EXPENDITURE TRACKING SURVEY IN SENEGAL: THE HEALTH SECTOR

A. INTRODUCTION

1. The health sector is among the priority sectors for the Government of Senegal (GoS) as stated in its PRSP 2002. For the last five years, many countries have increased allocations to priority sectors with little or no impact on outcomes. Senegal belongs to this group. Indeed, the public expenditure reviews conducted by the government in 1998 and 1999 reveal that the budget of the ministry of health (external funding included) has increased at a steady pace, from 29 billions in 1995 to 47 billions in 1999, a 12% annual increase rate.[1] This trend is reinforced today in the era of PRSPs the health budget from the government in 2003 has been voted at 35 billions from 30.5 billions in 2002. Outcomes such as infant or maternal mortality, access to health services, immunization rates, or the rate of deliveries assisted by a qualified medical staff, have improved but at a much slower pace during the same period. There is therefore a weak correlation between budgetary allocations at the central level, and outcomes at the grass roots.

2. Two reasons can be thought of to rationalize this disconnect between allocated public resources and outcomes. First, there might exist some delays and leakage in the system. Delays will hamper service delivery and have a bad impact on outcomes, because if resources are received late in the fiscal year, the beneficiaries cannot absorb them all. The adverse effect of leakage is more straightforward to grasp, indeed the fact that resources are diverted during their transit, means that allocations as recorded in the central budget do not really reflect the "true" level of resources in the sector. Outcomes are expected to be correlated with that true level of resources the sector gets, and which is to date unobserved in most developing countries. Second, even in the absence of delays and leakage, worse outcomes than would be expected can be a consequence of mismanagement or just inefficient use of resources at the service delivery point. The reality certainly lies somewhere in between these two extreme scenarios, each reason being part of the story.

3. The purpose of this study is to try and assess quantitatively the separate roles of delays and leakages, as distinct from inefficient service provision in Senegal. Although data has been collected to address both reasons each in its own right, the focus here will, however, be on delays and leakages. To that end, a tracking expenditure exercise has been conducted. In Senegal, this exercise has been designed to track public funds, from their origin to their destination and analyze how each hierarchical administrative step influences the size and the celerity of the traveling amount of resources. The questions we intend to answer are: 1) what percentage of the initial amount that left the central level reaches the final beneficiary, 2) how long does it take to that resources to reach its final destination. Answering these questions will in turn help to inform policy for an improved

[1] See Plan Stratégique « Pauvreté Santé », October 2001

budgetary system. Enhancing the efficiency of the system of resources flows is paramount in the era of PRSP during which more resources will be injected in the priority sectors. Indeed, if no relation between allocations and outcomes exists, the rationale for increasing priority sectors' budgets vanishes, since more resources would be put in a leaking bucket. Fixing the leak in the system is therefore a prior action, that can be well taken once bottlenecks and holes have been clearly identified.

Tracking methodology and sample

4. The methodology of the study involved surveys of government officials at each decision point in the transfer of health resources, to measure the flows of funds passing through the relevant stages and the amount of time taken at each stage. In sum, the surveys provide information on the flow of funds from origination to destination. In the investigation, the surveys were set at two levels.

5. At the central level, the survey was comprehensive in the sense that questionnaires were administered to each administrative level involved at a given point in the system of transfer of public funds from the central level to health structures.

6. At the periphery, a sampling strategy has been devised. Ten districts and 100 health centers have been sampled and administered comprehensive questionnaires. A stratified sampling methodology has been used. First, five regions have been randomly selected, then in each region two departments have been chosen. Within each department 10 health posts and one district have been selected for interviewing. The sample must be representative at the urban/rural level nationally. The list below presents regions and departments in which the survey has been carried out. Selected regions are underlined and selected departments are underlined and in bold. The list of all facilities is given at the end of the document.

Dakar: **Rufisque**, Dakar, **Pikine** and Guédiawaye
Saint-Louis: Dagana, **Saint-Louis,** and **Podor**
Tambacounda: **Bakel**, Kédougou, and **Tambacounda**
Thiès : **Mbour**, **Thiès,** and Tivaouane
Kaolack: Kaffrine, **Kaolack,** and **Nioro du Rip**.

