Financing of Basic Health and Education Services at the Locality level

Case study of North Kordofan

Federal and State Ministries of Health and Education

and

World Bank

March 2007

Abbreviations

FMOE	Federal Ministry of Education
FMOFNE	Federal Ministry of Finance and National Economy
FMOH	Federal Ministry of Health
PHC	Primary Health Care
SMOE	State Ministry of Education
SMOFEDL	State Ministry of Finance, Economic Development and Labour
SMOH	State Ministry of Health
SDD	Sudanese Dinars
USD	American Dollars

Exchange rates

	2003	2004	2005	1/7 2006
SDD to USD (period average)	261	258	244	228

Source: IMF 2006

Inflation rates

	2003	2004	2005	2006 projected
CPI (annual average) growth	7.7	8.4	8.5	7.5

Source: IMF 2006

Population in North Kordofan 2005

Gabrat el Sheikh	100,881
Bara	319,561
Sheikan	449,483
Sodiri	169,072
Um Rwaba	562,968
Total	1,601,965

Source: FMOH

Population growth rate: 2.6%

Table of Contents

1. Introduction

The Government of Sudan has pursued decentralisation through a series of reforms over the past decade. Among the objectives have been strengthening the delivery of basic services, including health and education, especially with a view to improving services in rural and remote communities.

Correspondingly, the resources transferred from the Federal Government to the States have increased. Increased financing overall may be a prerequisite for substantially improved services, but will not *per se* ensure increased resource availability at the individual health facility or school. Therefore, one of the questions that arise is what impact this increase in transfers has had on the resources available for service delivery at locality level. Are resources available and if so, how are they used? If not, what may be the constraints in the system?

Furthermore, the Government of Sudan is currently looking towards revising its financing strategies for health and education services by increasing resource mobilisation as well as reforming resource allocation to respond to problems of efficiency, quality and equity. However, the knowledge of the current financial situation at the locality level is very limited, both with regard to resources available for health and education and their allocation within and between localities.

The objectives of this case study are:

- To provide a brief overview of planned and on-going reforms of relevance to locality financing for the sectors and to assess relevance, feasibility and constraints to implementation of planned reforms in the light of information on locality financing

- To provide basic information on locality financing and management of health and education services that can be used as input to the development of an overall financing strategy for the sectors in terms of
    - Concrete data on locality level financing of health and education and flow of funds
    - Understanding the processes, the linkages and the capacity for health and education sector management at locality level

- To pilot data collection methods for possible replication in other states.

2. Methodology

2.1.1. Material and method

The analysis relies on a combination of various sources of information and the results have been developed by triangulation.

There is only a limited relevant documentation, and even less is in English. The available documents have been reviewed and complemented with qualitative interviews and data collection.

A small team including one staff each from FMOH and FMOE was fielded to collect financial data on health and education services from the Locality Administrations. A template for desirable information, if possible for a period of five years, was developed (see Annex 1). In recognition of the fact that the Localities may have difficulties providing the information in the desired breakdown, the team was instructed to collect all available financial information concerning the two sectors in

whatever format available such that the team could organise it in relevant tabular form. The team also collected financial data from the State Ministry of Finance, State Ministry of Health and State Ministry of Education for North Kordofan.

Finally, a health and education Facility Survey in North Kordofan collected information on sources of financing and expenditures at the level of schools and health facilities. These data have been analysed to supplement the information from the Localities.

2.1.2. Limitations

North Kordofan State at the time of the development of the study consisted of five localities. Since then, West Kordofan was dissolved and four localities were added to North Kordofan. Since study planning had already started, and since the four localities from West Kordofan would in any case not be included in historical data, it was decided to focus on the five "old" localitites. At the time of the field visit for collection of the locality financial data, the road to Sodary Locality was, however, said not to be passable and the data collection team therefore only visited the four localities of Sheikan, Um Rawaba, Bara and Gabrat el-Sheikh.

The financial information in the desired breakdown of locality expenditures turned out to be very difficult to retrieve and generally the collection was restricted to the most recent years. This is in line with the findings of the Information Gap Analysis that was undertaken by the FMOH in 2003.

The data collection team did not manage to produce *any* financial information for the education sector at locality level, but only at state level. This limits the scope for analysis for the education sector considerably.

3. National context

3.1.1. Planned and on-going government reforms

Sudan started the decentralisation process more than a decade ago with the introduction of the federal system. The Federal Act in 1993 divided the country into 26 states, which were further sub-divided into smaller sub-state units. In 2003, the Local Government Act (2003) consolidated the sub-state units into somewhat larger Localities with the intention of improving service delivery of basic social services to reach more of the rural and remote communities. Recently, there has been another move to increased federalism with more autonomy given to the states and localities.

With the Federal Act and the establishment of state-level line ministries, states became responsible for administration and management, while overall responsibilities for national planning and coordination, as well as monitoring and evaluation, remained with the federal ministries. In terms of service delivery, the Federal Ministries are involved in tertiary service delivery, i.e. teaching hospitals and university education, and a few vertical programmes such as Malaria Programme. States are responsible for secondary services, and – through the localities – for primary services. In the poorest states, effective decentralization to the localities is limited, as they serve, at best, as conduits for salary payments from state government funds.

The federal line ministries do not have any role in determining sector spending in the states. Federal transfers to the states are in the form of untargeted block grants to be allocated to sectors by the state government. The only exception has been federal development programmes, which are relatively limited in financial terms. The increased state autonomy from 2006 includes the responsibility to sign loans and grant agreements for development expenditures. Federal transfers to the states have increased in recent years, with the dramatic growth in government revenues due to oil production and economic growth. There is an intention to move from an intergovernmental

transfer system that relies on negotiations to a more transparent and equitable transfer system generally driven by formulas.

3.1.2. Health sector

Sudan has a three-tiered health care system. Basic health services are provided by a system of primary health care units, dressing stations, dispensaries and health centres. Service delivery at this level is the responsibility of the states, sometimes devolved to the localities. Secondary care, including rural hospitals and specialised hospitals, provide basic hospital services and are the responsibility of the states, whereas tertiary services provided in teaching hospitals is the responsibility of the federal government.

The health policy emphasises the need to expand health services to underserved populations. The policy is to increase access of the population to health care by providing a minimum package of basic health care services and free emergency care. While it has been approved in principle in 2005, technical consultations are on-going regarding the specification of the package as to address the main health problems using cost effective interventions and at the same time be affordable.

Further, the health policy mentions the need for a more equitable distribution of health services and for a formula-based approach to resource allocation that takes into account such factors as health indicators, service coverage and access, geographical factors and others.

The decentralisation of the health care system has focused on the roles and responsibilities at various levels of care. It is, however, important that sufficient funding is available for performing the activities and that the incentives in the financing system is conducive to the objectives. The FMOH is considering whether it would be relevant to include first referral level hospitals in the locality health service delivery system under the responsibility of the Locality in order to encourage integrated financing and management of primary and first-referral services under the classic “district” model.

3.1.3. Education sector

In 1992 a reform of the general education system was initiated. Sudan has a three tiered education system. Basic education lasts for 8 years and is compulsory. General secondary education lasts for 3 years. Higher education is provided by universities, institutes and colleges. Running and financing of the basic education system is the responsibility of the states, which sometimes devolve functions to the localities. State responsibilities include the construction of new schools and supply of furniture, equipment and books as well as hiring of staff, payment of salaries and supervision. Secondary education is the responsibility of the states, while all universities are autonomous but under the responsibility of the Federal Ministry of Education. In parallel, shorter more concentrated non-formal education that caters for out-of-school children or adults exists and a mobile school has been introduced by the state government in North Kordofan to ensure provision of basic education for the nomadic population.

Civil society is involved in the form of Education Councils, a form of parent-teacher association.

The 2001 General Education Act stipulates the right to education for all children of eligible age without discrimination of any kind. The objective is to provide equitable, efficient and quality basic education for all. The government is committed to the MDGs and the national policy is to provide free access to all 6-13 year olds by 2015, to eliminate gender differences and to increase quality.

Steps in this direction includes the development of a national curriculum, strengthening of the teaching profession of higher quality through training, morale and social and economic status and by developing transparent and flexible administrative systems. In recent years responsibility for teachers' training has been decentralised from the federal to the state level, although the federal standards for teachers' qualifications are generally applicable. The 1992 reform raised these standards to require teachers to have a university degree wheras previously they were trained in specialised teachers' colleges.

Among the challenges is resource mobilisation, lack of qualified administrative and technical staff, lack of adequate learning facilities and lack of timely flow of reliable data. There is only limited information on resource generation, allocation of resources and the resulting outcomes with regard to access and participation to education.

4. Current situation in North Kordofan

4.1. General context of health and education sectors

4.1.1. Organisation of services administration

State level

The State Ministry of Education (SMOE) and State Ministry of Health (SMOH) are two of nine state ministries. The State Ministry of Finance, Economic Development and Labour (SMOFEDL) is the coordinating ministry for sector ministries and localities in terms of finances. Transfers to localities are made from SMOFEDL and it is to SMOFEDL that localities are held accountable on financial issues.

The main role of the SMOH is to oversee the implementation of health services in the localities and hospitals from a technical point of view and to provide technical supervision and coordination. The technical support may include supervision, monitoring, inspection and technical back-stopping.

The SMOH itself finds that the supervision and regular inspections are well-functioning and a strength of the current system. However, the supervision and inspections are mainly related to health professional issues with only little support in areas of planning, management and finance. Further, within the SMOH, the departments for revenue collection and expenditure are considered to have improved and to be well-functioning.

One of the main problems in relation to implementation of the SMOH responsibilities is the unavailability of necessary management information and, where available, delays in information flow and quality of data. Further, the lack of computerisation and the absence of a network in the SMOH are perceived by staff as barriers to efficient sharing and use of available information. Among the perceived additional challenges for the future is an excess number of some categories of employees with low qualifications. Finally, there is a perceived need for creating transparency in decision-making and actual allocations and developing clear priorities for the state, reflected by resource allocation.

