Will patients be better off with a decentralised basic health service?

Effectiveness of a decentralizing basic health service in Burkina Faso

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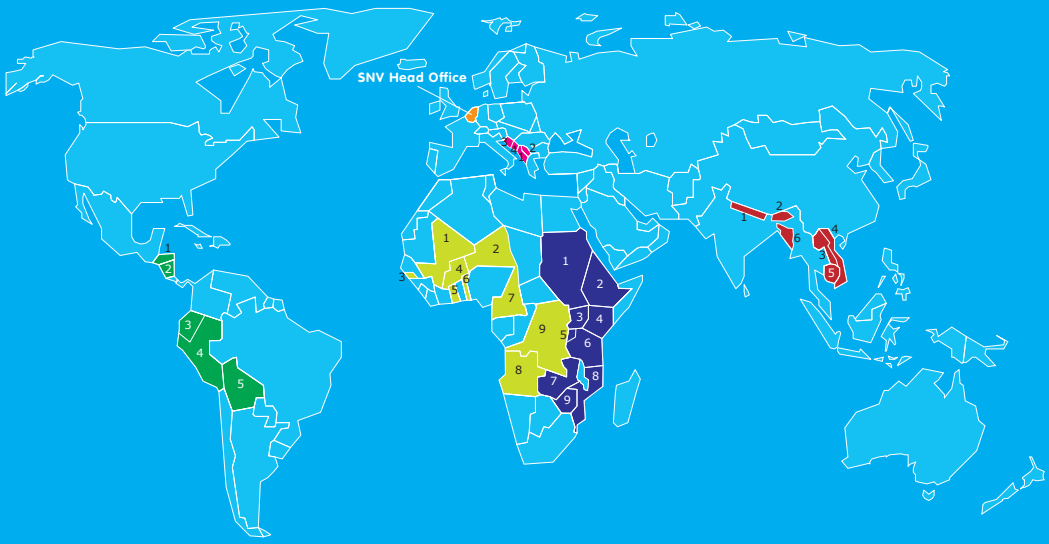

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Abstract

In Burkina Faso basic health services are progressively being decentralised to municipalities after the local elections of 23 March 2006. However, contrary to expectations, decentralization in many African countries has not lead to improvements in basic service delivery. This raises the question whether Burkina can fare better. This study analyses the nature of the relationship between four key actors ('policy maker', 'service provider' and 'beneficiaries' and 'donors') in terms of its effect on health service delivery. Risks are identified, which permits to focus on the restoration of the disrupted mechanisms of accountability. If no corrective arrangements are taken, the poorest patients risk paying the price.

1. Introduction

Three of the eight Millennium Development Goals (MDGs) are explicitly related to health: less child mortality, less maternal mortality and combating HIV/AIDS, malaria and other illnesses. Therefore it is logical that the international community encourages to focus on basic care and to accelerate results in this sector (Akin et Waal, 2005). Burkina Faso is unable to satisfy the need for basic health care of its population. Only 35.2% of the population has access to health care. In absolute numbers only two out of twelve million Burkinabé have access to 'acceptable health care',[1] with a large variation between regions. Furthermore indicators in the World Health Report 2006 regarding Burkina's performance on health care are also not encouraging. Life expectancy is 48 years,[2] under 5 mortality rate[3] is 192‰. Total expenditure on health as a percentage of GDP is 5.6%

1 'Access to health care' is one of the principal indicators to compose the Human Development Index of the UNDP, on which Burkina takes third last place.

2 Life expectancy at birth (in years) for both sexes, for the year 2004.

3 The probability (expressed as per 1000 live births) of a child born in a specific year dying before reaching five years of age, if subjected to current age-specific mortality rate, for the year 2004 (WHO, 2006, p.176)

in 2003 and has shown only 0.2% growth since 1999[4] (WHO, 2006).

Burkina is making progress, but it is too slow according to international objectives. What can change this trend?

Progressive decentralization in Burkina Faso's health care

Faced with financial difficulties, Burkina Faso engaged in the structural adjustment programme of Bretton Woods institutions in March 1991. As is the case in many African countries,[5] decentralization has been a dominant factor in the restructuring of Burkina's administrative system, with the creation of 53 so-called 'districts sanitaires' as its first important mutation.[6] This mutation we may describe as a form of administrative decentralization, or de-concentration. Districts function as local representatives of national administration and public servants are not elected.[7]

Decentralization in the health sector of Burkina Faso has reached its second phase with the local elections of 23 March 2006. From this day on Burkina Faso anticipates on a progressive transfer of responsibilities regarding basic service delivery to regional and local government (urban and rural).[8] This latest mutation we may describe as 'devolution', meaning a transfer of responsibilities accompanied by matching administrative and political power and an equally matching budget (fiscal decentralization).

4 Surprisingly the poverty reduction strategy paper 2003 of Burkina paints a much more positive picture of health care development. (Ministère de l'économie et du développement, Décembre 2004). However, looking at other documents and related indicators like corruption, government spending on health care and frequentation we can see the WHR is more realistic. See: AFC Consultants, April 2005, REN-LAC, 2003 and 2004, MFB, April 2003, Abadie, July 2005

5 There is a great interest for the decentralization process in many African states and for the community of international cooperation (Sebahara, 2000). For a general reflection on the decentralization process in West Africa, see Bako-rifari N. et Laurent P.J (eds), Les dimensions sociales et économiques du développement local et la décentralisation en Afrique au Sud du Sahara, Bulletin APAD, n° 5, 1998.