8. In 1996 the GoS launched decentralization reforms that transferred nine responsibilities namely: (i) land use, (ii) environment, and natural resources management, (iii) population, health, and social action, (iv) youth, leisure, and sports, (v) culture, (vi) education, (vii) planning, (viii) land development, and (ix) urbanization and habitat, to the local governments. To compensate local governments for the transfer of these responsibilities, the central government also transferred resources to the local governments, in this process most of the budget for the functioning of the health centers budget is now managed by local authorities. The local governments are therefore a central part of this study and needed to be interviewed. A total of 37 local governments

are included in the sample. It is worth stressing that local governments have been included on the basis of the sampled districts and facilities. All local governments managed the funds of at least one district and/or facility in the sample.

9. There are three types of local administrative units, (i) the region, (2) the commune, and (3) the rural communities. We will sometimes use the generic name of communes to name local administrative entities. Because the administrative decentralization did not take into account the already existing decentralized health system, a set of health posts that are managed by a single district may belong to different communes. This can be the origin of frictions and conflict. Indeed, the district is the direct hierarchical unit above the health posts, giving training, supervising, etc, but the financing part rests on the hands of the commune. All local governments are fully independent, there is no vertical relationship between them. Even if rural communities are located within a region, the mayor of that rural community is not hierarchically inferior to the president of the regional council of the region in which the rural community is. The mayor takes the decisions that concern his locality without any need to refer to a superior, except the central government, at the Direction of Local Governments, located in the Ministry of Local Governments delegated to the Ministry of Interior.

10. In the decentralization reform, the following prerogatives have been given to the local authorities concerning the health sector:

> *The Region:* 1) management and maintenance of regional and departmental hospitals; 2) management, maintenance, and equipment of rural health centers located in rural communities; and 3) implementation of prevention and hygiene policies.
>
> *The commune:* 1) management, maintenance, and equipment of urban health centers; and 2) building, management, maintenance, and equipment of urban health posts
>
> *The Rural community*: 1) building, management, maintenance, and equipment of rural health posts, rural maternities and health huts (cases de santé).
>
> The communes in our sample are given in the following table:

Table 1: Communes and districts in the sample of the survey

REGION	DEPARTMENT	COMMUNE	RURAL COMMUNITY	DISTRICT
DAKAR	Pikine[2]	Pikine		Pikine
	Rufisque	Rufisque Bargny Sébikotane	Sangalcam	Rufisque
KAOLACK	Kaolack	Kaolack Ndoffane	Thiaré; Ndiaffatte Keur Socé; Ndiebel	Kaolack
	Nioro	Nioro[3]	10 rural communities listed in footnote	Nioro

[2] There is no rural community in the department of Pikine which is totally urban.

[3] The ten rural communities in the district of Nioro are: Medina Sabakh; Paos Koto; Prokhane; Kaymor; Ngayene; Keur Madiabel; Keur Maba Diahou; Ndramé Escale; Wack Ngouna; Taïba Niassène

THIES	Thiés	Thiés	Notto Fandem Diender Guedj	Thiés
	Mbour	Mbour	Malicounda	Mbour
TAMBACOUNDA	Tambacounda	Tambacounda[4]	6 rural communities listed in footnote	Tambacounda
	Bakel	Goudiry	Kothiany; Koulor; Bala; Bélé; Kidira; Bani Israël; Dougué	Goudiry
SAINT-LOUIS	Saint Louis	Saint Louis	Mpal Gandon	Saint Louis
	Podor	Podor Ndioum Gollere	Fanaye Ndiayéne Pendao Mboumba Galoya Toucouleur Pété	Podor

11. We will only study the after-decentralization period which covers the years 1997 to date. The government finances the local government through two main channels, the Decentralization Fund (Fonds de Dotation a la Decentralisation (FDD)), and the Equipment Fund (Fond d'Equipement des Collectivités Locales (FECL)). The FDD covers current non-salary expenditures, whereas the FECL covers for the investment program.

B. THE TRACKING EXERCISE: THE FLOW OF FUNDS

12. The circuit followed by flow of funds from the central level to the frontline service provider depends on the nature of the resources, which has also a bearing on the administrative actors involved in the system. To better understand that system let us first quickly recall the main features the decentralization reforms have introduced into the health sector.

1.1 The health ministry has organized the supply of health services in a pyramidal way with three distinct levels of provision:

primary health care is delivery by the health centers, posts and huts. These facilities are under the formal authority of the district for the Ministry of Health's administration;

secondary health care is provided at the level of departmental and regional hospitals under the authority of the medical region;

tertiary health care At the top of the pyramid is provided at national hospitals and hospital with a research component directly under the authority of the Ministry of Health.