The principal role of the SMOE is to oversee, supervise and coordinate the implementation of education services in the localities and secondary schools on technical matters. The technical input is provided through guidelines, inspections and monitoring. This could in principle also include assistance on administration and management, but this does not happen. The SMOE does not want to interfere in locality decision-making.

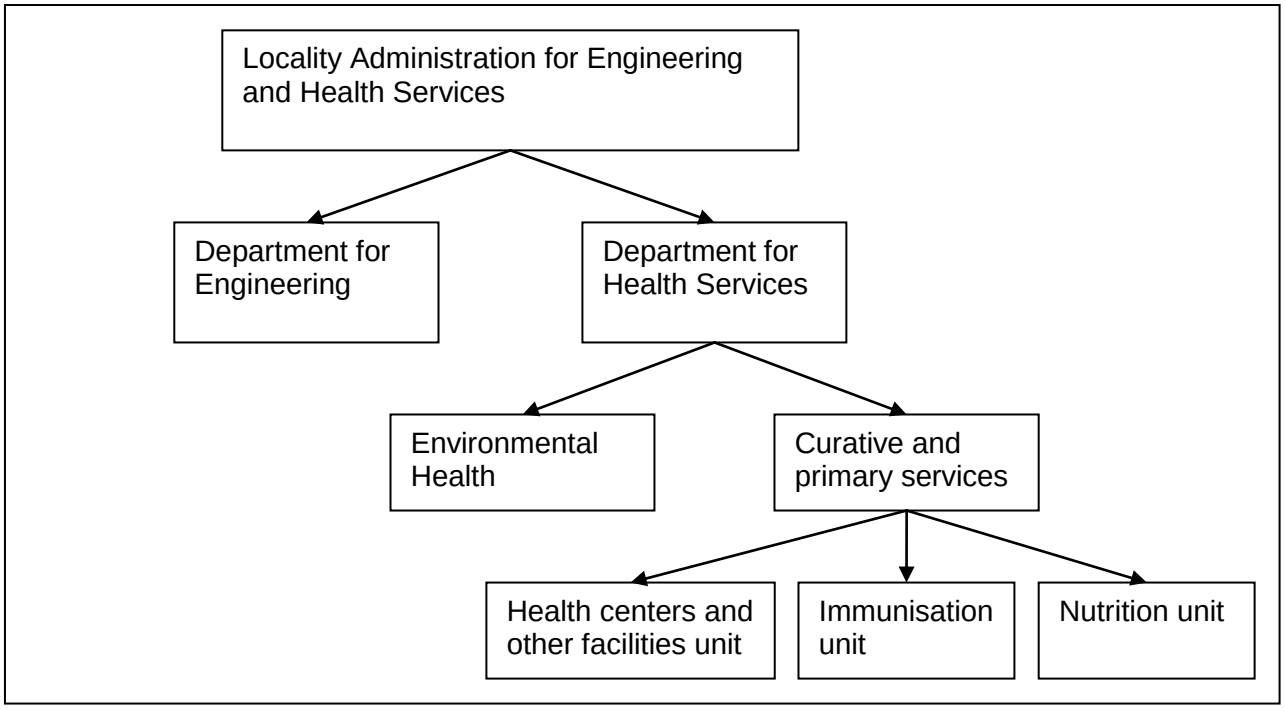
The two state ministries clearly feel independent from the federal sector ministries in terms of non-interference with their administration, yet in some critical areas still perceive that important decisions remain with the federal ministries. For example, the SMOH sees the role of the FMOH viz-a-viz the SMOH mainly to provide material support with medical devices and equipment, to manage the deployment of professional staff (specialists and consultants) and to have a technical role in the training and capacity building of health workers. The federal ministries are not considered as a resource for technical support except in specialised technical issues, which does not include areas of planning, management and financial administration.

Locality level

Locality administrations have been harmonised and have a common organisational structure with four departments: 1) Finance, Economic Development and Labour, 2) Agriculture and Animal Resources, 3) Health and Engineering and 4) Education and Social Affairs.

The administration of locality health services has been combined with the engineering services. Previously, the health administrations were separate units or combined with education. The Health Departments under the Administration for Engineering and Health Services are sub-divided into two units, Environmental Health and Curative and Primary Health Care Services. The latter is further divided into sub-units that vary between localities. The case of Sheikan Locality is illustrated in Figure 1.

Figure 1: Organisation of the health sector administration in Sheikan Locality, 2006.



Similarly, the Locality Administrations for Education and Social Affairs has a Department for Education that has two sections, one for basic education and one for secondary schools. These sections are often sub-divided into units.

The locality administration is responsible for public health and general education programmes as well as for overseeing the basic level service delivery and provision of basic materials. The main activities viz-a-viz the health facilities and schools are to provide staff salaries, and undertake regular supervision. There is generally no budget for other operational costs to the facilities and

schools. Resources for operations are available in kind, e.g. vaccines through EPI programme, school books through special programmes. Health facilities and schools can also access funding or resources by sending requests to the locality administration, e.g. when in need of replacement of light bulbs etc. Such resources are, however, limited and service delivery units to a large extent rely on other sources, e.g. user fees, community contributions, donations. In practice, only on emergency basis or in case of need for rehabilitation will funding from the localities be provided beyond salaries.

Except for Um Rawaba, the health departments in the localities are headed by medical assistants. In Um Rawaba, the head is a doctor. The head of the department generally has no specific training in health planning and management or financial administration. Similarly, the heads for education departments, who have a background as teachers, have no specific training in planning, financing and management. The SMOH perceives the capacity of the localities to take on their responsibilities as weak, mainly due to lack of financial resources, but also due to weak management capacity, yet locality administrations tend not to ask line ministries for assistance in this area. For education, lack of capacity building for planning and management has been further aggravated in the past by relatively high staff turnover.

The perceived challenges for efficient locality administration and efficient service delivery are many. Apart from the lack of management skills, there is lack of information: health management and financial information systems are not functioning and archives are in disorder so it is difficult to retrieve information from the past. Further, there is lack of transparency in the budget allocation process and lack of accountability. Budgets are generally not separated for departments or units making it difficult to see how many of the resources in an administrative area should be expected or have been spent in the fields of health or education. In relation to this there is lack of accountability and regular evaluation against the planned and budgeted activities, making it easy to divert funding to unplanned areas or in case of shortfall of funding letting the shortfall predominantly fall on one unit. Finally, the human resource management system is not adapted to putting the right persons in the right places.

4.1.2. Planning and budgeting process

Following is the budget process: The Federal Government level will issue guidelines for budget preparation mainly focusing on overall objectives and general policies. The State will adapt and approve the guidelines, issuing state guidelines outlining the state objectives and targets as well as policies and principles to be adopted. The SMOFEDL will establish Technical Committees to undertake economic and social situation analysis and to assist line ministries in budget formulation. Budget proposals are submitted to the SMOFEDL. At the same time Localities develop their annual budget proposal by Chapter and sector and submit it to the mini-parliament at locality level for approval for subsequent submission to the SMOFEDL. The budget proposals from localities are discussed with the line ministries and the relevant technical committee and compared to guidelines. After compilation the budget proposal is discussed in the state Cabinet and submitted to state parliament for discussion. Technical committees will receive the comments from the parliament and cabinet to be incorporated before resubmission of the budget proposal with a view to approval. The Locality Commissioner and key staff will present the Locality budget proposals to the Cabinet and the State parliament.

Generally, historical budgeting is applied (adjusted for inflation). The planning and budgeting process does not seem to be guided by any strategic plan that is based on identification of state needs and priorities and correspondingly no active prioritisation of the few resources seems to take place. The strategic analysis is to some extent limited by lack of data and inconsistent reporting that does not allow follow up and monitoring of activities and budget implementation.

The development of state plan and budget is based on information provided by localities and line ministries on revenues and expenditures and any new expected development. Revenue targets are set based on past performance and change in fees. In principle, the Cabinet and parliament determine fees based on actual cost estimates for service delivery. Workforce information will feed into the budgeting for Chapter One. Further, at least in principle, all assets and infrastructure will be listed and categorised according to status, resulting in annual depreciation, actual value and recurrent and capital investment costs that is used for basis for Chapter Two and Three. In practice, this is to large extent based on last year's budget and expenditures. Cases for major investments are used to develop budget and plans for Chapter Four.

Localities submit composite locality plans, e.g. including all sectors, to the SMOFEDL. Until recently the state ministries would plan for state level activities, but would not be deeply involved in planning at locality level. SMOH and SMOE would also not receive copies of the proposed locality plans for approval or technical comments. However, for the first time there was an initiative by SMOH in 2005 to compile a state plan for health for 2006 that would include all locality plans. While the sector plan is compiled in the SMOH and while SMOE are making some attempts at a joint planning process for the sector, once the budget has been approved, there is no further interference or monitoring of budget execution from the line ministries. All relations between locality and state regarding finances take place between the state and locality finance administrations.

Box 1: Budgeting for health services in Sheikan Locality

The budget proposal for health is developed by each unit in the Health Department (basically on an historical basis) and the proposal is compiled by the Health Department. There are no budgets developed for individual health facilities. The head of the Health Department does not receive support from the SMOH in development of plans and budget, but the locality finance administration will assist.

The budget proposal is submitted to the head of Engineering and Health Administration, who combines the budget for the Department and forwards the proposal to the Locality Administration for Finance, Economic Development and Labour. It will then become part of the comprehensive locality plan and budget to be discussed in the Locality mini-Parliament. After deliberations and adjustments, this will be sent to the State Cabinet for review and final presentation to the State Parliament.

The budget approved is usually less than the budget proposed and a re-planning exercise takes place in the Department of Health. When funds are released they are usually less than the approved budget and resources are again re-planned. Furthermore, fund releases are usually delayed often due to late approval of the budget. For example, in the 2006 financial year the final budget approval was made by end of March/early April. Funds usually start coming at the end of April. As funds cannot roll over from 2005, this implies that no activities take place during this period except for when credits from suppliers can be negotiated.