6 For a more extensive study on the process of decentralization in Burkina see the article of Sebahara (2000).

7 There are three types of decentralization: political, administrative and fiscal. The progress of these types of decentralization can also take three forms: de-concentration (or delocalisation), delegation and devolution. We do not mean to enter into an abstract discussion of the definition of decentralization. Here we only want to indicate that Burkina is progressively decentralizing its health sector towards 'devolution'.

8 Together these three entities – rural municipalities, urban municipalities and regions- make up the 'Collectivités Territoriales' of Burkina Faso.

Is decentralization a favourable factor for basic service delivery?

Decentralization is widely thought to improve democratic governance by bringing government closer to the people and thereby increase state responsiveness and accountability (Oxhorn, 2004). These decentralised governments should therefore be more likely to conceive and implement pro-poor policies. The Department of Health and Social Security of Burkina also sees the progressive decentralization of the health system as one of the opportunities for a successful execution of the Plan National de Développement Sanitaire.[9] However, other studies seem to proof the opposite. Decentralization may lead to a territorial secession in multi-ethnic and multi-religious societies, which may put national integrity at risk. Newly created autonomy may be manipulated by local elites, increasing corruption, inefficient use of scares resources and jeopardizing equity among different localities (Saito, 2001). Crook (2003) concludes that particularly for sub-Saharan African countries it is unlikely that decentralization leads to more pro-poor outcomes.[10]

Thesis and research questions

This is a worrying analysis which leads the authors to ask *whether patients in Burkina Faso will be better off with a progressively decentralizing basic health service.* Can Burkina be the exception to the 'rule'?

Given the negative examples of decentralization in other African countries and the slow progress on basic development indicators the authors feel that *it is unlikely that current devolution policies will cause a significant improvement, up to 2015, in the basic health services.*

9 The Department of Health has developed a decennial health plan (2001-2010) (Ministere de la Sante, juillet 2001). The fact that decentralization is seen as an opportunity is repeatedly mentioned in the official documents that have followed, like for instance in the 'document de base: table ronde des bailleurs de fonds du plan national de développement sanitaire 2001-2010, Ministère des Finances et du Budget, April 2003.

10 Much of the detailed evidence used in his article is drawn from a study carried out in 1999-2000 for a background article prepared for the World Bank World Development Report, 2001. Given the need for rich case-study evidence the analysis is based primarily on the best document African cases: Ghana, Cote d'Ivoire, Nigeria, Kenya and Tanzania, although others are referred to where relevant.

Our hypothesis leads us to the following questions:

1. Which key actors are responsible for the delivery of basic health care in Burkina Faso?
2. What are the conditions for these key actors to be effective in relation with basic health?
3. Why do the key actors till now not meet the conditions to be effective, given the current context of administrative decentralization, or de-concentration?
4. To what extent does devolution change the position of these key actors in Burkina?
5. Does the process of devolution improve the position of the key actors to meet the conditions of effectiveness in basic health care?

If the answer to this final question is positive it is more likely that devolution will cause a significant acceleration in the near future. If not, Burkina Faso will need to look for opportunities to accelerate the performance to meet the goals it has set concerning basic health services.

In the following we present indicators to measure performance of basic health care at local level. We introduce the framework of 'accountability relationships', developed by the World Bank (2004), which permits to identify key actors and discuss the 'effectiveness' of their relationships. The research questions are elaborated systematically. In the final part we answer our hypothesis and reason whether we think the patients in Burkina will be better off with a progressively decentralised basic health service.

2 Methodology

This article builds on qualitative data, we gathered from multiple sources (see annex 2). We mainly used interviews to collect the qualitative data and checked most of the data with different resources. This qualitative data we backed up with quantitative data, presented in official documents. For instance the different health reports produced by the Ministry of Health, or by the official institute for national statistics (INSD). The study executed by AFC Consultants (2005) provided much information on the evolution of fiscal decentralization in Burkina Faso.

The authors have executed two case studies. The first study analyses the existing health care situation of the district 'sanitaire' of Léo. The second case study analyses the 'Centre Bucco Dentaire de Ouagadougou'. This case presents a decentralised health care structure, with its proper budget. Ouagadougou is more advanced than all the other municipalities of Burkina, thus this case provides an interesting example for what may be possible for the future in other municipalities.

