

## Implications of Decentralization for Reproductive Health Planning in Senegal

Based on the report “Evaluation du processus de planification dans le contexte de la régionalisation” by Idrissa Diop, Director of HYGEA; and Babacar Ba, Kalidou Sow, Alioune Zeiman Mbaye, Oscar Camara, Alioune Ndiaye, Oumar Diallo, Pape Mody, consultants, December 1998. Ellen Wilson prepared this brief.

### Background

Countries are increasingly implementing reproductive health services within decentralized health programs, which has important administrative, technical, and financial implications for service delivery. However, little is known about the effects of decentralization on the delivery of reproductive health services. This knowledge is important for policymakers, program managers, and donors to help ensure that local areas have the resources, knowledge, and skills needed to ensure that reproductive health services are available in communities.

During the past 20 years, Senegal’s health system has gradually moved from a highly centralized program that emphasized curative care to one that now stresses primary health care and community participation. As part of that process, the Ministry of Health (MOH) “deconcentrated” authority by transferring planning and administrative responsibility to district health officers who remained accountable to the central ministry.

The government of Senegal has also undertaken decentralization in the form of devolution, which involves the transfer of authority to semi-autonomous local government units. The process culminated in 1996 when the government transferred responsibility for nine sectors, including health, to 372 local elected councils (10 regional, 48 municipal, and 320 rural community councils). Based on operational budgets for 1996, central ministries, primarily health, education, and youth and sports, are required to contribute money to a fund

controlled by the local councils. At the municipality and rural community levels, the MOH is the largest contributor to the fund—close to 90 percent. Although the fund is provided as a grant for all sectors, it is accompanied by a line-item budget set by the ministries, and elected leaders are expected, at least in the first few years, to follow the allocations specified in the budget.

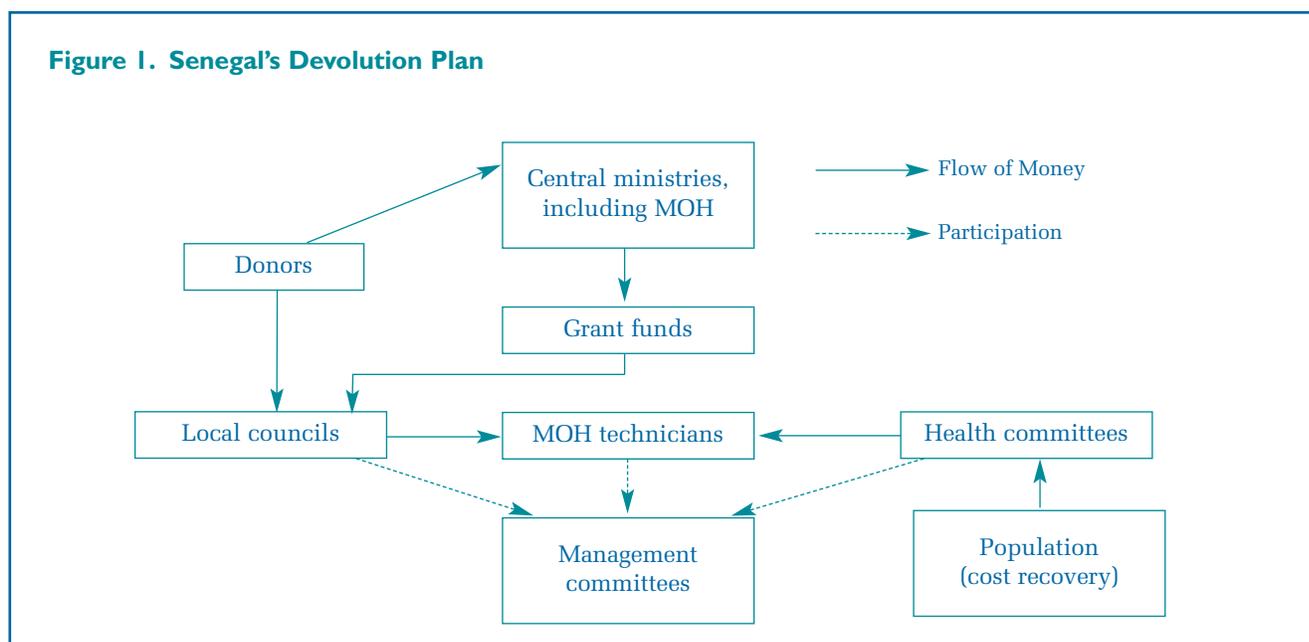
In theory, local councils will determine priorities and plan how health monies will be spent, with technical support from the district health officer. Local councils can also receive additional funds directly from donors, who will no longer be required to pass resources through the central-level ministries. Health committees will continue to manage funds generated through cost recovery. Management committees, composed of representatives of the local council, MOH personnel, and health committees, will ensure coordination at the community level (see Figure 1).