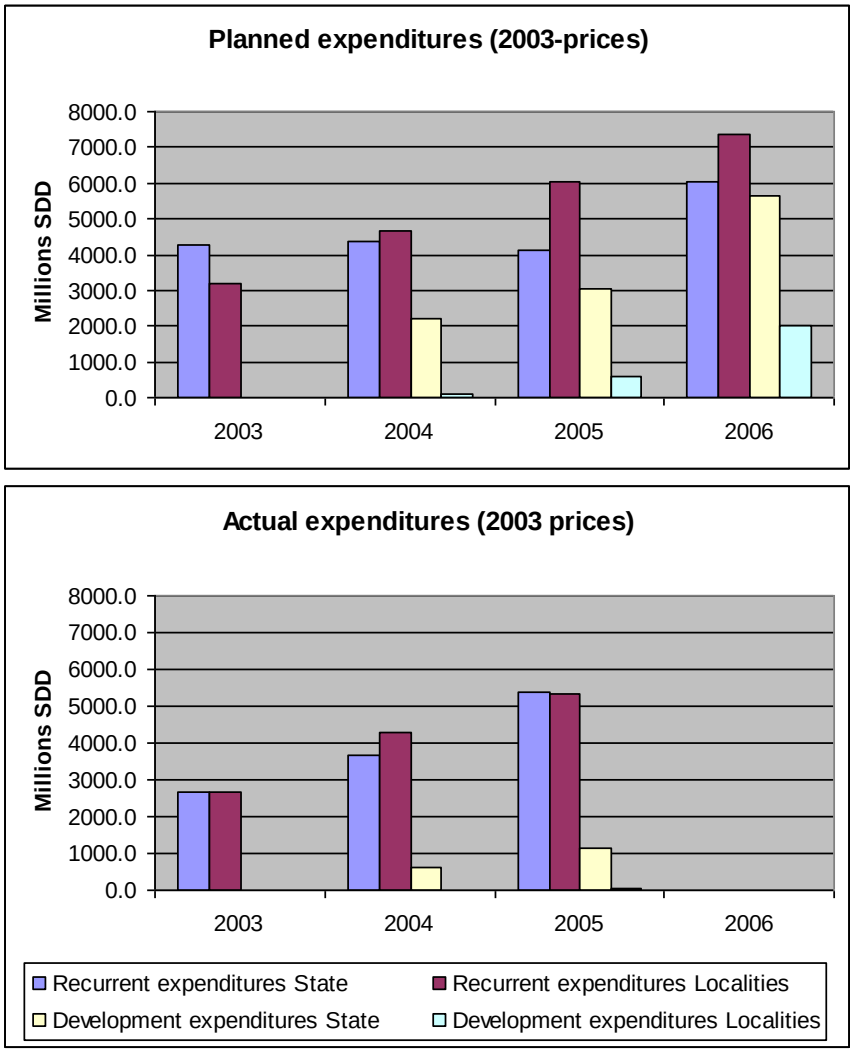
There is a gap between the proposed and the approved budget and likewise between the planned and actual expenditures. The budget execution rate for the SMOH was 72% in 2005. The gap is due to delays in subsidies from the federal level FMOFNE as well as dependency on agri-pastoral production for state revenue generation and therefore vulnerability to unpredictability in the production determined by climatic variations.

The public financial management system is cash-based and disbursements take place only as liquidity is available. The first priority is given to salaries. One implication of this is that predictability of the locality budget is low. Low predictability in the flow of funds, in the form of general delays in release of funds and actual releases below the planned levels, provide little incentive for serious planning and reprioritisation generally takes place at the point of receiving the funds (see Box 1).

4.1.3. Overall state and locality finances

North Kordofan State has taken on more responsibilities and received increased funding in the form of federal transfers in recent years. This has allowed for increase in the planned and actual overall expenditures in nominal as well as real terms at both State and Locality levels (see Figure 2).

Figure 2: Planned and actual State and Localities expenditures in fixed prices (2003). North Kordofan 2003-2006.



Note: Recurrent expenditures = Chapter One + Two; Development expenditures = Chapter Three + Four.

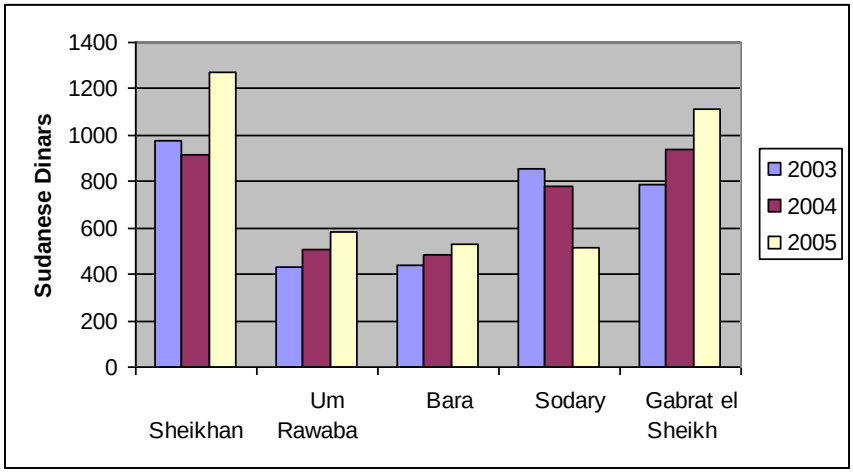
The stepwise decentralisation is reflected in the expenditure structure as illustrated in Figure 2. It appears that total recurrent expenditures (Chapter One and Two) were planned to increase at both state and locality level. In line with increased decentralisation, the planned growth for localities was higher than for the state, i.e. the average annual growth 2003-2006 for planned recurrent

expenditures in fixed 2003 prices was 32 % for localities and 12 % for the state level (with zero growth in real terms 2003-05). While actual expenditures have increased steadily for both levels of administration, locality expenditures increased less than planned and state expenditures more than planned in 2005. Development expenditures (Chapter Three and Four) were first decentralised to the state level and later to the locality level. While planned for, the budget execution of development spending is lagging behind, and actual expenditures low, but increasing.

Apart from problems in the implementation of development projects, including delays in procurement, this also reflects the fact that the public financial management system is cash-based with the implication that disbursements will be made only when liquidity is available. Generally, as in many resource constrained settings, first priority is given to payment of salaries (Chapter One), second priority is given to operations and maintenance (Chapter Two), while development budgets have the lowest priority.

To finance expenditures the localities receive transfers from the state government and generate own revenue. The five localities vary in terms of affluence (and perhaps revenue collection capacity) as reflected in the revenue per capita they are able to generate, which in 2005 ranged from 511 SDD per capita in Sodary to 1274 SDD per capita in Sheikan Locality, see Figure 3.

Figure 3: Actual revenue per capita in five localities in North Kordofan, 2003-2005.



Sheikan may be considered atypical as it is the state capital, but it clearly appears that Sheikan and Gabrat el Sheikh are considerably better off than Um Rwaba, Bara and Sodary in terms of revenue generation ability. This seems not to correspond to the general perception of the relative attractiveness of the localities, in which Um Rawaba is considered attractive, and may not be a reflection of revenue generation potential.

The focus of this report is the extent to which this increased overall funding has resulted in increased resources for health and education sectors at state, locality and facility level.

4.1.4. Sources of financing and flow of funds

The main sources of funding for locality health services are the funds received from the state, mainly for staff salaries, and user fees. Other sources include the special programmes of the State and Federal MOHs and community contributions, mainly for development costs.

The flow of funds varies by expenditure category. Figure 4 below provides an overview over the flow of funds for recurrent expenditures for locality health services as reported for North Kordofan State.

Chapter One in the Government budget classification contains personnel expenditures in terms of salaries for staff in permanent positions. Until recently, staff in localities were counted on the salary rolls of the states. In 1995 staff were transferred to the "health areas", but remained paid by the SMOH. After the creation of the Localities, such staff are supposed to be transferred to the payroll of the locality administration. However, while this is the case for many staff, there are still some staff that continue to be on the State payroll although they work at Locality level. Consequently, the State budget for Chapter One includes some staff that work at Locality level and in terms of resource distribution this will tend to lead to an overestimate of the resources at state level and underestimate the resources at locality level. For localities, salaries for all locality staff are budgeted, paid and accounted for directly from the Locality Finance Administration. This practice makes it difficult to disaggregate salary expenditures for health.