Measuring improving performance of basic health care: from MDG to municipality

In April 2003, a round table for donors was organised to discuss the financing of the Plan National de Développement Sanitaire (PNDS), which had been adopted in July 2001.[11] The need for 'indicators' to monitor progress and success was expressed at this meeting. By November 2003, the 'Comité de suivi' had developed 35 indicators in 9 categories. Twenty-five indicators are related to the most decentralised level of health service in Burkina at that time: district level. To the present day there is no list of indicators related to the most decentralized actors: the municipalities. The authors of this article have singled out six of the existing indicators that can be influenced by municipalities:[12]

1. Percentage of the population living in the range of less than 10 kilometres of a basic public medical centre (centre de santé et de promotion sociale)[13]
2. Percentage of medical centres functioning within the required equipment norms
3. Number of new contacts with primary health service structures per capita and per year

11 The PNDS is the operational plan of the Politique Sanitaire Nationale (PSN), adopted in September 2000.

12 The authors have set the performance indicators alongside the competences which are transferred to local authorities after the election of 23 March 2006 (see also annex 3). Indirectly more of the 35 indicators will be influenced by the activities executed on local level. However, the authors have selected the indicators on which local governments can have the most direct influence and therefore a more direct effect on these success factors.

13 This criteria has in fact been adjusted to 'less than 5 kilometres' (AFC Consultants, 2005:18), which is however not used in any of the official state documents. All the calculations in this research have been based upon 'less than 10 kilometre distance of a public medical centre'.

4. Percentage of basic public medical centres working with the appropriate number of personnel
5. Degree of resource mobilisation
6. Degree of execution of the mobilised resources (expenditure)

Framework of accountability relationships: determining effective service delivery

The World Bank (2004) unbundled the service delivery chain into three sets of actors: poor people, policymakers and providers. Successful services for poor people emerge when 'these actors are linked in relationships of power and accountability' (2004:47). Services can be improved by strengthening and balancing the relationships. If one actor has significantly more power than the other(s), the mechanisms of accountability may be disrupted, which may lead to ineffectiveness, corruption or in the case of health care a low frequentation.

Accountability is a term that has been translated in many different ways. We work with a notion of accountability as 'a set of relationships among service delivery actors', which includes five features:

1. **Delegation:** explicit or implicit understanding that a service will be supplied.
2. **Financing:** providing the resources to enable the service to be provided by paying for it.
3. **Performing:** supplying the actual service.
4. **Information:** obtaining relevant information and evaluating performance against expectations and formal or informal norms.
5. **Enforcing:** being able to impose sanctions or provide rewards when performance is good.

In the following tables we present the way these features may be applied to the three relationships distinguished by the World Bank.

Relationship	Strengthening accountability	Determinants of success *(non exhaustive enumeration)*
Beneficiaries - Policymakers	Stronger voice and political pressure	**Delegation:** beneficiaries delegate to politicians the functions of serving their interests (elections). **Financing:** policymakers can make tax and budget decisions. Governments are financed through their taxes **Performing:** the actual service is supplied (health care, laws etc.) **Information:** transparency about outcome, providing information, access to information, public information campaigns **Enforcing:** capacity to control the executive –either politically of legally. Not just through periodic elections, but also through the presence of advocacy groups, lobbying, media activities (2004:48). Local organisational capacity is needed.
Policymakers - Providers	Stronger compacts[14]	**Delegation:** the policymakers communicate clear responsibilities for outputs or outcomes and delegate power to providers. **Financing:** responsibilities with an appropriate budget and other resources (human resources, instrumental and technical means) needed to be effective in executing the given task. **Performing:** provider supplies the service. Policymaker provides the 'means'. **Information:** information about the actual performance is monitored and generated. **Enforcing:** capacity to reward and penalise. This goes for the policymakers to the provider and also inside the providing organisation, where **management** is applied to create good working conditions and optimal outcome.
Beneficiaries - Providers	More client power[15]	Providers can be made directly accountable to beneficiaries by passing decisions and powers directly to citizens or communities: the **'short route'** of accountability. When such client power is weak or not possible to use, more typically when public sector is involved, clients must use voice and politics in their role as citizens to hold politicians accountable – and politicians must in turn use the compact to do the same with providers. This combination is known as the **'long route'** of accountability.

Weaknesses in any of the relationships can result in service failure. Donors are not placed directly in the triangular framework, but the World Bank recognizes that 'the way donors provide their aid, matters a lot' (2004:203). Instead of 'poor people' we will refer to 'beneficiaries'.

Most important for us is to recognise whether devolution can contribute to strengthen the accountability relationships between the principal actors involved in basic health service delivery in Burkina

14 'The broad, long-term relationship of accountability connecting policymakers to providers is usually not as specific or legally enforceable as a contract, but an explicit, verifiable contract can be one form of a compact'. (World Bank, 2004:48-49)

15 'The relationship of accountability connecting clients to the frontline service providers, usually at the point of service delivery, based on transaction through which clients express their demand for services and can monitor supply and providers' (World Bank, 2004:48)

Faso. This may lead to better and more service delivery in Burkina's health sector. In the next chapter we identify the key actors in the basic health sector of Burkina.

3 Key actors in Burkina Faso's basic health care

In the de-concentrated arrangement of before the latest local elections, health care is composed of an administrative chain (where *politicians or policymakers* are dominant) and an executive chain (where *providers* are dominant). Furthermore there are clients involved who demand efficient health care, good quality of service and information. In this research this actor is called the beneficiary. Most African countries rely on exterior sources to finance its health system. Burkina is no exception and therefore donors form the fourth key actor in the basic health care system of Burkina. We describe the position, or role, each group of actors plays in this system.