Considerable confusion has surrounded the decentralization process since it went into effect in 1997, and numerous problems are preventing health planning at the decentralized level from working as envisioned. Furthermore, little is known about the attitudes and characteristics of the local leaders who are now responsible for decision making, which complicates the design of effective interventions.

In June 1998, ISADE/HYGEA<sup>1</sup> conducted a study of local elected leaders and the planning

<sup>1</sup> Institut Supérieur Africain pour le Développement de l’Entreprise/Le Cabinet d’Etudes et de Recherche HYGEA.

**Figure I. Senegal's Devolution Plan**



process for health at the decentralized level. The objectives of the study were to understand

- Socio-demographic characteristics of the local elected leaders and their knowledge and attitudes about reproductive health;
- What local elected leaders and health technicians know of their own and each others' roles in the context of decentralization;
- How health planning is carried out since decentralization; and
- The role civil society representatives play in the health planning process.

## Methodology

The study consisted of both quantitative and qualitative components and covered four of the 10 administrative regions in Senegal. In each region, five municipalities and 10 rural communities were selected at random, for a total of 60 communities. For the quantitative component, five elected leaders in each community were interviewed. To the extent possible, these leaders were selected at random. In total, 300 council members responded to the quantitative questionnaire. For the qualitative component, individual in-depth interviews were carried out with elected leaders and representatives of the MOH, health committees, and civil society. Separate question guides were developed for each of these groups.

## Findings

### Characteristics of Leaders

The elected leaders tend to be men (80%) and older (55% over age 50). Most are in polygamous marriages (52%) and have six children or more (69%). Nearly one-half of the elected leaders work in agriculture (47%). Educational levels are generally low, and many elected leaders are unable to read or write French (47%), particularly in the rural communities. (About one-half of those illiterate in French can read in Arabic or national languages, however.)

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### ***Understanding the Decentralization Process***

On the whole, local elected leaders do not have a clear understanding of the decentralization process or their role in it. Seventy-nine percent admit that they do not have sound knowledge of the laws and regulations pertaining to decentralization, and when asked about their roles in the process, their responses were general and vague (“Respond to the needs of the population,” “Participate in the development of the community”). This lack of understanding is not surprising, given that only 22 percent reported they had received any kind of training regarding decentralization, with the majority saying their training was informal, either through colleagues or from studying the regulations on their own.

While the majority said they have access to the data they need for effective planning, only 31 percent knew the amount of the grant received from the central level, and only 1 percent was able to make a reasonable estimation of the population size of their community.

### ***Participation in Planning***

Elected leaders most often cite health as a top priority in their communities, yet they exercise almost no role in planning for health.

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***“We have no concept of planning.”***

— Local elected leader

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No council has developed a plan specifically for health, and few have any kind of development plan at all. Likewise, few elected leaders have participated in the development of district health plans, and 85 percent had not even heard of one. Health technicians and elected leaders generally agree that a critical part of the role of the elected leaders should be to set the health policy and determine the health priorities of the community; however, they are not yet performing this function. Leaders who felt that they had accomplished something in the area of health generally cited the construction or renovation of health facilities.