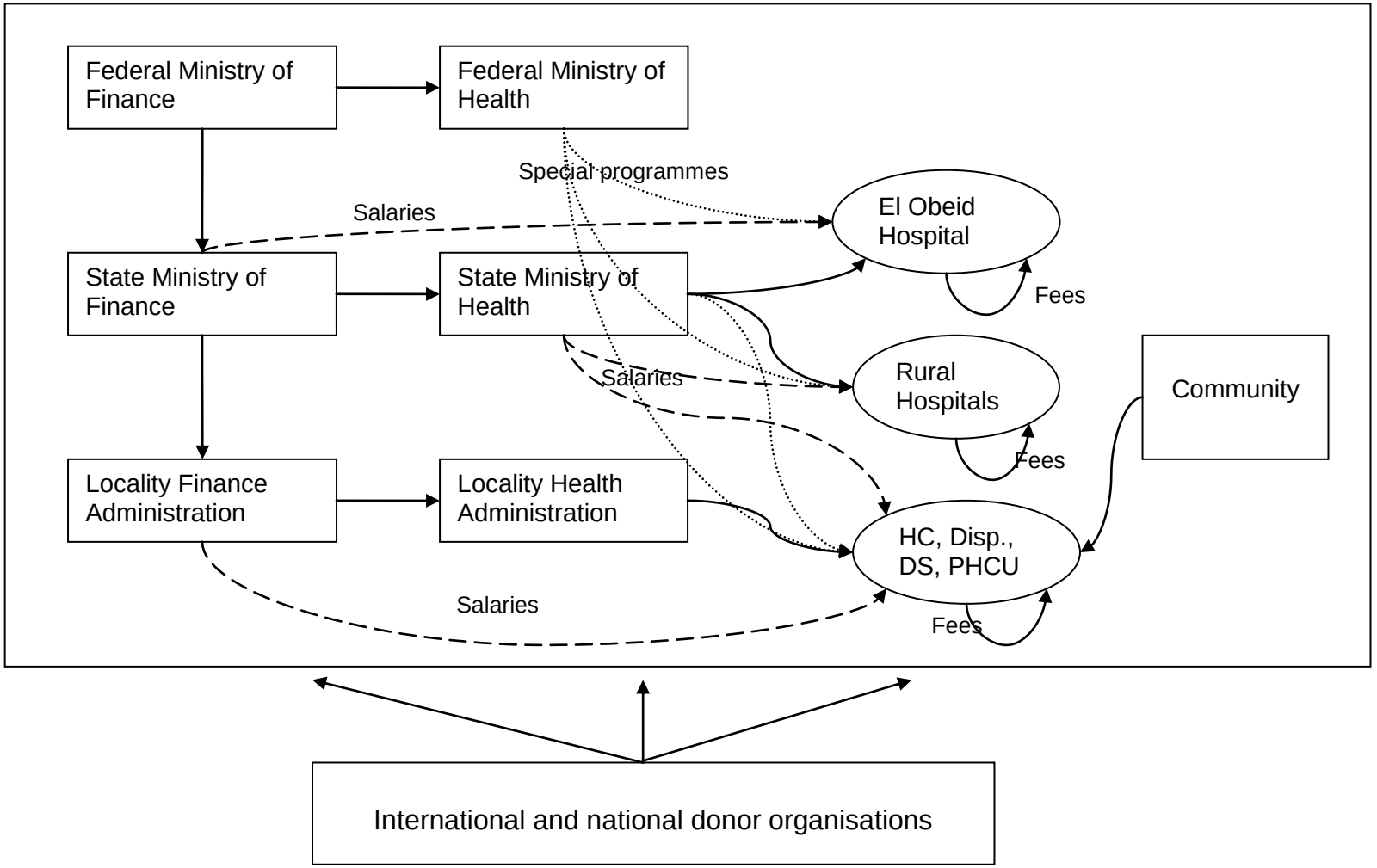
Box 2: Financing sources reported by Sheikan Locality Health Department.

> The financing of health services in Sheikan Locality depends on the budget from the Locality Finance Administration, which in turn largely depends on transfers from the State Ministry of Finance. Although some financing comes from the SMOH through programmes like the malaria programme, such funding is not planned for and cannot be relied upon. It is therefore not included in the budget. Furthermore, it happens sometimes in case of emergencies that the SMOH will channel funds directly to the Locality Health Department. Another source of revenue is the fees paid by patients.

Chapter Two in the Government classification system contains other recurrent expenditures. This includes also some personnel expenditure for temporary employees and bonuses for permanent staff. SMOFNE allocates funds for Chapter Two expenditures to SMOH, some of which are channelled to El Obeid Hospital. Out of the general transfer to the localities, locality finance administrations allocate funds for Chapter Two to the Department for Health Administration. Until recently these were the only category of expenditures planned for by the locality health administrations. Some additional financing for Chapter Two expenditures comes from Special Programmes at the FMOH, for example to carry out immmunization campaigns. Such funding through Special Programmes in principle features in the expenditure statements as it is channelled through the SMOH and locality health administration as appropriate.

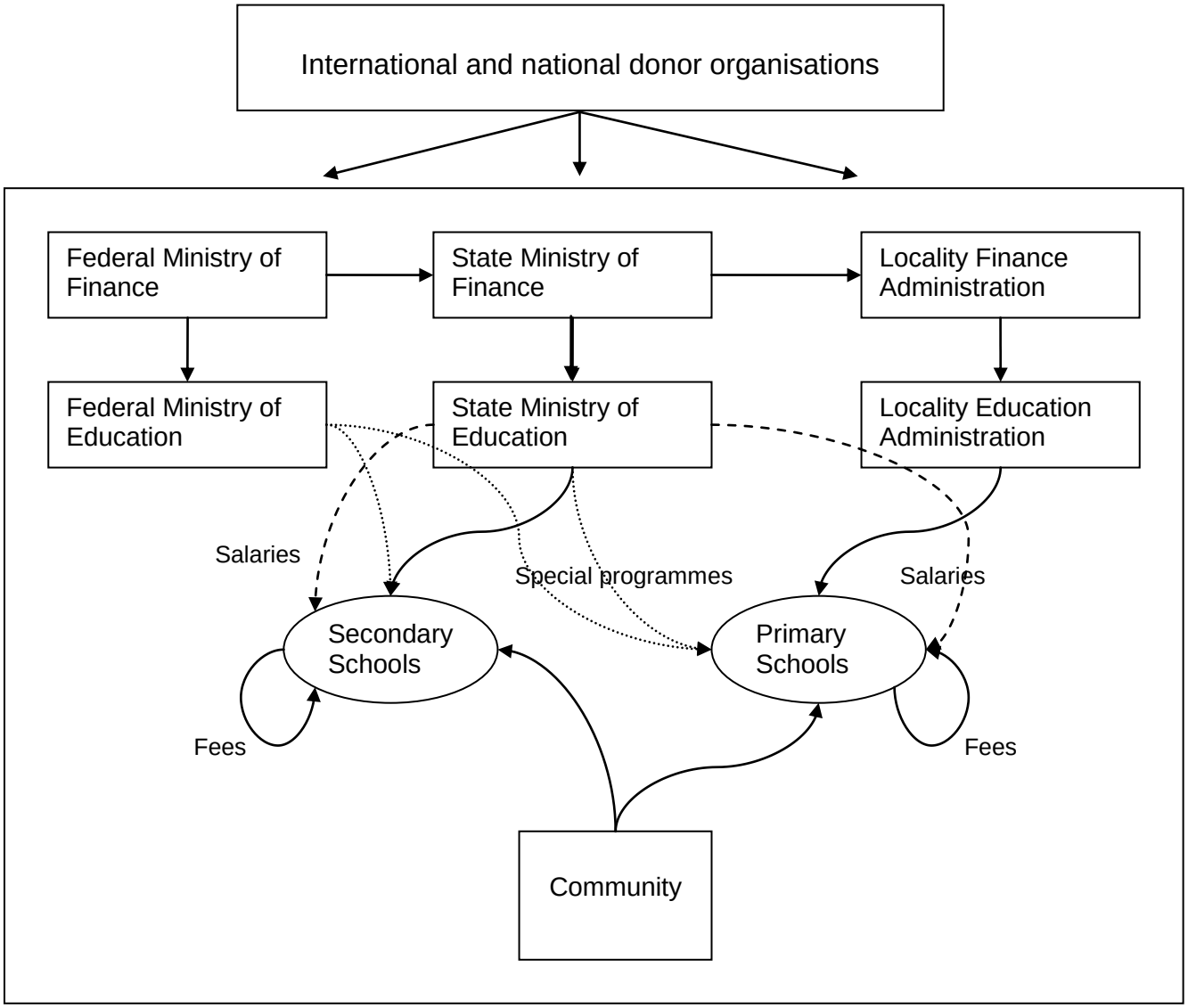
For Chapter Three (capital costs) and Chapter Four (development schemes) funding flows vary. Equipment is sent from FMOH via SMOH, whereas development projects may involve direct relations between FMOH and contractors (with copies to the SMOH).

Figure 4: Illustration of flow of funds for recurrent expenditures in the health sector in North Kordofan.



The flow of funding to end-users of education follow a somewhat similar pattern, cf. Figure 5. The main sources of funding are the locality (from state transfers, mainly for salaries), parents, on which the schools rely heavily, and fund-raising by private organisations. Transfers are made from FMOFNE to the state ministry of finance and from there to the locality finance administration. At each administrative level the funds are allocated to sectors, including Education. The main sources of funding for the basic schools are the locality, user fees and community contributions. In addition, support from special programmes under SMOE and FMOE, for example school feeding, benefit the schools.

Figure 5: Illustration of flow of funds for recurrent expenditures in the education sector in North Kordofan.



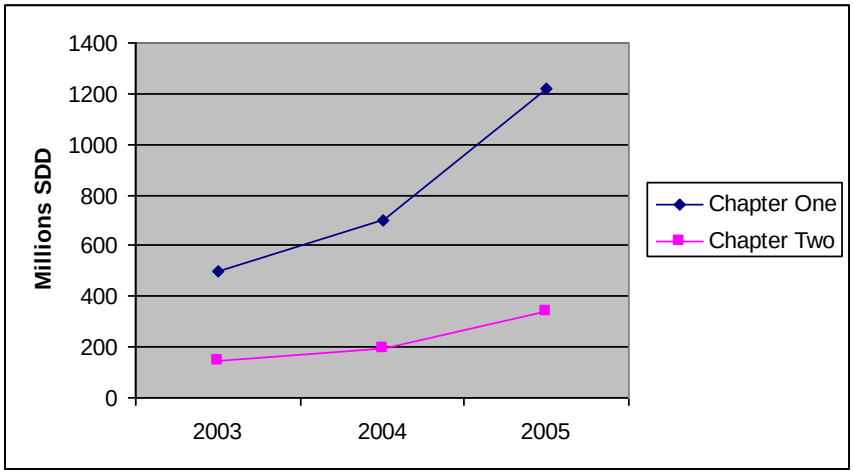
With regard to development funding, special programmes or mobilisation of the communities are the usual sources of funding.

4.2. Financing of locality level health services

4.2.1. State level expenditures for government locality health services

Salaries
In nominal terms the planned salary expenditures by SMOH has increased considerably, cf. Figure 6, on average 45% annually over the period 2003 to 2006. This has happened despite the administrative transfer of staff to the locality level. However, in line with this transfer, the SMOH salary bill as a proportion of total state salary expenditures has decreased from 43% in 2003 to 31% in 2005. Still, a part of the state salary expenditures are for remaining staff on the SMOH payroll working at locality level. There is no information of the numbers of such staff or the relevant salary expenditure.[1] As the number of staff working at locality level who are on the state payroll is likely to decrease over time as new staff are appointed and old staff retire, this in itself should result in a theoretical resource shift in terms of salaries from state to locality level (theoretical because a resource shift for this reason would reflect a shift in administrative practice rather than a physical shift in human resources). In any case, given the expectation that there should be a trend towards a lower SMOH wage bill as responsibility is shifted to the localities, the increase in state salary expenditures remains to be explained. Possible factors could be increases in wage levels for the higher level cadres (ie. doctors) who are likely still on the state payroll as well as possibly transfers to the state of responsibility for doctors who were previously employed by FMOH.