Policymaker: the de-concentrated administrative chain

The administrative chain (policymaker) consists of three levels: central (Ministry of Health), intermediate ('directions régionales' de la santé) and peripheral (districts sanitaires).[16] Through this channel resources and information are transferred. The 'carte sanitaire' organises the country in 53 'districts sanitaires', each administered by an Equipe Cadre de District (ECD). The ECD is charged with management of the clinics and health research.

Provider: the executive chain

Burkina Faso is characterised by an unequal balance between public, private and traditional health sectors. This research will focalise on the public sector. The *districts sanitaires* are the real technical level where basic health services are located: *Centre de Santé et de Promotion Sociale (CSPS).* The head nurse of the CSPS is the administrative and decisional organ of the Ministry towards the users (beneficiaries).

16 The concept of district (administrative subdivision of a department) is not practical. The main obstacle seems to be the difficulty to match districts (53) and the 300 administrative departments. (Ministry of Health, July 2000 :50)

Beneficiaries: citizen, client, user of the service

Since the Alma Ata declaration of 1978 on primary health care, community participation in decision making has been identified as an important mechanism for promoting health care and ensure accountability in the offer of services to the public. This is confirmed by the Bamako initiative adopted during the 37th regional committee of the World Health Organisation, which defines this participation as *«internal capacity of the population to influence decisions in its favour».*

In Burkina Faso, the Bamako initiative has lead to a greater implication of communities in the management of health structures through managements committee (or 'comité de gestion', COGES) of the CSPS and Health Council of the *districts sanitaires* (MFB, 2003:19). Technically, CSPS are managed by staff from the Ministry and financially by the population (users) through this COGES.[17] COGES are composed of an executive board of five (5), of which four are elected amidst the population, plus the chief medical officer of the CSPS who is automatically a member.

The average household of Burkina Faso (counting 7.5 persons) spends yearly 32,901 Fcfa (50 Euro, or 6.7 Euro per person) on health care. Rural households spend 3.5 times less on health care than urban households (MFB, 2003:17). More than 90% of the practical acts at CSPS are off preventive and non-curative nature (Abadie, 2005:48-49). Households spend their money mostly to buy medicines (83.2%). Population covered by social security (insurance) was estimated at 11% in 2001. Population covered by private insurance is marginal (less than 1%).

Donor: a powerful actor

An analysed estimate shows that over 40% of the national health program is financed by external resources, or donor aid.[18]

17 Management committee find their origin in the decree that devote autonomy of management of health structures that are at the periphery. Joint management suppose that health, in a periphery structure like the CSPS is jointly managed by both parties (Ministry of Health, July 2000, p.50).

18 In Burkina, as in most African countries, there are many donors, bi- and multilateral partners and NGOs who directly subsidise municipalities, or indirectly through budget support.

The financing of the execution of the decennial plan (PNDS) is estimated to be a total amount of 649,188 million Fcfa (about 989.3 million Euro) for the years 2003 till 2010. Of the total amount 73,236 million Fcfa (about 111.6 million Euro) is financed through the fund for highly indebted countries and 100,239 million Fcfa (about 152.8 million Euro) is financed by donors and 120,082 million Fcfa (about 183 million Euro) is still to be found outside national budgets (MFB, 2003:36)

Looking closer at the World Health Report 2006 we notice that for Burkina the private expenditure on health as a total expenditure on health exceeds the percentage of general government spending on health, for every year covered by the report. This strengthens the impression that donors, or private funding organisations, must be seen as influential actors.

The next part assesses the accountability relationships of all four actors within the de-concentrated system.

4 The ambiguity in the relationships of accountability between the key actors in the health sector

In this chapter we answer our third research question, which is 'why the key actors do not meet the conditions of effectiveness in the current context of administrative decentralization'. Apart from general findings on the relationships of accountability, we present the biggest problems of the district 'sanitaire' of Léo.[19] Furthermore, we analyse the increasing collection of local revenues of the municipality of Léo, against a decreasing transfer of State aid. The latter seems *contradictory given the importance the state 'says' is given to decentralization.*

19 This district, of which the municipality of Léo is the capital, covers the province of Sissili (central plateau of Burkina Faso), with a population of 211,937. This district has 23 Centres de Santé et de Promotion Sociale.

Beneficiaries and providers (CSPS): Blocking the short route of accountability

Within the COGES the head nurse is the secretary. This creates on obvious conflict of interest. Is he or she 'open' to complaints of patients? The latter can only (re)turn to the traditional medicine man, or private sector as an alternative to complain with the poor performance of public health service.

The document 'table ronde secteur santé' identifies three threats to the successful execution of the national health plan (PNDS) (MFB, 2003:42). These threats are all related to the weak position of the beneficiaries:

1. Limited access to health care by the weak financial position of beneficiaries.
2. Decreased impact of preventive activities by limited information.
3. Restraining socio-cultural factors, which in practice is translated by pernicious, or damaging, traditional practices such as the existence of taboos related to nutrition and religion, or domestic violence. All these apply to the action plan 2006 for the district sanitaire of Léo (MFB, 2003:79).