13. The head of both the district and the region is called he medical chief of the district (region). The chain of command within the organizational structure of the MoH goes

[4] The six rural communities in the district of Tambacounda are: Sinthiou Maléne; Koussanar; Koumpentoum; Nétéboulou; Missirah; Maka

from the Cabinet of the Minister, to the medical chief of the region, then the medical chief of the district, and finally the head of the facilities. The administrative local government counterparts are as stated above the region, the commune, and the rural community, with their delegated responsibilities.

14. To date, the central government provides support to the local government for the nine transferred responsibilities only for non-wage recurrent expenditure. The budget support comes through two main channels, the decentralization fund (FDD or Fonds de Dotation de la Décentralisation) for recurrent non capital expenditures, and the local government's equipment fund (FECL or Fonds d'Équipement des Collectivités Locales) for capital and investment expenditures.

15. The wage bill is still centralized and received by the health agents directly. Although it would be interesting to track salaries, this study only focuses on non-wage expenditures. A similar study will be conducted in Education where salaries will be tracked mainly for the purpose of detecting ghost workers, i.e. paid civil servants who no longer exist or work elsewhere, and reconciling the Ministry of Finance and the Ministry of Education human resources databases. This exercise might also be prove very interesting in the health sector, in which anecdotal evidence suggests than there are many workers whose position in remote area is vacant while those agents live in Dakar. This is a serious inefficiency that will need rectification in a subsequent exercise. This type of wastage also explains part of the weak correlation between budget and outcomes. Indeed, these wage expenditure that plunder the Ministry of Health budget have a negative, or at best zero, payoff for the health sector.

16. Through the decentralization fund, the health providers are supposed to receive resources to cover if not all, at least part, of their running costs. Since the beginning of cost recovery, private expenditure partially crowded out public expenditure since the central government reduces its budget support to health facilities that were deemed to have enough resources in their revolving funds for drugs. However, since the decentralization, the health budget is managed by the communes. The region receives and manages the budget of the departmental and regional hospitals, and also the budget of the rural district; the commune receives and manages the budget of the district; the rural community is supposed to receive the budget of the health posts.

C. TRAJECTORY OF THE FLOWS OF FUNDS

17. The path of any resources is contingent on its type. Capital and wage expenditure do not follow the same circuit and are even not executed by the same governmental agency although they both depart from the central government budget and are intended to reach the same beneficiary. Table 2 describes for the different resources the path they follow.

Table 2: Flow of Resources Trajectory

Expenditure Type	Source of Finance	Executing Agency	Final Recipient
Wage	State Budget: current expenditure	MoH – MoF	
Recurrent Expenditure *(non-wage)*	FDD LG own resources Subsidies	LG IDPH	Health Posts, Health Centers, Hospitals
Capital Expenditure	FECL CIB	CL AGETIP CSP	

Note: CIB= consolidated investment budget; CSP = commune support program; IDPH (PDIS) = integrated development program for health;

18. This study will be mostly interested in the decentralization fund which constitutes the main resource for the day-to-day running of health posts that supply most of health services in the country. The other types of expenditure will also be quickly analyzed.

19. One of the major drawback of the design of this fund is its linking to VAT receipts which depend on a number of factors completed out of line with the health needs of the country. The percentage of VAT that goes to the FDD has, however, not yet been fixed by the government. A better rule would be to decide on the amount to allocate to this fund depending on expressed needs of the beneficiaries and the government's priorities in the health matter. Notwithstanding the way it is decided, a good feature of the FDD is that its global annual amount is at least known to all actors since it is recorded in the State budget. Table 3 shows the evolution of the FDD since the 1996 decentralization reforms:

Table 3: FDD trends

Structure and Allocations of the FDD

In Current CFA Francs

	1997	*1998*	*1999*	*2000*	*2001*	*2002*
Regions	3,026,809,255	3,026,809,255	3,548,785,255	3,698,048,164	3,931,976,258	4,011,976,258
Communes	1,622,240,355	1,622,240,355	2,020,264,385	2,121,830,914	2,508,329,692	2,924,581,682
Rural communitys	142,692,666	142,692,666	222,692,666	242,494,962	338,963,470	652,979,060
Support to deconcentrated services	97,794,724	97,794,724	97,794,724	527,162,960	255,133,795	200,000,000
Regional Agency of Development					255,133,795	300,000,000
TOTAL FDD	4,889,537,000	4,889,537,000	5,889,537,030	6,589,537,000	7,289,537,010	8,089,537,000
variation			20%	12%	11%	11%