Figure 6: Actual recurrent expenditures 2003-2005. SMOH, North Kordofan.



The shift in the balance between Chapter One and Two expenditures may reflect a shift in the balance between personnel inputs and other recurrent inputs over the three years or may reflect shifts in relative prices, e.g. higher salary increases than general price increases.

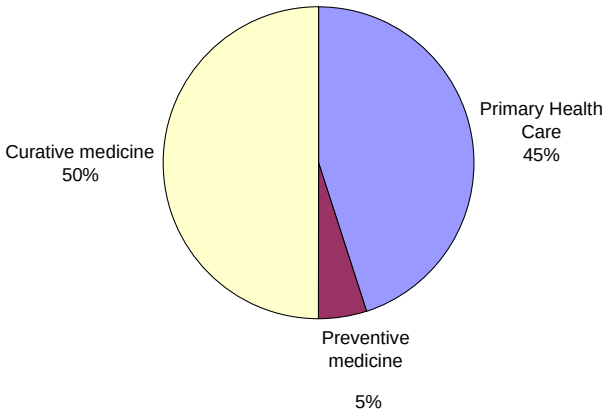
Other recurrent expenditures
The SMOH has experienced considerable growth also in non-salary recurrent expenditures in recent years. The health sector accounts for an increasing percentage of total state non-salary recurrent expenditures, increasing from 10% in 2003 to 14% in 2005. A part of the expenditures at state level is used for activities at the locality level.

[1] At least such information is not easily accessible, but would involve manual compilation based on the entire pay-roll for SMOH.

Recently, the SMOH has started using a functional classification for the budget that categorises expenditures into curative medicine, preventive medicine and primary health care, cf. Figure 7. For 2005, half of the SMOH budget was used for curative medicine. Curative medicine mainly includes running costs for El Obied Hospital (60%), other hospitals (23%) and pharmaceuticals (14%), while the remainder is for regional laboratory services, health information system and other costs.

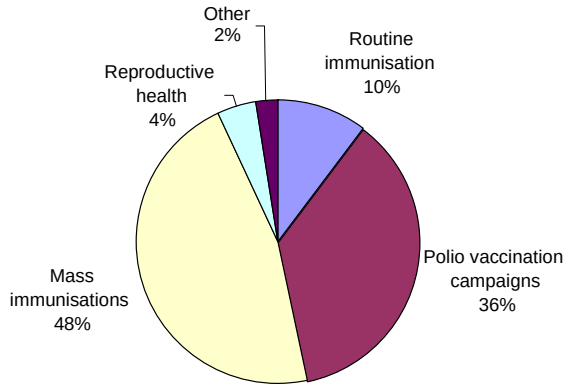
Expenditures for preventive medicine are mainly targeted for activities in the localities, such as malaria control. Such activities take up only a minor part of the budget.

Figure 7: Distribution of non-salary recurrent expenditures (Chapter Two) by functional classification. SMOH, North Kordofan, 2005.



The breakdown of the PHC expenditures, presented in Figure 8, shows that the majority of expenditures are aimed at the implementation of services at community level with polio vaccination campaigns and mass immunisation consuming the majority of non-salary recurrent expenditures. In this respect the state funded and implemented programmes supplement service delivery at locality level.

Figure 8: Distribution of non-salary recurrent expenditures (Chapter Two) for Primary Health Care (PHC). SMOH, North Kordofan, 2005.



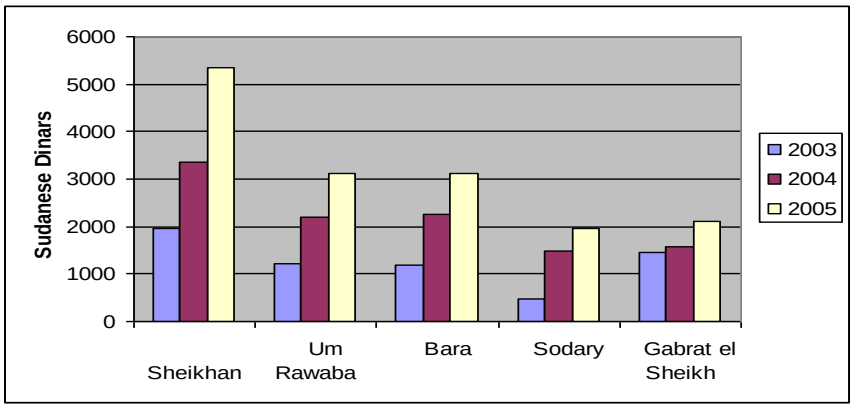
4.2.2. Locality level expenditures for government health services

Locality expenditures are generally funded from two sources, transfers from the state and own revenues. As shown in Figure 3 (p. 9), per capita revenue varies considerably between the

localities and thus also their scope for raising funds from own sources. Locality expenditures which are financed by a combination of own revenues and state allocation therefore, not surprisingly, show a somewhat corresponding pattern. From these sources the locality has to finance health and education services among other things.

The locality receives and reports un-earmarked Chapter One transfers from the state. It has therefore not been possible to establish the amount of Chapter One expenditures for locality health services separately. The general development in Chapter One spending in the five localities is illustrated in Figure 9.

Figure 9: Actual locality per capita expenditures for Chapter One (all sectors) by locality.



Chapter One expenditures depend on staff distribution as the budget for personnel follows the staff. It appears that Sodary and Gabrat el Sheikh had the lowest per capita personnel expenditures in 2005, indicating a higher population per staff than other localities or staff with generally lower qualifications and correspondingly lower pay. Actual per capita expenditures for Chapter One have increased in all localities, however mostly in Sheikan, Um Rwaba and Bara, while Gabrat el Sheikh experienced only limited growth. In 2003, the difference between the highest and lowest per capita Chapter One expenditure was 1478 SDD, while in 2005 it was 3393 SDD. While indicative, this is the overall picture for Chapter One, e.g. including all sectors, and the distribution of human resources for health and consequent per capita salary expenditures could be different.

A closer examination of the data reveals that the increase in salary expenditures coincides with an increase in staff numbers, see Table 1 regarding the health sector in Bara. However, at the same time there appears to have been considerable allocations to payment for temporary staff and bonus incentives included under Chapter Two previously, e.g. Bara. The staff increase observed could either be due to transfer of staff from the SMOH payroll, to giving permanent position to temporary workers and to hiring of additional staff. Only in the latter case do increased locality expenditures signify increased resources available for service delivery.

A rough assessment of Chapter One expenditures for health can be made based on the number of staff and the information collected in the Health and Education Facility Survey. In the survey, facilities when asked about their budget generally appear to consider Chapter Two. However, asked about other sources of financing available for the health facilities, most facilities mention salaries and many specify an exact amount. Cross-check reveals that the amounts reported are reasonable for the number and level of staff reported in the specific facilities.

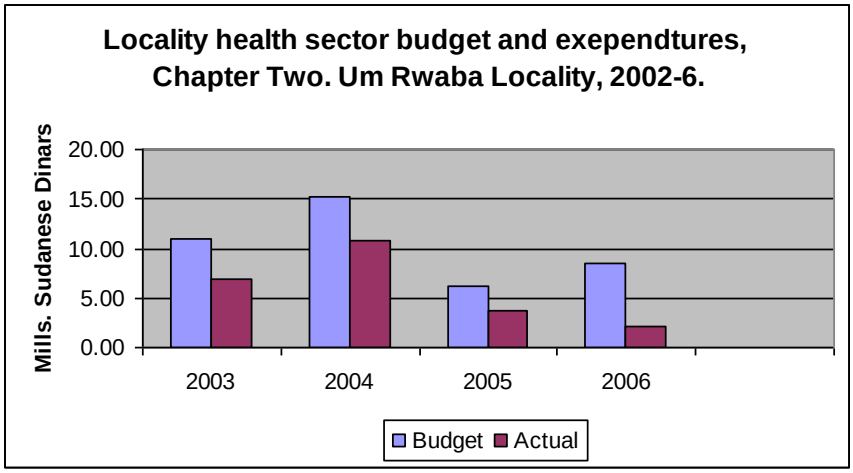
Table 1: Locality health sector man-power in Bara

Health Sector	2000	2001	2002	2003	2004	2005
Doctors	2	2	2	3	3	3
Assistant Doctors	17	22	22	25	30	30
Nurses	35	34	34	30	29	28
Helpers-Health Officers-Mosquito Obs.	56	58	58	58	59	59
Sweepers-Guards-Gardeners	60	60	56	56	89	89
Total	170	176	172	172	210	209

The average salary payment per facility represents an average given the staff numbers and skills mix of the selected health facilities. Assuming that the selected health facilities are representative for the state 1) in terms of skills mix and staff numbers for facility type and 2) in terms of mix of facility types, the average salary payment per facility from the sample can be used for extrapolation to the locality level. There is no a priori reason to believe that assumption 1) would not be the case. Further, since the facilities were selected proportional to size on the FMOH list of facilities, it might be assumed that the facility type mix would also be representative for the state (assumption 2). With a mean salary support of 408,000 SDD per health facility at health center level and below and 542 health facilities as per the FMOH list, the estimated salary bill in the locality health services would be 221 million SDD, financed by the localities and the state.

However, a facility survey undertaken in 2003 (yet to be officially endorsed) suggests that the number of functional facilities may be lower than than the FMOH list especially at the lowest levels of services, in which case the facility mix may no longer be representative. The average salary bill varies slightly between facility levels, but there is no statistically significant difference. The application of facility level specific average wage bills only marginally changes the estimated salary bill (from 221 million to 224 million using the FMOH number of facilities). However, the estimated salary bill is considerably lower, if the lower number of functioning facilities found by the 2003 facility survey is used. In this case, the estimated salary bill is reduced by about 50% to only 111 million SDD. These estimates only include facility staff at health centre level and below and exclude hospital and administrative staff.