Another indicator of malfunction within the relationship between beneficiaries and providers is corruption.[20] The risk of corruption is increased when people are badly informed about their rights, if there is a large information gap, no other alternative or high urgency. In 2003 'health' has been the sector where people experienced the most corruption in Burkina, showing a negative trend since the year 2000.[21] Fifty percent of the 'beneficiaries' within the group of respondents say they were confronted with corruption in the health sector in 2003 (REN-LAC, 2004:34-36). It is not our intention to elaborate on all aspects of corruption in Burkina's health system. We aim instead to offer a sufficiently documented insight on how strongly corruption and health are entwined. Public health providers

20 For more information on corruption in (West) Africa we recommend all literature related to this matter published by LASDEL (Laboratoire d'études et recherches sur les dynamiques sociales et le développement local). Especially interesting are 'études et travaux' number 02, number 03, number 19 and number 40.

21 Health sector with 45% (corruption experienced), followed by the police (44.9%), education (42.9%), customs (34.4%), media (34.2%), public administration (34%), tax authorities (29.9%), city-hall (27.2%), public contract (20.4%), justice (11.8%) (REN-LAC, 2004:22).

'personalise' the administrative relationships in Burkina to make private gain.

Case : The district 'sanitaire' of Léo: big problems, small budgets

The district sanitaire of Léo elaborated an extensive action plan at the end of 2005, which results in a list of no less than 117 problems to tackle. These problems have been analysed and translated into actions, which have been 'costed' and budgeted. This budget totals to an amount of 254,911,435 Fcfa (about 388,000 Euro) for the year 2006. This is a large amount to manage by a municipality that works annually with a budget of less than 50 million Fcfa (about 76,000 Euro).

The district has made a list of the 21 most urgent problems. Analysing this list, we see that 9 are directly related to weak client power and that 4 are related to weak financing (from central to district level).

Beneficiaries and policymakers (Ministry): Deaf-and-Dumb

As explained above the situation of the beneficiaries is weak. They lack information, have little means to access information and are not well organised. During our research, we have rarely been exposed to an open discussion on the subject. Users are not convinced that they have opportunities to voice their unhappiness to politician. For them, politicians (the Health Ministry in our case) are very far and virtual to directly feel any responsibility. More over, the latter have no elected mandate so that voters can disapprove them in case they are not pleased. *Although insufficient, this seems to be the best means of pressure to create reciprocal links between these actors.*

Policymakers (Ministry) – Provider (CSPS): Identical twins

In the previous relationship, the user was confronted with the fact that two roles were played by the same actors (the Ministry) and finally obey to the same public administration. The same body is thus judge and party.

Furthermore, the sector specific programs are incoherent with the decentralization policy, even after more than 10 years of decentralization. (AFC consultants, 2005:p.84).

Case : Municipality of Léo: better municipal performance, but less transfer of state aid.

In general the 47 municipalities have improved the total collection of revenues from the year 1998 till 2002 with 22.3% (5.6% annually) (AFC Consultants, 2004:39). The municipality of Léo has not been an exception with 10.53% growth. In absolute numbers however this does not lead to big budgets, because the municipalities don't work with big budgets. For instance the revenue per capita in Léo is 994 FCFA (1.5 Euro) (2005:41). Though these kinds of budgets do not allow for big investments, it's a positive development. We also note however a structural overspending of the municipal budgets. Although only at an average of 1% annually it indicates an insufficient control of the budget at local level and a risk of chronically overspending (2005:69).

Almost 25.50% of total expenditure is 'investment', which has increased with 5.57% annually between 1998 and 2002. In Léo investment has increased with 10.77% annually, which stands for about 2.4 million Fcfa (3,650 Euro). This progress of investment is positive, although also here in absolute numbers it is not much, knowing that to build a centre sanitaire one must quickly calculate with 35 million Fcfa for (about 53,000 Euro) the construction only.

On the other hand we note a decreasing transfer of state resources (Treasury) to local level authorities (communities). The transfer of state aid has decreased with an average of 11.7% from the year 1998 till 2002. Forty of the forty-seven municipalities have experienced a negative evolution in terms of receiving state aid. In Léo this aid has decreased by 12.58% over 1998 to 2002. The consultants of the research note that *'here we can speak of a contradiction between the importance the State gives to decentralization on paper and its factual financial engagement'* (2005:51-52).

Relationship between donors and the three other actors

We have seen that over 45% of the national health program is financed by external resources, or donor aid. Another difficulty is for the donor to respect the long route of accountability and to avoid mixing up into the decision-maker-service provider relationship. Without denying local responsibility in the improvement of health care services, the asymmetric character of the donor-recipient relationship

is one of the major obstacles in building a solid and performing infrastructure and avoiding any conflict of interest (Sakiko Fukuda-Parr, 2002).

Direct aid towards local budgets also entails a risk for the municipalities. The gifts of donors are at the end not controllable by the municipality and may therefore not be included in the budget prevision (AFC Consultants, 2005). This may bring uncertainty in the planning of activities. An analysis of three 'plans de développement communaux' shows that these plans are all far too optimistic relative to their duration (mostly around about 10 years) (SNV, 2006). This may also indicate a lack of planning skills at the local level.

Although the national health plan combines already some donors, the Ministry of Finance and Planning (2003:18, 28) speaks of 'an insufficient coordination of the intervening partners to realise common goals and a poor management of divers procedures of the donors'. This has a negative influence on an effective utilisation of the available resources.

