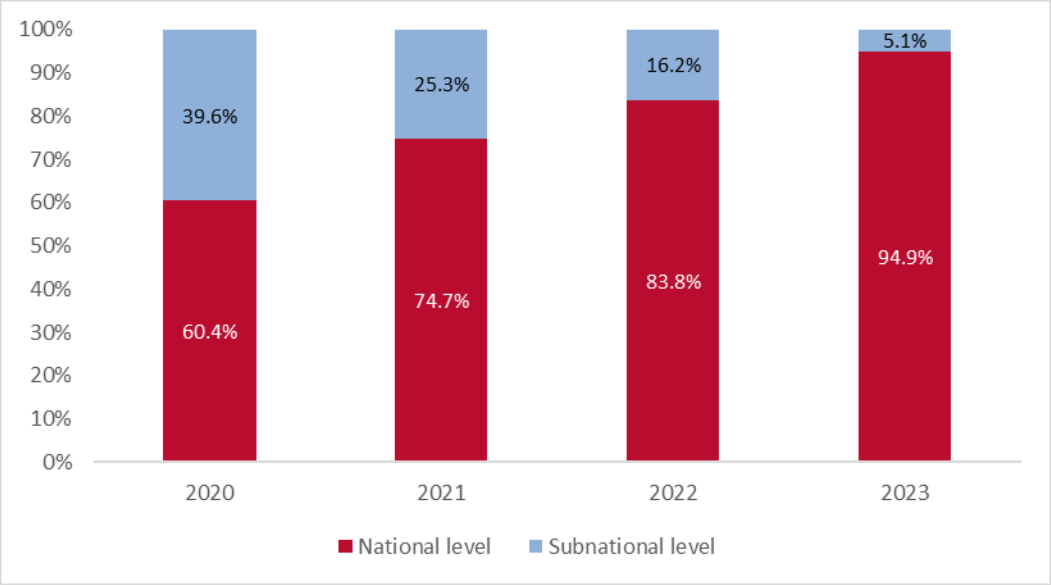
High budget allocation to the central level undermines the integration of community needs and budget execution.

The AWPs developed by the BHCs are based on local stakeholder engagement and incorporate community needs. Despite these efforts, the budget decided by the Council of Ministers often ends up with priorities that are not aligned with those defined in the AWPs. The *2018-20 Public Expenditure and Financial Accountability* report for Madagascar highlights that the process itself of "budget preparation has been heavily centralized at the MEF and the Presidency since 2019" (MEF 2021).

In addition to the centralization of budget formulation, the budget allocations are also becoming increasingly centralized. The proportion of the MOPH budget allocated and managed by the regional and subnational structures was reduced from 40 percent in 2020 to 5 percent in 2023 (Figure 5) (MOPH 2023b). On average, between 2020 and 2023, 81 percent of the MOPH's budget was allocated to the central level. This could be explained by the fact that the central level manages the budgets for large infrastructure projects, paying salaries and large

procurements such as for medicines. For salaries, centralizing the management of personnel and payroll helps reduce delays in processing staff movements.

Figure 5. Distribution of the MOPH Budget at the Central and Subnational Levels



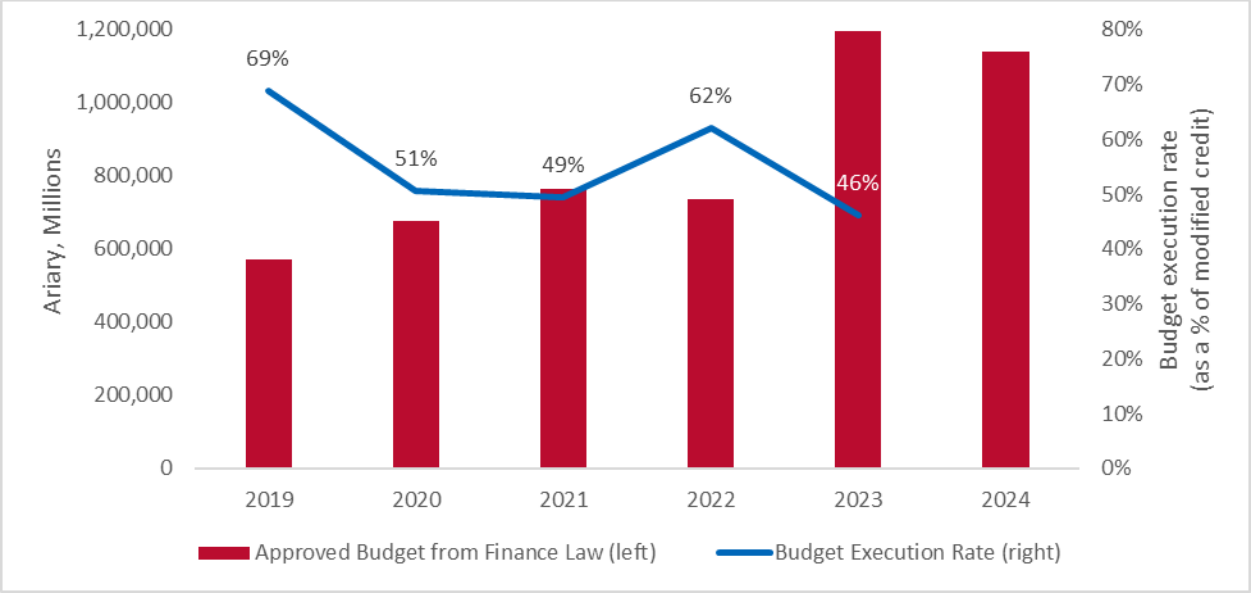
Source: MOPH 2023.