Figure 10: Locality health sector budget and expenditures for Chapter Two. Um Rwaba Locality, 2002-2006.



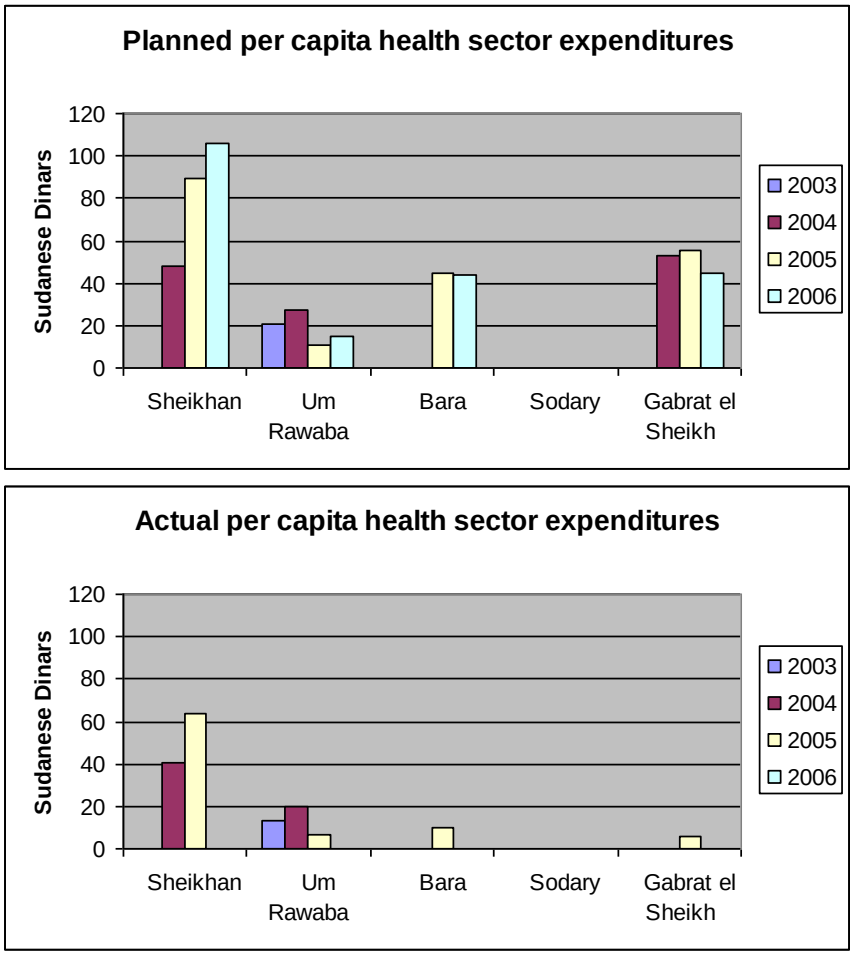
Note: Actual expenditures for 2006 comprise first quarter only.

As regards Chapter Two, the localities tend to have disfavoured the health sector either by decreasing budgets (and expenditures) as in the case of Um Rawaba, see Figure 10, or in relative

terms as in the case of Gabrat el Sheikh, see Figure 12. Um Rwaba has experienced decreasing budget allocations and expenditures from 2003 to 2005, but the trend appears to have reversed for 2006, as the budget was increased compared to 2005 and expenditures for the first quarter of 2006 had reached a level corresponding to half of 2005 expenditures.

Even when the budget for Chapter Two in nominal terms have remained more or less stable over time as is the case in Gabrat el-Sheikh Locality, the percentage of total locality spending that is allocated for health has decreased from 5.1 % to 3.9%. That is, out of the little increase in per capita Chapter Two expenditures overall, relatively less of the increase has benefited health than other sectors.

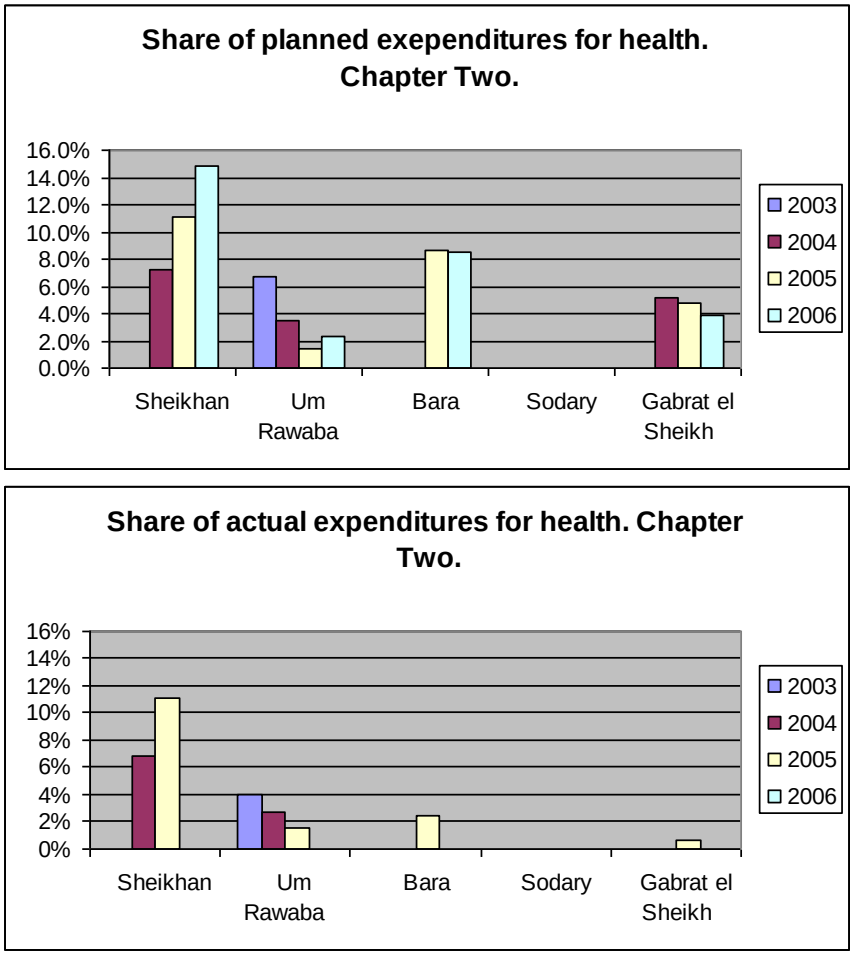
Figure 11: Planned and actual per capita health sector expenditures for Chapter Two.



The data availability varied between localities, but some cross-locality comparisons can be made. Interestingly, the planned per capita health expenditure is lowest in Um Rwaba, only 15 SDD per capita in 2006, whereas Bara and Gabrat el Sheikh planned for 44-45 SDD per capita and Sheikan highest with 106 SDD per capita, cf. Figure 11. The trend seems to be a slight decrease in planned per capita Chapter Two expenditures for health, except for Sheikan. Planned expenditures do, however, not always materialise and actual expenditures per capita are much lower. For last financial year (2005) Um Rwaba, Bara and Gabrat el Sheikh reported equally low health care expenditures for Chapter Two at 6 to 9 SDD per capita compared to 64 SDD per capita for Sheikan.

The share of the total Chapter Two budget allocated to health to some extent reflects the priority given to health. The percentage seems to be generally decreasing except for Sheikan, indicating that increases in the overall Chapter Two locality budgets have mainly benefited other sectors, cf. Figure 12. Priority in terms of budgetary allocation appears to be highest in Sheikan, reaching 11% in 2004 and 15% in 2006, followed by Bara with slightly below 9%. When it comes to actual allocation and expenditures, Sheikan is still spending relatively more of its total spending for Chapter Two on health (11% in 2005) than the other localities (1-2% in 2005). It is worth noting that the percentage allocation of the actual releases more or less corresponds to the percentage allocation of the budget in Sheikan and Um Rwaba. This could reflect a larger capacity to develop reasonable projections or a kind of budgetary discipline in terms of sharing the released funds (although less than budgeted) proportional to the budget.

Figure 12: Share of actual and planned Chapter Two expenditures for health.

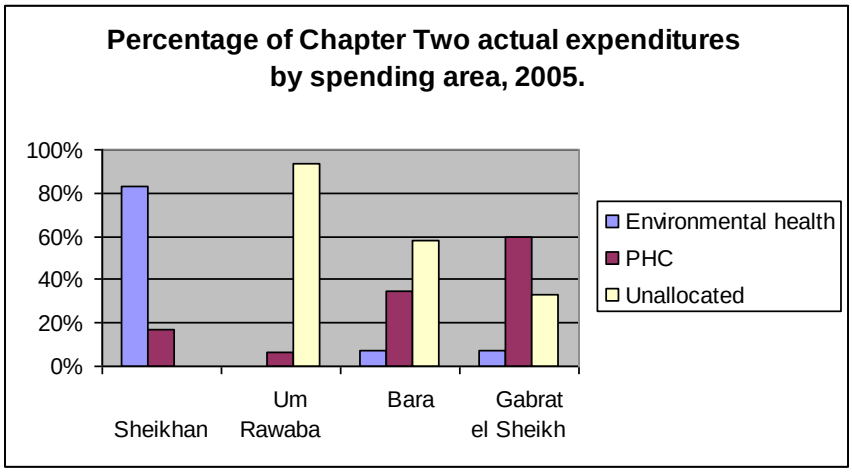


Expenditures by functional area

Only very limited information is available regarding the functional areas of expenditures. Classification of expenditures is generally made only against line items such as utilities, bonuses, advertisements etc. Some items can, however, clearly be identified as environmental health or primary health care. The distribution between expenditures for environmental health, primary health care and unclassified line items for 2005 is shown in Figure 13. It appears that in Um Rawaba almost all and in Bara more than half of expenditures cannot be classified according to functional area. In Sheikan, on the other hand, all line items were classified according to

environmental health or primary health care with the two sub-units essentially having individual budgets.

Figure 13: Percentage of Chapter Two actual expenditures by functional area, 2005.