We see that all the relationships are weak, which may add to the explanation of the actual underperformance of Burkina's health care system. Particularly striking is the weak position of the 'beneficiary', who seems powerless. The providers seem also to be in dire straits, with a lack of resources, low motivation, poor training, little capability and lack of direction. Last but not least the position of the policymaker is also questionable: are they not willing, or not able to perform? The fact is that there is a lack of coordination on the decentralization process and insufficient coordination of the donors. Although there may be small successes noted, there seems to be a deadlock on the actual system. Will it be breached by devolution?

5 Changing accountable relationships with devolution

The most important change after the local elections of 23 March 2006 (the second phase of decentralization) is that municipalities have taken over certain competences of decision making and policy making from the Ministry (see annex 3). This makes the relation between 'policymaker' and 'provider' more transparent and strengthens the principle of accountability.

Secondly, it should strengthen the relationship between the 'beneficiaries' and 'policymakers' (being municipalities). Contact between elected representatives and beneficiaries is often more direct on a local level. Beneficiaries may more easily sanction the policymakers and file their complaints. This could lead to stronger 'voice' of the beneficiaries. This 'shortening' of the long route of accountability seems to be the key to success of the *Centre Bucco Dentaire* of the municipality of Ouagadougou.

Case : Centre Bucco Dentaire of Ouagadougou

Ouagadougou, the biggest municipality of Burkina Faso, has constructed its Centre Bucco Dentaire in 2000. This was possible in Ouagadougou, because it has a 'statut particulier'. The special status, which it shares with the second largest city Bobo-Dioulasso, gives these municipalities more responsibilities to develop socio-economic activities3. The objective of the centre is to supply good dental care to its lowest possible cost. An advantage of this centre is the surrounding density of population and the 'relative' wealth of its citizens.

Since its opening, the development and diversification of needs of the patients has led to the evolution of the centre with the construction of other services: a health centre, a laboratory, a medical depot and an eye clinic. The quality of the performance has made the centre 'un centre médical de référence' for the city of Ouagadougou according to the acting manager.

Which are the main differences? Possible advantages of being characterised as a 'unite socio économique' are:

- The ability to keep its budget outside the municipal budget, which can make it more transparent. Extensive data was however difficult to obtain. The information at our disposal reveals a steady budget over the last three years of about 135 million Fcfa. Striking is the high percentage of investment over the past three years. Although decreasing steadily, investment was still 41% of total budget.
- Most of the health workers are under contract with the municipality, and therefore submitted to a more direct control and more result orientated. Its clients may not only judge the quality, but are also better able to sanction. This they may do by going to the press (almost every year an article on the functioning of the Centre is published – almost always positive), complaining to, or voting against the local representatives.
- The COGES consists of representatives of the centre itself, of the population, but also of civil servants and members of the council. This may create a synergy and more dynamic efficiency.

It is tempting to see the case of the Centre Bucco Dentaire as best practice. The different interviewees all speak of high usage of the centre because of the good quality of service and low service fees (not higher than public CSPS fees). However, no quantitative data could be presented to evidence these opinions. At a closer look we see a fragile model, because the centre depends largely on donors and on personal relations between the major of Ouagadougou and these donors.[23]

A closer look at municipalities and their capacity to strengthen the accountability relationships

The transfer of competence knows a 'period transitoire' for the Regions and the rural municipalities of three years (art.75 CGCT). For the urban municipalities the transfer has taken immediate effect with the local elections of Mars 2006. New recruitment of personnel for decentralised services will be organised per municipality. Those who will be recruited will be the staff of those municipalities and will be directly managed by the latter.

23 The centre (without extensions) has cost 260 million Fcfa (about 396,000 Euro), mainly financed by the Association Internationale des Maires Francophones (AIMF). The centre recently received a gift of 7 million Fcfa (about 10,650 Euro) of the city of Quebec with which Ouagadougou is twinned (Opinion, 2006)

This 'period transitoire' means that the first three years the municipalities will be limited in their ability to manage effectively its personnel, for they will not be able to hire and fire. This will be the case for the rural communities, which represent 77.7% of the population of Burkina. In terms of accountability, the **'enforcing' capacity remains weak** over a period of three years.

Most municipalities are not used to holding records, collect or monitor **information** on the financial **performance** in respect of health care in the two largest and best organised municipalities of Burkina, Ouagadougou and Bobo-Dioulasso, was extremely difficult. It took several public servants over two weeks to come up with the rough data. The function of the districts in this matter is not clear. A parting consultant at the Ministry of Decentralization wrote 'we need to anticipate a very weak managerial capacity, especially in the rural municipalities'. He continues to characterise the management culture as a 'commanding culture', which needs to be replaced – he does not specify with which culture –, and will mean a 'fundamental rupture' (Peterson, 2006:1).