20. It should be emphasized here that this concerned all nine delegated domains of responsibilities. A share of the FDD is allocated to the deconcentrated services of the State to finance their costs in the technical help they provide to local authorities in the management of their new responsibilities. Around 10% is also allocated to regional services and agencies such as the regional agency of development. The lion's share of the FDD belongs to the eleven regions probably commensurate to their relative charges. The share of health is, however, earmarked which considerably facilitates the tracking exercise. For instance, the FDD-Health is 2.48 and 2.55 billions of CFA francs in 1999 and 2000 respectively. FDD-Health is therefore around 40% of the total FDD underscoring the importance the government attaches to this component. In absolute terms, however, the amount of the FDD is quite small, even though it is supposed to cover only current non capital and non wage expenditures.

The mobilization circuit of the FDD

21. Now we know the level to which the FDD is fixed every year, let's turn to the real issue of how it is mobilized and how it reaches the intended beneficiaries for its health component. There are seven main steps for the mobilization of the FDD resources:

1) the amount of the FDD is fixed by the MoF and voted by the National Assembly in the Law of Finance. The FDD is accounted for in the budget of the Ministry of Interior (MoI) that is the authority for the local governments;

2) the National Council for the Development of Local Governments (CNDCL Conseil National de Développement des Collectivités Locales) meets and decides on the allocation of the FDD among the different local governments. This council is presided by the President, members of the government, two members of the parliament, two governors, two delegates from the Mayors' Association, and two president of regional council sit in this high level council which meets once a year if ever. A decree of repartition is taken as an outcome of this meeting, the decree specifies the aggregate amounts allocated by *function* in the FDD, e.g. support to deconcentrated services;

3) the inter-ministerial committee composed of the MoF and the MoI meets to decide on the final repartition of the FDD, by local government and according to the different credit lines as health, education, support to deconcentrated services, etc, the outcome is an inter-ministerial arête;

4) each local government on the basis of its allocated budget in the FDD, writes its global budget which is transmitted to the MoI;

5) the MoI submits the commitments of the local governments to the MoF;

6) the MoF after internal operations of control and puts into place lines of credit for the local governments and notifies them through "mandats de préposés";

7) the local governments have their budget and can spend it on the behalf of the health facilities as earmarked.

21. Having disaggregated the circuit of the FDD it is now possible to precisely evaluate this system and pin down those steps where delays are most important. A further step will be need to reach the front line provider, indeed, the seventh step stops at the local government level. We are therefore still at the central level. Our ultimate goal is to know how much resources the local government sends to the beneficiary provider. This question will be answered thanks too the questionnaires, when data has been collected.

The evaluation of the FDD circuit

22. The tracking is interested in two main issues, 1) delays and 2) leakages. Let us first have a look at potential delays in the mobilization of the FDD.

Mobilization time

23. Because each step in the mobilization of the FDD is followed by an administrative act, it is fairly straightforward to quantify the time it takes for the FDD to be available to the local governments. Unfortunately, this time might hugely vary from one year to another. Indeed, although these seven steps must follow each other (or quite), there is no safeguards that can avoid sliding schedules, and therefore induce variations in the length of the mobilization time. Before getting into more details, let us first quickly give a flavor of the average year with table 4:

Table 4: the average year for the FDD circuit

Step Number		Periods
1.	Adoption of the Finance Law by the Parliament	December n-1 to January n
2.	Meeting of the CNDCL: Decree of repartition of the FDD	March of the current year
3.	Inter-ministerial meeting MoF and MoI: Inter-ministerial Arrêté	April of the current year
4.	Local governments budgets sent to the MoI	May
5.	MoI sends local governments' budget to MoF	May – June
6.	Line of credit in place and notification to the local governments	July – October
7.	Budgets for recurrent non-wage expenditure at the frontline health services providers are in place	September – October

24. It takes on average ten months for the FDD resources to be at the disposal of the providers. This leaves only two months to the facility to absorb those resources. There is clearly an imbalance in the system. The meeting of the CNDCL that only decides on aggregate allocations and hands out the work to the inter-ministerial meeting seems out of purpose. Indeed, it takes three months for this meeting to take place mostly because it is presided by the President whose time is very limited. This step has no benefit, and imposes long delays on the FDD resources, hampering service delivery.