Comparison between localities is difficult due to the variation in expenditures unclassified according to functional area. The balance between the two functional areas appears to vary significantly. The large share of the budget for environmental health in Sheikan is due to an Environmental Health Support Programme. The relatively high allocation of environmental health rather than PHC may reflect the fact that in the past the main responsibility of local government areas was environmental health. For Gabrat el Sheikh, trend data are available and show no major change in the balance over time.

4.2.3. Health sector revenues

Revenues generated in the health sector at the administrative level include health licenses for restaurants etc. as well as health cards issued to individuals allowing them to work in food-handling. Further, fees related to inspection of slaughtering and meat transportation, garbage collection and sewerage are considered part of health sector revenue, possibly reflecting the emphasis hitherto on environmental health as the main responsibility for the sub-state level administration in the health sector. Most likely it is also this focus that has guided the decision to merge the health and engineering department in the localities. In addition, user fees are collected in relation to service delivery, see below, but only Gabrat el-Sheikh locality includes user fee collections in its reporting on health sector revenues.

Revenue information was available for three localities only. Um Rawaba and Bara localities provided information on fees generated at locality administration level and Gabrat el Sheikh provided information on fees related to health service delivery.

The actual revenue collection is lower than the expected revenues, cf. Figure 14 and Figure 15. This can indicate poor projection skills or leakage in the system. This is a problem for motivating planning. Planning is only meaningful if the plans more or less reflect resources available. In case of large discrepancies, between projected and actual resources available, re-planning is needed. Health licenses are a relatively important source of revenue in both localities, contributing approximately 50% of revenues.

Figure 14: Expected and actual health sector revenues. Um Rawaba Locality

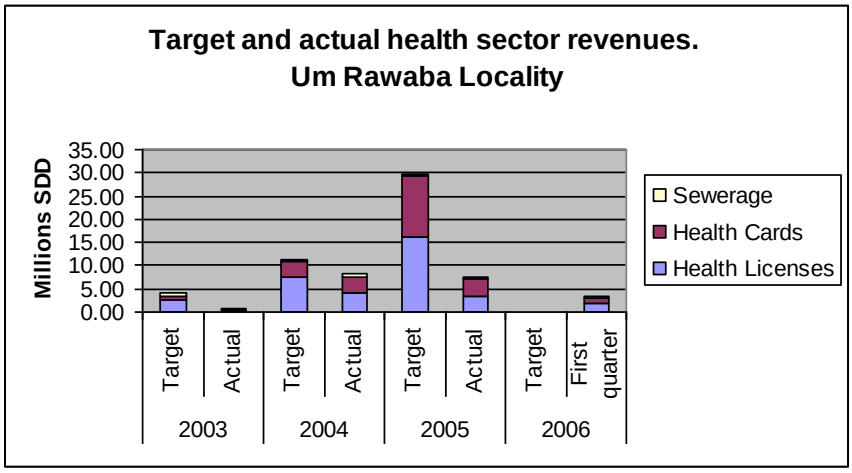


Figure 15: Expected and actual health sector revenues by category of fee. Bara Locality.

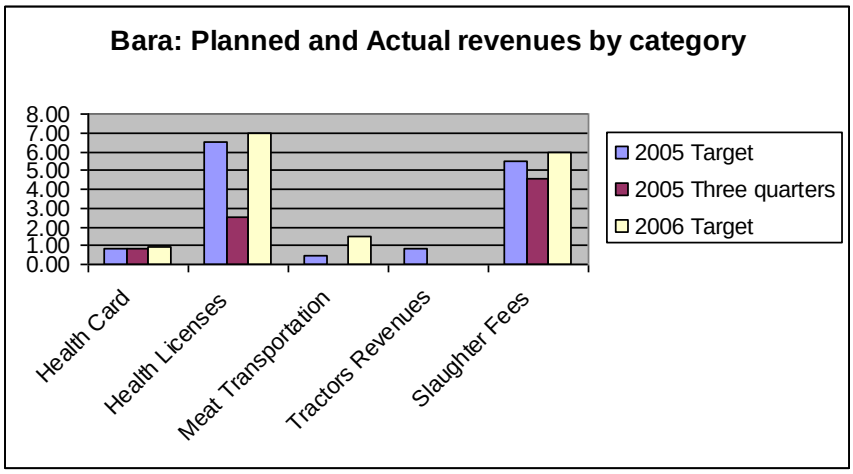
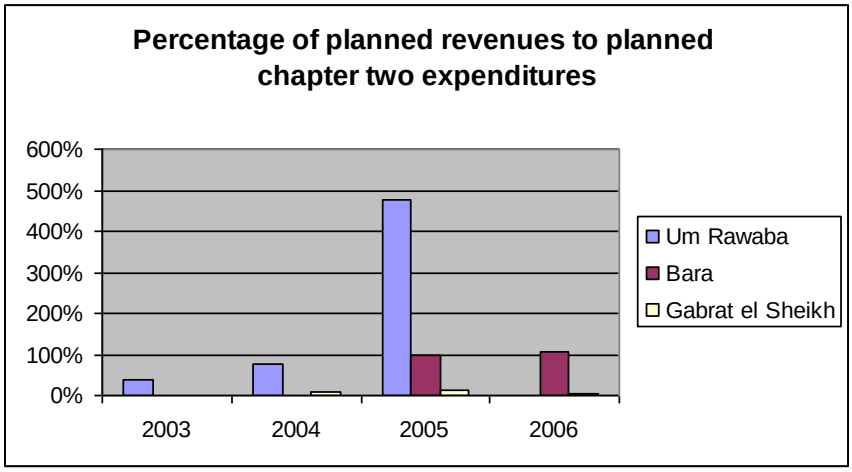


Figure 16: Percentage of expected revenues to planned Chapter Two expenditures.



To gain an impression of the relative importance of the revenues generated in the health sector at locality administration level, the revenues can be compared to the operational expenditures. It

appears, cf. Figure 16, that in 2003 planned revenues covered less than half of planned Chapter Two expenditures, with the remainder to be financed out of the state transfers to the locality. In 2004, almost 100 % were planned and actually collected, whereas in 2005, the planned Chapter Two expenditures could be covered almost five times and even the actual health revenues were twice the size of the actual Chapter Two expenditures. This implies that health administrative revenues can contribute not only to Chapter Two, but also to Chapter One. In Bara, the planned revenues correspond almost exactly to the planned Chapter Two expenditures.

4.2.4. User fees for health services

Neither Um Rawaba nor Bara localities reported user fees as a source of revenue. However, user fees are collected for such items as laboratory services, surgery, and outpatient visits, in all facilities. SMOH provides guidelines for setting fees, but does not know to what extent they are followed. The national strategy for pharmaceutical supply is to establish drug revolving funds, which in most cases recover full costs from the patients. The facility survey found that such funds function in some facilities.

According to respondents in the Health and Education Facility Survey, the user fee revenues were retained in 88% of the health facilities. The reports from the Localities does not include revenues from the health facilities – at least in any disaggregated form. User fee collections at El Obeid hospital and rural hospitals are reported by the SMOH.

In the Health and Education Facility Survey, respondents were asked to report on user fee revenues. Only 30 facilities report user fees as a source of funding: All hospitals, most health centres (82%), many dispensaries (42%) and almost none (5%) of the PHC units and dressing stations. However, all health facilities later in the survey questionnaire confirm that patients attending the facility have to pay user fees. It is therefore assumed that user fees are collected in all health facilities, but that for some reason the respondents do not consider user fees a source of financing (perhaps because the question was asked in the context of the budget) or have not been willing or able to tell about the amounts. The budget and financing may be perceived as something that comes from the government and should be planned for, while user fees are used as unplanned resources to make services run.

The average user fee collections by health facilities that report their collections are used to estimate total collections in the state, see Table 2.

Table 2: Mean annual collection of user fees by category of facility. '000 SDD.

Type of facility	Health and education facility survey			Data from SMOH	
	Mean	90% CI	N	Planned total	Actual total
Federal hospital	175,480	-	1	175,500	147,900
Hospitals	11,572	2,155 – 21,xxx	9	71,400	90,600
Health centres	1,226	529 -1,923	9	n.a.	n.a.
Below health centres	264	138 - 391	11	n.a.	n.a.

The user fee collections are statistically significantly different between the four categories of facilities and collections increase with increasing levels of service as would be expected. It is assumed that the sample selected and of these, the reporting facilities within each type of health facilities, are representative of the pattern of user fee collection in the entire State. Given the relatively low response rate to this particular question, the uncertainty is not insignificant.

If the responding facilities are representative for facilities in the state, then the total user fee contribution to the running of the government health services can be estimated:

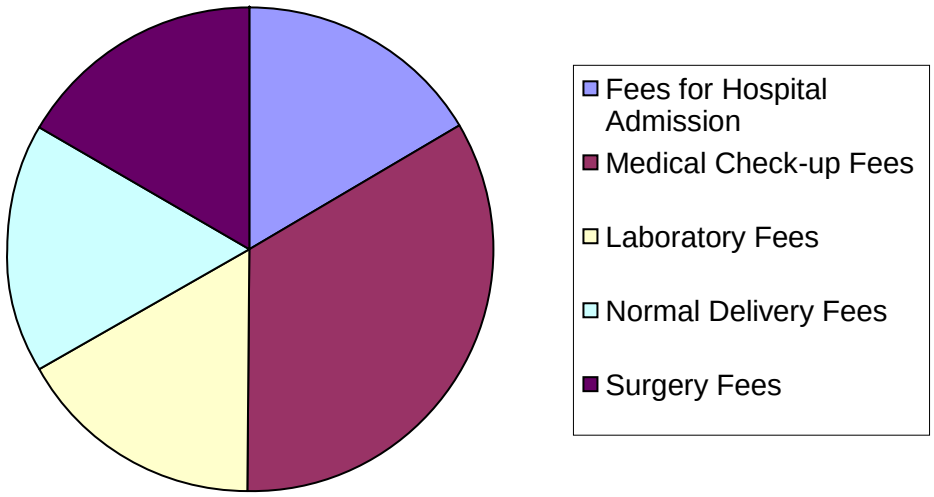
Table 3: Estimated user fee contributions. In thousands SD.