Looking at the six indicators that can be influenced by municipalities (see the methodology) we notice a strong need for bigger budgets at local level. In practice we have analysed a decrease of state aid over the last four years (see also the case of the municipality of Léo earlier). Therefore a sound centre-local fiscal transfer system is needed. We see three **obstacles regarding effective fiscal decentralization** and transfer of budget at this moment:

1. 'Fiscal decentralization, necessary to improve the financial means of the 'collectivités locales', seems hardly to be on the national agenda' (AFC Consultants, 2005:94)
2. There are too many financial mechanisms in place, which are managed in an incoherent manner, preventing an optimal spending of available funds. The problem seems to be the State, which has not been clear and has failed to encourage the different donors to all join in a single financing mechanism (2005:96, 126).
3. Weak absorptive capacity of local governments. The flow of funds should not swamp absorptive capacities relating to demand or supply.

As the first two obstacles indicate a lack of vision and capacity to **delegate**[24] at national level, the third indicates the danger of non-sustainable fund flow. Absorptive capacity is defined by:

- Local governments capacities to plan, budget and administer
- Local private and sector department capacities to deliver goods and services
- Local government and community capacities to manage and maintain assets.[25]

As we have seen in this research all these capacities are weak at local level in Burkina Faso.[26] Over-funding may lead to less service delivery, as may under-funding. There is a need for sustainable modest funding. However, 'sustainable modest levels of fund flow appear to be far below what is needed to make a rapid impact on poverty-related problems…' (UNCDF, 2005:54).

Strong State?

'Success of decentralization ultimately rests on the quality of state governance' (Chabal, 2005), its ability to be strong and impartial (Chabal, 2005). This means the State should take responsibility for [i] equitable policies; [ii] professional standards; [iii] and regional inequalities (Chabal and Daloz, 1999). The State has not been able to deliver on any of these criteria. Here the authors do not intend to research extensively the concept of a strong State.

i The economy of Burkina has been growing at an average of about 5% annually over the past four years. Although higher growth is necessary to attain the MDGs, this growth is not equitable.

24 See for further analyses the publication of SNV Burkina Faso (Capo et al, May 2005) in which the local governance programme has capitalized four years of experience with decentralization.

25 UNCDF experience suggests that 'average flows approximately $1.5 to $3 per capita of population resident in the local development programme area are appropriate, at least in the early stages. It should be noted that this represents a very modest fraction of development budget per capita ratios, which typically range from $20-$50 per capita per year in Least Developed Countries, and is also a small proportion of typical government budget revenues per capita' (p.54). UNCDF, October 2005.

26 Also, a study of the decentralization of the public health sector in Uganda provides preliminary evidence that local government health planners are allocating declining proportions of their budgets to public goods activities (Akin, J, P. Hutchinson and Koleman Strumpf (2005).

The poor are not getting richer, but the rich are getting richer. The gap has widened till 47.07%.[27]

ii The State has not been able to enforce professional standards. Regarding corruption we have observed an increase over the past four years in the health sector. People want to change this situation[28] but they seem unable to do so. On the question asked by REN-LAC (2004) whether the respondent feels that the government fights corruption, 67% answer 'no'. Many official government documents have been written on this issue, but no positive evidence of changing behaviour is noticed by the public, according to REN-LAC.[29] Furthermore the director of 'la Promotion de la Solidarité Nationale' reveals a disintegrating solidarity in Burkina, caused by the influence of other values, notably Western, the imperative of competition and privatisation. Organised forms of solidarity, such as social security (Caisse de Sécurité Sociale) and other insurances are insufficient or inaccessible.[30] Specifically mentioned as a problem, is the limited number of health and education structures. Some actions have been suggested. However, Burkina is clearly changing towards a more 'individualistic' society (ACS, 2006).

iii As we have argued in the first part of this article, differences between regions in Burkina Faso are very big when it comes to health indicators.

27 The Centre pour la Gouvernance Démocratique (CGD) of Burkina Faso made a survey of the state of democracy. It shows that 34.12% of the Burkinabé are in a bad economic position, that 46.43% seldom has a job. The CGD has made its survey in April/Mai of 2006 (Sidwaya N°5636, Jeudi 29 juin 2006)

28 REN-LAC asked if the respondent was ready to engage him, or herself to fight corruption. 70% answered this question with 'yes'

29 In a newspaper article REN-LAC calls for the president to act upon this matter, for they say he has not engaged himself in any way on fighting corruption during his latest presidential campaign (of October 2005) L'observateur Paalga, 8th December 2005

30 Here it is said that only 7% of the population is covered, although other documents speak of around 11%.

6 Analysis and Conclusion

'In 1990, 4 out of 10 African women were helped by professional health workers delivering a baby. 15 years later, that is still the case' (John Page, chief economist at the World Bank in: De Morgen, 2006)

Four key actors in the administratively decentralised, or de-concentrated, health care system are identified in Burkina Faso: 'policymakers', 'providers', 'beneficiaries' and 'donors'. For these actors to have a positive impact on basic health care they need to strengthen their accountable relationships.

In the case of Burkina's basic health care system, we see that the mechanisms of accountability are heavily out of balance. The position of 'beneficiaries' is especially weak, for they lack (access to) information, they do not participate in decision making and their formal structure (being the COGES) is practically powerless and not motivated. They have few means to express their satisfaction, or to be heard in general. Finally, they suffer from corruption, especially in the health sector. Putting it briefly: they have no 'voice' and no 'client power'

If it is true that the success of decentralization ultimately rests on the quality of state governance we cannot be too optimistic about the near future in Burkina. We see a State that is not in control of the decentralization process and does not meet the criteria to be a strong State. The State seems overpowered by donors, who set the tempo and influence policymaking. Not only do donors influence the State directly, indirectly many organisations intervene at the meso and micro level. The State has just delivered a coherent vision on 'decentralization',[31] but has not shown much strength in the coordination of the actual process so far.