25. Let us quickly present from 1997 to 2001 the different dates at which the CNDCL met, if it did, the decree promulgation dates, and all the different steps resources ought to go through before being at the disposal of the health services providers.

Table 5: Steps for the trajectory of FDD resources

#	Identification Step	Units	*Year*				
			1997	1998	1999	2000	2001
1	**Adoption of the Finance Law**	date	12/31/96	12/8/97	12/31/98	12/13/99	12/27/00
		Law N°	96-32	97-01	98-51	99-88	2001-13
	- FDD Amount	('000) F	4,889,537	4,889,537	5,889,537	6,589,537	7,289,537
	- FECL Amount	('000) F	3,500,000	3,500,000	3,500,000	3,500,000	3,820,000
2	**CNDCL Decision**						
	Comité **N**ational de **D**éveloppement						
	des **C**ollectivités **L**ocales						
	- CNDCL Meeting	date				01/26/00	01/30/01
	- Decree of FDD allocation	date	12/27/96	06/10/98	03/04/99	03/15/00	
		Decree	96-1126	98-500	99-181	2000-206	
3	**Inter-ministerial Meeting**						
	Distribution of FDD between LGs	date	02/17/97		04/21/99	05/19/00	06/08/01
4	**LGs send their budgets to the MoI**						
	Ministry of Interior						
	- Dakar Region						
	Region	date		5-Jun	13-May	8-Aug	5-Jun
	Commune of Pikine	date		10-Jul			
	Commune of Rufisque	date		18-Sep			
	Commune of Bargny	date	28-Sep	13-Mar		29-Mar	22-Jan
	Rural community of Yenne	date			1-Dec	15-Feb	29-Jan
5	**MoI asks MoF for credit lines to be put in place for LGs**	date	4-Mar	17-Jul	4-May		16-May
6	**Actual Receipt of « mandats de prepose » by Local Governments**	date					

	- Dakar Region *Region*			10-Aug	1-Aug	9-Oct	16-Aug
	Commune de Pikine			25-Aug	16-Aug	24-Oct	31-Aug
	Commune de Rufisque		31-Oct	16-Oct	10-Jun		29-Sep
	Commune de Bargny		31-Oct	16-Oct	10-Jun		29-Sep
	Communauté rurale de Yenne		31-Oct	16-Oct	10-Jun		29-Sep
6′	**Actual Receipt of « mandats de préposé » by Local Governments**	date					
	- Thiès Region						
	Region		May	May	August	August	August
	Commune of Thiès		May	May	August	August	August
	Commune of Mbour		August	May	August	August	August
	Rural community of Notto		August	August	August	September	July
	Rural community of Tassette		August	August	August	September	July

26. Let us discuss more in detail each of the first six steps of the FDD resources mobilization process. These steps almost exclusively involve the central level agencies only.

Step1: The Finance Law

27. It is regularly voted by the National Assembly in December of the year preceding the actual fiscal year. Table 5 shows that the Law is voted at the latest on 31 December. The amount of the FDD and the FECL are recorded in the Finance Law.

Step 2: Meeting of the CNDCL

28. The CNDCL meets and decides on the allocation of the FDD among the nine delegated responsibilities. The allocation is then recorded in the "Decree of Repartition" (DoR). All line ministries along with the Ministry of Decentralization and the Ministry of the Budget seat in the CDNCL. Apart form 1997, the first year of the decentralization, the decree of repartition is available at the earliest on March. In 1998, the decree has been promulgated in June and in 2001 the decree has even not been promulgated. The CNDCL is in fact a very cumbersome step to pass, indeed it is presided by the President whose time is very limited. However, after three unsuccessful attempts for the President's availability, a restricted committee is put in place to decide on the repartition, this has been the case in 1997 and 2000. Because it only decides on rough aggregate allocations, and imposes huge delays on the process, the usefulness of the CNDCL meeting can be questioned. In 2001 for instance, the Decree of Repartition has even not been promulgated but the process did follow its course.