Municipal mayors and district health officers reported differences of interpretation of the texts on decentralization. In particular, some district health officers expressed frustration that the municipal councils do not give them all of the funds intended for health, but instead allocate these funds to other

areas. Most district health officers would prefer to act independently of elected leaders. Management committees—envisioned as a means of facilitating coordination among MOH technicians, elected leaders, and members of the health committees—have been created in a few communities but are not functional in any community covered by this study. Representatives of civil society generally play a small role in representing the health needs of the population to the elected council.

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***“Everyone works in his own corner.”***

— District health officer

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### ***Attitudes toward Reproductive Health***

Elected leaders are generally supportive of reproductive health activities. The vast majority (80%) is in favor of family planning to space births, and 45 percent believe that a greater portion of the budget should go to family planning programs. However, 55 percent believe that youth should be excluded from family planning programs, and 45 percent are opposed to the use of contraception in order to limit births. Furthermore, many leaders expressed doubts about the safety and efficacy of family planning methods, as well as the acceptability of family planning to Islam. More than one-half feel that AIDS is a serious concern in their community.

### ***Funding***

Funding is a major constraint. The grants received by the local councils are relatively small: between US\$245 and \$1,700 in rural communities, and \$1,800 and \$68,000 in municipalities. Funds generated through cost recovery and managed by the health committees are generally much greater than those allotted for health in the decentralization funds; however, they are primarily used to maintain the revolving drug fund and are not adequate to maintain the entire health post. Additional funds are available to the council through the collection of local taxes, although tax revenues are generally quite limited in rural communities (between \$240 and \$16,700). Mayors are generally better informed than presidents of rural communities regarding the possibilities of support from international donors and local organizations; however, even mayors have taken little advantage of alternative sources of funding. Moreover, many donors and other agencies are

still determining how to channel funds to the decentralized level, and these sources are sure to be more widely exploited as the systems are put in place. Several municipalities reported that they had already requested funds from a local funding organization, but at the time of the interviews, none of these requests had been approved.

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**“They have transferred great responsibilities to us without giving us the means.”**

— Rural community president

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### **Policy Implications**

The promise of decentralization is to make reproductive health programs more responsive to local needs, allow greater community participation, and produce a greater sense of local ownership than centralized programs. However, as this study revealed, much remains to be done before decentralized health planning can achieve its potential.

Elected leaders are eager to take on new responsibilities; yet the majority is scarcely involved in planning at all, much less in planning for health. One-shot training sessions may help to reduce some of the confusion and conflict regarding roles, but it will do little to help local leaders gain the skills needed to exercise their roles effectively. Central-level efforts to provide support to the nearly 400 councils in the country would be cumbersome and expensive and could never maintain the kind of ongoing support that would be needed.

Numerous technical personnel are in place at the regional and local levels, including in the areas of planning, statistics, community development, and health, who could provide technical assistance to local councils. New models of interaction between these personnel and the elected leaders

need to be developed to respond to the context of decentralization. The technical personnel need adequate tools and data to help them in this supporting role. Health technicians also need to be able to communicate clearly to elected leaders the actual costs of running a health facility and the programmatic implications of various budget decisions leaders might make.

Elected leaders generally support family planning and reproductive health programs; however, they are likely to support interventions that have the highest visibility and that are thus most likely to get them reelected. When elected leaders were asked what they perceived the priorities in health to be, they tended to cite tangible investments, such as medications, qualified personnel, infrastructure, and equipment (particularly ambulances). In this context, the benefit of preventive health programs is not immediately obvious. If decentralized programs are to be truly responsive to the needs of the population, members of civil society must be able to express their health needs to their elected leaders, lobby effectively for them, and hold leaders responsible for meeting these needs. Local councils should develop mechanisms to allow civil society to participate in the debate on priorities and programs. Health technicians can help both elected leaders and representatives of civil society understand the impact of preventive health programs and judge program effectiveness; for example, more on the basis of child survival rates than on the presence of a new clinic.

Finally, this study has shown the importance of increasing elected leaders' understanding and support for reproductive health programs. Many leaders retain doubts regarding family planning methods and need to have their misconceptions cleared up if they are to fully support efforts to improve reproductive health.