Will devolution in the health sector breach this deadlock and strengthen the accountability relationships between the key actors, causing significant improvement up to 2015?
In theory devolution may well serve as a crowbar to break the

31 The Cadre Stratégique de la Mise en Œuvre de la Décentralisation (CSMOD) has been adopted in August of 2006, but has not been made public at the moment of writing.

deadlock. With the second phase of devolution in the health sector municipalities have taken over certain responsibilities of national government. This, we have argued, may lead to a shortening of the long route of accountability. However there are some risks which may weaken the accountability relationships:

1. Fiscal decentralization **(finance)**, which we have argued is very doubtful in Burkina Faso. Looking at 6 indicators of success, sufficient 'financial and human capacity' is a must. Fiscal accountability is not likely to be strengthened with the transfer of competence to municipalities. The State has decreased the transfer of state aid, which seems contradictory with its politics. With a trend towards Sector Wide Approaches and budget support, budgets are more and more centralised, but responsibilities are decentralised. Burkina risks a lack of redistribution of the earmarked national budget towards local administrations.
2. On the other hand municipalities have **weak absorptive capacities.** Sustainable 'modest' funding appears to be far below what is needed to make a rapid impact on poverty-related problems. There is then a trade-off between 'the speed of development' and 'sustainable impact'. A sustainable impact in the health sector of Burkina before 2015 seems out of reach.
3. Limited **'enforcing capacity'** when it comes to managing personnel effectively during the transit period of three years. Where non-motivation of personnel is a big problem in the health sector, municipalities are blocked, because the Ministry stays in charge of the personnel.
4. Devolution does not necessarily lead to a strengthening of the position of 'beneficiaries', because they are not automatically better **informed**. The mechanisms for collecting and providing information do not exist in the average municipality. Furthermore, municipalities lack managerial **capacities** and do not know how to play their new role.

This analysis permits to focus on the restoration of the disrupted mechanisms of accountability between the key actors. The authors prefer to present measurements which are today existent, although somewhat hidden. Here we may think about more effective funding constructions, whereby donor aid put in national basket funds flows more efficiently to regional and local budgets to provide for better basic health services. Another possibility is catalyzing the creation of

the local insurance market. An absolute necessity is the creation of local data bases to monitor performance and to strengthen the compacts with regional and national government by reducing the 'imperfect information'.

The authors realise that the opportunities presented demand significant capacity strengthening, creation of new structures and changing behaviour of many actors involved. This will take time, probably more than the nine years till 2015. However, if no corrective arrangements are taken, the poorest patients risk paying the price.

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Annex 1: List of interviewed persons

Name	Position/title
Mr ATIOU, Antoine	Secrétaire Générale de la commune de Bobo-Dioulasso
Dr BANDE Karim	Directeur du Sous Secteur Privé (Ministère de la santé)
Mme BANDRE Rosine :	Directrice par intérim du centre santé communal de Ouagadougou
Mme Amina BILA	Coordinatrice du Réseau Africain des Mutuelles de Santé
Mr CISSE, A.	Administrateur Direction de l'Administration, Finance et Budget (DAFB) de la commune de Ouagadougou
Dr Mme DJAOUGA Mariam	Chirurgien dentiste en service au centre santé communal de Ouagadougou
HORST van der, Jan C.M.	Conseiller santé, Ambassade du Royaume des Pays-Bas
Dr KAMBIRE Luc	Médecin Chef du District Sanitaire de Léo
Sr KAMDO Bibiane	Enseignante au centre de santé des Sœurs de l'Immaculé Conception de Ouagadougou à Léo
Mr NIONDOGO Charles	Secrétaire Général de la Mairie de Ouagadougou
Mme OUEDRAOGO, Aminata	Directrice, Direction de l'Administration, Finance et Budget (DAFB) de la commune de Ouagadougou
Dr SIMPORE Lambert	Directeur du service d'hygiène de la commune de Ouagadougou
Sr TOUGMA Félicité	Infirmière au centre de santé des Sœurs de l'Immaculé Conception de Ouagadougou à Léo
Dr TRAORE Corneille	Coordonnateur de la Cellule D'Appui à la Décentralisation du Système Sanitaire

Annex 2: Health competences transferred to municipalities

Article 94 of the Code Général des Collectivités Territoriales of Burkina Faso.

Article 94 anticipates on a transfer of the following responsibilities competences to municipalities:

1. Construction and management of the basic health care institutions;
2. Organisation of the pharmaceutical provisioning, taking actions to be in line with regulations and with prevention;
3. Taking sufficient hygiene and sanitary regulations within its territory;
4. Control of the application of sanitary regulations;
5. Participate into resolving problems regarding sanitation;
6. Participate into establishing the 'tranche communale' and the national 'carte sanitaire'.

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