Step 3: The inter-ministerial meeting

29. This is the key meeting in the whole process of the FDD allocation. Once the DoR has been adopted by the CNDCL and aggregate allocation for the delegated

responsibilities decided, the Ministry of Budget and the Ministry of Decentralization meet with other line ministries who have a stake in the FDD and decide on the allocation to each commune. A list of the local governments with the precise amount of FDD that is allocated to each of them along with the breakdown for health, education, and so on is produced during this meeting. The inter-ministerial meeting normally takes place once the DoR has been promulgated. It takes on average one and a half month after the decree for this meeting to take place. The date the inter-ministerial meeting in 1998 is not available but since the DoR has been available in mid-june one can estimate this date around mid-august. Again, except for the very first year of the decentralization in which the inter-ministerial meeting has been held in february, this meeting is held in the best case scenario in april. In 2001 the meeting took place in june without the DoR.

Step 4: Local Governments send their budget to the Ministry of Interior

30. This is merely a technical step that has almost no bearing on the process. The local government's budget must be in conformity with the prescriptions of the Ministry of Finance in terms of allocations to the different sectors that reflect the government's overall objective. This is reminiscent of a centralized system and therefore somehow in contrast with the whole idea of decentralization that transfers policy orientation at the local level. The only rationales one can find for this procedure is the infancy of the decentralization process, and the lack of competence at the local level. The budget of the local government is approved by the authority that represents the central government at the local level, namely the Governor for the region, the Préfet for the commune, and the Sous-Préfet for the rural community.

Step 5: The Ministry of Interior seizes the Ministry of Finance for credit lines settlement

31. This is also a technical step. After the reception of the local governments budget, the Ministry of Interior requires the Ministry of Finance to credit the account of the local governments with the allocation they have been given at the inter-ministerial meeting. This procedure is handled by the Procurement and General Administration Directorate (DAGE) of the MoI. Because of the high number of local governments, and the lack of human resources at the DAGE level, this step can be very long.

Step 6: The Ministry of Finance puts credit lines in place and notifies local governments

32. The Ministry of Finance after receiving the request from the Ministry of Interior engages an internal procedure to make available to the local governments their funds. The Ministry issues notifications to the local governments once their credit is in place, the notification instrument is a "mandat de préposé". For a commune, the reception of its "mandat" means that funds are available at the regional treasury. How fast the "mandats" are issued depends on the effort the agents of the Ministry devote to this task, and on the availability of funds at the central treasury. From Table 5, the local governments can receive their "mandat" and the earliest in may and sometimes as late as october, which leaves them only two months to send the resources to the health services providers that

are supposed to absorb all these resources before the fiscal year ends. The date of availability of the funds at the local level varies between the regions. Unfortunately, due to very bad record keeping practices, data have been gathered only for the regions of Dakar and Thiès. Communes in Dakar seem to receive their funds later than communes in Thiès.

Recommendations for reducing the mobilization time of the FDD

33. The process of the mobilization of resources of the FDD can take up to ten months form the adoption of the Finance Law to the notification of the "mandats de préposés". Because the FDD constitutes an important source of funding for the providers, this is a real constraint for their day-to-day functioning. The steps that have been described above all take place at the central level and solutions for a much shorter mobilization time can be found. For any of these steps, except the adoption of the Finance Law which is timely, it is possible to find a way to reduce delays.

34. The first and most obvious action that jumps to mind is the suppression of the CNDCL meeting. Indeed, this meeting imposes very long delays on the process and does not have any added value. The aggregate repartition of the FDD, as decided by the CNDCL, can be done either at the Parliament level and included in the Finance Law, or during the inter-ministerial committee that would then decide on both aggregates and specific allocations. This would represent a gain of three months and relieve the President's schedule of the CNDCL meeting which he does not really need to attend.

35. A second way to reduce even further the delays on the FDD reconstitution due to rigidities at the central level is to decide on a deadline for the inter-ministerial committee meeting. If the CNDCL meeting is suppressed, this deadline can be fixed around mid- or end-january which is a reasonable date.

Leakages

36. After the end of the mobilization process of the FDD, the resources of the health providers are managed by the local government officials. There is therefore still one step remaining before the resources arrive at the intended beneficiaries. It is also at that level that leakages are possible. Let us analyze the amounts received by the communes in the regions of Dakar and Thiès, for which data are available, and the amounts they transferred to all health providers for which they hold the FDD budget.