The MEF justifies this strong trend toward centralization by citing the subnational level's lack of capacity to manage larger budgets. However, no initiatives are in place to build the capacity at the subnational level to manage larger budgets. This trend of reducing the budget share managed by the subnational level contrasts with practices in many other countries, which are moving toward decentralized planning and budgeting, with budgets increasing allocations to decentralized entities for more autonomous decision making and responsiveness to local needs (Thinkwell and World Health Organization 2022; World Health Organization 2022).

The budget execution rate at the central level averaged 55 percent between 2019 and 2022, meaning that almost half of its budget was not used. Meanwhile, the execution rate at the subnational level was 80 percent. The low execution rate at the central level may be partly due to lengthy public procurement procedures. Nevertheless, the centralization of budget allocation negatively affects budget execution for MOPH overall because funds cannot be reallocated quickly to meet changing needs or to move unused budgets to entities that need more funding and have the capacity to execute. Overall, the MOPH experienced a declining budget execution rate, from 69 percent in 2019 to 46 percent in 2023 (Figure 6). In addition, the Budget Execution Report of the fourth quarter of 2023 concludes that "the lowest commitment rate was observed in the health sector" (MEF 2024a).

The centralized process for budget formulation and for budget allocations have contributed to a perception by subnational-level stakeholders that the planning and budget process is undervalued.

Figure 6. Approved Budget from Finance Law and Budget Execution Rate, 2019-2024



Source: Integrated Financial Management Information System.

Budget modifications during the financial year are often linked to political priorities instead of the MOPH's plans.

The *2018-20 Public Expenditure and Financial Accountability* report (MEF 2021) cites, and the MOPH confirms, significant differences between the Finance Law's approved budget and budget expenditures due to factors outside of the MOPH's planning. Additionally, the justifications for these differences are not always transparent. For example, new initiatives or investment projects (such as hospital construction or the establishment of new financial protection schemes) may be added during the year without cost estimations or an analysis to understand their financial impacts. This budgeting process can therefore become demotivating for the MOPH, as the needs defined in the HSDP are often overridden by political priorities. Furthermore, these changes contribute to budget instability and disrupt the budgeting process, especially when there is a significant and unjustified divergence between the initial budget from the Finance Law and the revised budget during the year.

Budget allocations lack flexibility to respond to changing MOPH needs.

In public financial management, there is often a tension between the flexibility that the MEF accords to line ministries versus the controls that MEF requires to ensure proper use of government resources. The MOPH prioritizes flexibility because of the specificity of health sector needs. For example, the health needs of the population can be highly uncertain, both in terms of volume and in terms of geography. Secondly, a small group of the population (20%), for example children under five and pregnant women, tend to represent a large proportion of the health spending of the population (80%) (Cashin et al. 2017).

By contrast, the MEF requires that specific activities or outputs be defined up front in the budget, and the funds allocated to each activity are fixed to allow the MEF a level of oversight

and control. For example, the reallocations of budget lines of more than about $44,000 ($MGA 200 million) must pass through the Council of Ministers, which slows down the MOPH's ability to react to urgent needs. For the same reason, the MEF does not allow budget lines for "miscellaneous" or unforeseen expenses.

In Madagascar, this balance tilts significantly toward control rather than flexibility. As a result, it prevents the MOPH from quickly reallocating its budget to respond to urgent needs, while funds allocated to another budget line remain unused.

Monitoring and Evaluation

There are staff in charge of budget monitoring in each department of the MOPH. The DEPSI Office of Monitoring and Evaluation has the mandate for monitoring and evaluation of the entire ministry. However, this office is not operational, which has led to each health program conducting its own monitoring and evaluation in parallel. The monitoring and evaluation process within MOPH is meant to be bottom-up, from the BHCs, which develop monthly activity reports. The District Offices of Public Health compile the BHC reports and enter them in DHIS2[1]; following which Regional Departments of Public Health consolidate the financial and technical reports and submit them to the central level. The MOPH is required to prepare a multi-year programmatic performance report annexed to the MTEF and an annual programmatic performance report (the Annual Performance Report), which is attached to the Finance Law of the following year.

Budget monitoring reports do not facilitate the analysis of health sector performance for decision making.