Table 6: Health FDD received by the local Governments and health providers

Identification				Units	1997	1998	1999	2000	2001
7	**Amounts received for FDD/Health**								
	Dakar Region	Region				343,324		292,841	
		Commune of Pikine		K-FCFA	53,756	53,756	66,945	70,325	70,906
		Commune of Rufisque		K-FCFA	27,791	37,668	40,975	37,991	49,344
8	**Allocations to health services providers**								
	Medical Region of Dakar		Amount	K-FCFA		2,508	10,824	10,824	13,824
			Availability	Date		23-Mar	23-Mar	17-Feb	28-Mar
	District of Pikine		Amount	K-FCFA	26,878	26,878	33,473	35,162	34,453
			Availability	Date		28-Aug	6-Aug	16-Oct	21-Aug
	District of Rufisque		Amount	K-FCFA			30,943	34,675	34,678
			Availability	Date			10-Mar	22-Mar	16-May
7	**Amounts received for FDD/Health**								
	Thiès Region	Region		K-FCFA	115,751	132,416	153,562	159,321	151,800
		Commune of Thiès		K-FCFA	7,500	7,500	7,500	8,000	8,000
		Commune of Mbour		K-FCFA	5,000	5,000	6,000	6,000	10,000
8	**Allocations to health services providers**								
	Medical Region of Thies		Amount	K-FCFA	11,102	11,102	11,102	11,102	11,102
			Availability	Date	July	July	July	July	August
	District of Thiès		Amount	K-FCFA	10,811	10,811	10,811	10,811	10,811
			Availability	Date	July	July	July	July	August
	District of Mbour		Amount	K-FCFA	15,297	15,297	15,297	15,297	15,297
			Availability	Date	July	July	July	July	August

37. For the administrative region of Dakar, only the amounts in 1998 and 2000 are available. Among the communes, the regions receive larger amounts of resources than the communes. This is commensurate with their responsibilities because they have the departmental and regional hospitals. The communes in the region of Dakar also receives more resources than communes of the same level in the region of Thiès.

38. Let us first note that local governments can allocate some of their own resources to health. Therefore the amount of health expenditure at the local level may be higher than the FDD allocation. The contrary is also possible, i.e. expenditure smaller than FDD allocations. However, because of the fungibility of the FDD allocation it is not possible to tell how much of this allocation the local government gives to providers. There is here also a serious problem of asymmetric information. Indeed, the health providers do not know how much has been allocated to the commune under whose responsibility they are to spend on health.

39. It is interesting to note the variation in the dates of availability of resources at the provider level. In the region of Dakar, although the region receives its FDD resources at the earliest in august (see Table 5), it transfers resources to the medical region between february and march. The region therefore takes on its own budget to transfer to the health providers and probably recollects its money once the "mandat de préposé" is received. The same pattern is also observed for the commune of Rufisque. On the contrary, the commune of Pikine always awaits funds to be available (or nearly) to disburse to its health providers whose resources are available at the earliest in august. The region of Dakar and the commune of Rufisque try to protect their health sector from the volatility of the date of availability of funds – a risk imposed by the central government – whereas Pikine completely transfers this risk onto its providers. For the region of Thiès, a strange regular pattern appears in which all communes make resources available to their health providers at the same time and sometimes after sometimes before they themselves receive the funds.

Table 7: Ratio of amount received to amount disbursed

Allocations vs Actual Receipts *In ('000) FCFA*	1997	1998	1999	2000	2001	Mean
Dakar Region						
Region of Dakar			343,324		292,841	
Medical Region		2,508	10,824	10,824	13,824	9,495
Ratio A/AR			*0.0315*		*0.0472*	***3.9%***
Commune of Pikine	53,756	53,756	66,945	70,325	70,906	63,138
District of Pikine	26,878	26,878	33,473	35,162	34,453	31,369
Ratio A/AR	*0.50*	*0.50*	*0.50*	*0.50*	*0.49*	***50%***
Commune of Rufisque	27,791	37,668	40,975	37,991	49,344	38,754
District of Rufisque	ND	ND	30,943	34,675	34,678	33,432
Ratio A/AR			*0.76*	*0.91*	*0.70*	***86%***
Thiès Region						
Region of Thiès	115,751	132,416	153,562	159,321	151,800	142,570
Medical Region	11,102	11,102	11,102	11,102	11,102	11,102
Ratio A/AR	*0.104*	*0.119*	*0.138*	*0.143*	*0.136*	***12.8%***
Commune of Thiès	7,500	7,500	7,500	8,000	8,000	7,700
District of Thiès	10,811	10,811	10,811	10,811	10,811	10,811
Ratio A/AR	*1.44*	*1.44*	*1.44*	*1.35*	*1.35*	***141%***
Commune of Mbour	5,000	5,000	6,000	6,000	10,000	6,400
District of Mbour	15,297	15,297	15,297	15,297	15,297	15,297
Ratio A/AR	*3.06*	*3.06*	*3.06*	*2.55*	*2.55*	***285%***