The MOPH's Annual Performance Reports are expected to highlight the results achieved under the HSDP, which can then be compared with budgets spent to achieve those results. This type of comparative analysis should guide MOPH program managers in reallocating the budget to meet objectives or make other necessary adjustments. However, the Annual Performance Report "focuses more on activities than outcomes. The program-based budget is still not fully functional, as most performance indicators remain activity-based rather than outcome-based" (MEF 2021). More important is that these Annual Performance Reports have not been available since 2021 due to a lack of regular monitoring or supportive supervision of cost centers' achievements. Consequently, during budget negotiations with the MEF, the MOPH is unable to (1) know whether expenses were sufficient or effective to achieve the results and (2) demonstrate the impact of government funds on health results.

Lack of visibility on donor spending prevents the MOPH from having full visibility on resources available.

A major challenge is the lack of reporting on the allocation and use of donor funding recorded in the government budget (MOPH's) and the programmatic performance of this funding. The IT system in the Prime Minister's Office, which is used to compile reports on expenditures from external financing, stopped functioning in 2022. Additionally, the dissolution of the MEF's Monitoring and Evaluation Directorate means that quarterly reports on the execution of technical

[1] DHIS2 is a software platform for the collection, management, visualization, and analysis of health data.

and financial partner funding are no longer produced. During the COVID pandemic, this department was dissolved because the Prime Minister's Office had centralized the management of COVID funds.

Since 2022, these monitoring and evaluation channels have not been replaced, which has caused a gap in the reporting of budgets and expenses of partners. The MTEF cannot fully account for the financial support from technical and financial partners, meaning that the MOPH is unable to program activities with a clear understanding of the total amount of resources available.

Lack of visibility on spending at the health care provider level complicates health sector planning and coordination.

Government transfers to regions and communes follow "relatively transparent mechanisms and precise, specific rules" (MEF 2021). However, the MOPH reports a lack of visibility on actual expenditures. The Integrated Financial Management Information System is available from the central level down to the district level, but the subsequent funding flows, such as spending of government funds by the communes (recall Figure 2), are recorded manually. As a result, the MOPH lacks confirmation of when, how much, and how funds are disbursed to BHCs.

Often, the funds are not even distributed to BHCs due to reasons such as (1) the lack of personnel and capacity, as many communes only have a Mayor and a Communal Treasurer; (2) exorbitant expenses rejected by communes; (3) absence of suppliers in isolated areas; and (4) absence of supporting documents to justify expenses.

Additionally, the existence of multiple reporting tools required by each technical and financial partner results in a burden on subnational-level actors such as BHCs, while supportive supervision from the District Office of Public Health and Regional Department of Public Health remains limited.

Conclusion

The proper management of public finances is now widely recognized as a potential strategy for increasing resources effectively available for the health sector. Strong planning and budgeting are key practices that will enable the health sector to not only use all the resources allocated to it but also spend those resources in a way that maximizes health outcomes. By improving budget execution, the MOPH could access resources more rapidly than relying on the "trickle-down effect" of macroeconomic growth. This approach also offers the MOPH a proactive opportunity to demonstrate to the MEF its judicious and impactful use of government resources. Public financial management initiatives, such as strengthening planning and budgeting, should be integrated into the national health financing strategy to increase resources available for health.

All line ministries must follow the PPBME process, which is defined by the MEF. The MEF has developed several in-depth guidelines to support the line ministries in preparing the documents required for the PPBME, such as the MTEF, AWPs, and the budget dossier. The MOPH has also, for its part, developed clear reference documents for the sector, such as the HSDP and the national health financing strategy. The MOPH is also implementing promising initiatives such as e-AWPs and the alignment of its HSDP and AWP programs with those of the Finance Law and the MTEF.

Notwithstanding these initiatives, there remain several opportunities for the MOPH to strengthen how it applies the PPBME process; for example, (1) engaging in evidence-based planning and budgeting that demonstrate the value of investing in health in order to reduce the possibility of outside interference in budget allocations; (2) strengthen collaboration between MOPH actors at national and subnational levels, including the provision of more supportive supervision to help cost centers develop plans and budgets; and (3) advocate to MEF for greater flexibility of MOPH budgets, especially at the subnational level, that is accompanied by the necessary capacity strengthening.

This report synthesizes the current challenges encountered by the MOPH in the PPBME process to raise awareness among authorities and stakeholders about the opportunities to improve planning and budgeting, thereby contributing to making more resources available to the MOPH. The analysis of the challenges in this report was conducted in collaboration with the entities responsible for planning and budgeting, including DAAF, DEPSI, and CA-CSU. These stakeholders have subsequently identified recommendations to address the challenges mentioned in this report, and developed an action plan to implement these recommendations. The ongoing collaboration between these three MOPH teams will be a key factor in successfully strengthening MOPH planning and budgeting.

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Appendix A: Institutions Interviewed for PPBME Analysis

Central Level

- Department of Administrative and Financial Affairs
- Secondary Authorizing Officer of the Preventative Medicine General Department
- Project Coordination Unit
- Technical Working Group of the Sub-Committee of Health Financing

Subnational Level

- Regional Department of Analamanga Health
- Regional Department of Itasy Health
- District Office of Public Health, Manjakandriana
- District Office of Public Health, Miarinarivo
- District Office of Public Health, Arvonimamo
- Manjakandriana Basic Health Center
- Ampefy Basic Health Center
- Manalalondo Basic Health Center