40. Table 7 gives the amounts received by the local governments for the FDD health versus the amounts they sent to the health provider, there is a row which gives the ratio of these two terms, for the different communes in Dakar and Thiès. For both Dakar and Thiès, the medical region receives very little from the resources allocated to them and managed by the president of the regional council. In Dakar, for the two years both

numbers are available, the region allocates on average only 3.9% of the resources earmarked to the medical region, whereas the ratio climbs to only 12.8% for Thiès. The picture is sharply different at the commune level. Indeed, in Dakar the communes of Rufisque and Pikine give less than they receive to their health providers, whereas in Thiès the communes of Thiès and Mbour give more to the providers than the resources allocated to them by the FDD.

41. Some local governments give resources in advance to the frontline service providers whereas others wait for funds to be available, some give more resources than normally allocated whereas others divide allocated resources by two or even 25 for some regions. How can one rationalize these huge variations in the same system? There are at least two possible determinants one can think of. First, the local governments that are now responsible for the health policy have their own fiscal revenue apart from what is transferred to them by the central government. Therefore, those that have health as a priority might allocate more resources and make those resources available to the health providers before the central government send the FDD resources. Second, in the process of decentralization the local governments have been transferred nine responsibilities and therefore have other priorities than health. Health is allocated the highest share in the FDD leaving other areas of responsibility with small resources. If the priorities of the local governments is, say, urbanization and habitat they can divert resources from health and allocate them to their number one priority. This effect is exacerbated by the fact that only the local governments have the information on the breakdown of the FDD. And even if the providers had the information, they have no handle to induce the local authority to disburse the money to them. However, having this information will anyway put them in a better position to claim their resources and increases their bargaining power.

42. The fact that region are bigger, and have more priorities probably explains the very low share of health resources that get to the health providers. The regions use most of the resources earmarked to health for other purposes.

43. In Dakar, leakages are very important in the communes of Pikine and Rufisque that allocate less resources to the health providers than the FDD requires. In contrast, the communes of Thiès and Mbour in the region of Thiès take from their own resources to add to the FDD allocations which are however much smaller than the allocations for Pikine and Rufisque. Note also that throughout the period of 1997 — 2001 the communes of Thiès and Mbour allocate a fixed amount to the health sector. Therefore, increases in the FDD allocation do not affect the policy of the local governments, they merely crowd out existing resources.

D. CONCLUSION

44. This study has mainly looked at the trajectory of the resources of the Decentralization Fund from the central level to the service providers. Apart from user fees, the resources from the FDD are the main revenue at the disposal of the health facilities and therefore receiving these resources in full and in a timely manner can help greatly improve the quality of public health services.

45. A number of constraint have however been identified in the process of the mobilization of the FDD resources. These constraints can induce both delays and/or leakage of the resources. The first and very important constraint to be underscored is the very late reconstitution of the FDD resources. Indeed, it takes between eight and ten months for the FDD resources, irrespective of the size of the amount, to reach the frontline service providers. The process is burdened by a number of usually useless steps as for instance the CNDCL meeting which takes three to six months and has no value added.

46. Another important ingredient that is crucial mostly for leakage is the asymmetry of information between the local governments and the frontline service providers on the amount of the FDD health allocated to the local governments. To reduce this asymmetry the list produced as a result of the inter-ministerial meeting should be sent to all health providers.

47. The decentralization process has introduced major changes in the health sector. Among them, the most important is the transfer of their resources to the local governments. There is a misalignment between the objectives of the health centers and the detainees of their financial resources, namely local authorities such as the president of the regional council, the mayor, or the president of the rural community. The central budget allocated to the health sector is transferred to the local governments that also have other priorities and have been transferred other responsibilities as well. If asymmetries of information are important between the managers of the health centers and posts and the local governments, financial means might never reach the facilities. It is also crucial to assess the “true” level of accountability of the local governments to their constituencies to be able to gauge the impact of the effectiveness of the decentralization process which is still in its infancy.

48. Health centers and posts have no handle on the local government to get the resources allocated to them by the central government. Moreover, local governments have no incentive to channel up the money to the health services because they believe that health facilities have already enough money through the revolving fund of drugs, that they themselves manage with complete autonomy and discretion since the Bamako Initiative.