Type of health facility	Mean user fee revenue	Number of facilities		Total user fee estimate A		Range for user fee estimate	
		A	B	A	B	A	B
El Obeid hospital	175480	1	1	175480	175480		
Hospitals	11572	13	12	150436	138864		
Health centers	1226	37	40	45362	49040		
Below health centers	264	505	232	133320	61248		
Total		556	285	504598	424632		

Note: A-Based on the FMOH list of facilities; B-Based on the findings of the

The planned revenues from Gabrat el Sheikh indicate the expected contribution to revenues from various types of fees. The largest contribution to revenues is expected to be generated from medical check ups, while the remaining fee categories are expected to contribute equally to the revenues.

Figure 17: Expected revenues from hospital user fees by fee type, Gabrat el Sheikh, 2005.



In addition communities as a whole sometimes contribute, mainly in the form of support for development expenditures. The Health and Education Facility Survey found that 59% of facilities were constructed with community contributions, mainly at the lower levels.

4.2.5. Overview of resources for operation government health services at locality level

In summary, an overview across sources of the financing of locality level health services can be provided for 2005. Based on the various sources of information and some assumptions, the recurrent financing of locality health services can be estimated. Locality health services may be defined as health services delivered at health centres and below, as the localities do not have any responsibility as regards hospital services. The estimated financing for running the locality health services in 2005 amounted to 382 SDD per capita or approximately 1.6 USD per capita, cf. Table 4. It appears that of the total financing of recurrent expenditures, 36% is spent on salaries and 64% on non-salary recurrent expenditures. However, non-salary recurrent expenditures also include bonuses and incentives. Users contribute 29% of total recurrent financing, and 46% of non-salary recurrent expenditures.

Table 4: Estimated recurrent financing of locality health services (health centres and below), North Kordofan 2005.

Expenditure category	Actual expenditures (Millions SDD)	Distribution by	
		Chapter	source
Chapter One	220	36%	
Chapter Two	391	64%	
Localities	*41*		11%
State	*171*		44%
Users	*179*		46%
Total	611	100%	100%
SDD per capita	382		
USD per capita	1.6		

Assumptions:

1) Chapter One expenditures can be extrapolated from survey data.
2) 50% of SMOH Chapter Two expenditures support PHC and Prevention interventions that are implemented at the lowest level of the health care delivery system
3) Per capita Chapter Two expenditures in Sodary Locality are similar to the average of Um Rawaba, Bara and Gabrat el-Sheikh. Sheikan being the capital is considered atypical and therefore not included in the average.
4) User fee revenues can be extrapolated from survey data. These revenues are used for non-salary operational costs.
5) Number of facilities according to FMOH list.

Since hospital services may be considered part of a broader locality health service system, and since there is no clearly defined gatekeeper referral system requiring referred access to hospitals, it is also relevant to consider hospital services.

Table 5: Estimated recurrent financing of first referral hospital services, North Kordofan 2005.

	El Obeid	Other hospitals	All hospitals
Chapter One	N.A.	N.A.	N.A.
Chapter Two	279	189	468
State	*103*	*39*	*142*
Users	*176*	*150*	*326*
Total	279	189	468
Per capita in			
SDD	174	118	292
USD	0.7	0.5	1.2

Unfortunately, data on Chapter One (salaries) in hospitals are not available, but this would included in total SMOH Chapter One expenditures.

It appears that for hospitals, Chapter Two expenditures exceed by 20% the estimated Chapter Two expenditures for health centres and below and that users contribute 70% of non-salary recurrent expenditures.

Both planned and actual per capita Chapter Two hospital expenditures varied considerably across localities, with 64 SDD per capita in Sheikan and 6-9 SDD per capita in actual expenditures in other localities. This can partly be explained by services in Sheikan having a different focus with

Sheikan being the state capital and referral centre, but most likely also reflect the larger revenue generating potentital in Sheikan.

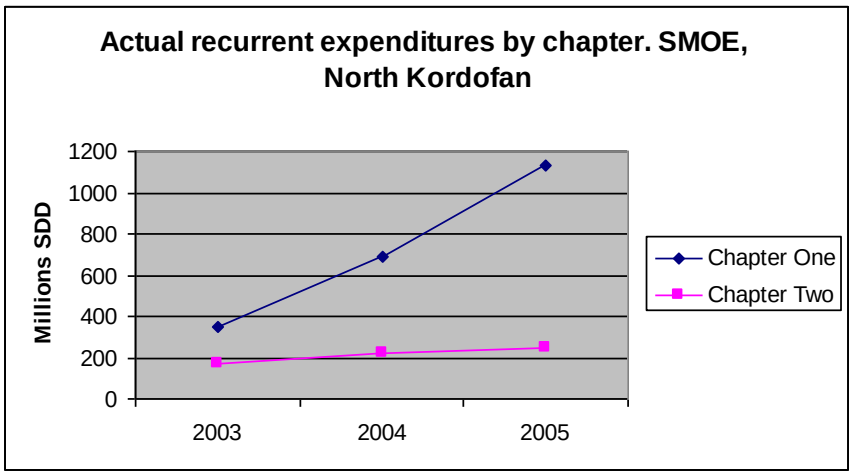
4.3. Financing of state and locality education services

No information was obtained for the locality level, cf. section 2.1.2 (p. 2), the following is therefore based on state level information and findings from the Health and Education Facility Survey.

Expenditures

In parallel with the development in actual recurrent state spending in the health sector, the SMOE budgets and expenditures have increased considerably in recent years, see Figure 18, although mainly for salary expenditures.

Figure 18: Actual recurrent expenditures by chapter, SMOE, North Kordofan.



In per capita terms the actual expenditures have more than doubled from 923 SDD in 2003 to 2385 SDD by 2005. This is mainly due to a dramatic increase in salary expenditures (Chapter One) which more than tripled over the same period, see Table 6. At the same time, other recurrent expenditures also increased, but much less dramatically, thus resulting in a shift in the balance between Chapter One and Two expenditures. In 2003, 62% of the budget (67% of actuals) was allocated to salaries; in 2006 it was 85% of the budget.

While considerable amounts have been allocated for the development budget, budget execution has been very low at 1-3%.

The SMOE salary bill accounts for 34% of the total state salary budget and 30% of actual salary expenditures. These shares have remained stable over the period 2003-2006. The education sector further accounts for 12% of total state non-salary recurrent expenditures.

Except for one school, none of the schools participating in the Health and Education Facility Survey reports the state or the locality to be the main financial source. More than half of basic schools rely on user fees as the main source of finance, while 25% rely on a combination of user fees and community contribution and 14% on community contributions. For secondary schools the main source of finance is fees in two thirds of schools, while one third rely on both fees and community contributions. It is assumed that this excludes salary expenditures. However, 90% of schools reported to have received supplies/educational materials from the state.

Table 6. Planned and actual per capita expenditures by expenditure chapter, State Ministry of Education, North Kordofan. In SDD. *2002?*

Planned Expenditures

	2003	2004	2005	2006
Chapter One	820	1285	1757	2853
Chapter Two	509	676	445	513
Chapter Three	0	35	60	169
Chapter Four	0	2054	1465	1492
Total	1329	4050	3727	5026

Actual expenditures

	2003	2004	2005
Chapter One	617	1203	1922
Chapter Two	306	392	424
Chapter Three	0	0	0
Chapter Four	0	21	39
Total	923	1616	2385

According to the survey, the expenditures for the schools last year ranged between 150,000 and 4,200,000 SDD with a mean of 245,798 SDD for basic schools and 694,845 SDD for secondary schools. The mean expenditures per student, cf. Table 7, were significantly higher for secondary schools compared to basic schools. There was no statistically significant difference between girls' and boys' schools.

Table 7. Expenditure per student by level of school

	Mean	Lower 95% CI	Upper 95% CI
Basic school	517	332	702
Secondary School	2164	1192	3137

Source: Health and Education Facility Survey

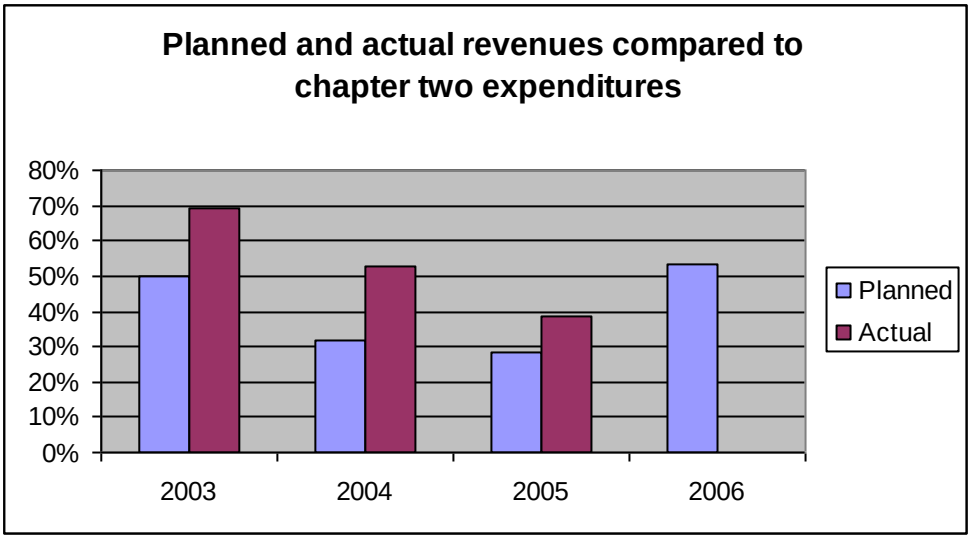
Assuming that the sample is representative for the schools in North Kordofan in terms of levels of expenditures per student and number of students, total reported expenditures for the schools in the state last year can be estimated at 361 million SDD or 225 SDD per capita (approximately 1 USD per capita).

Revenues

Fees are collected for tuition, examinations, books, water or private tuition. As of 2005 no school fees apply for primary schools according to national policy. There are certain fees for each class, but the poor and orphans are supposed to be exempt. According to the Health and Education Facility Survey 25% of students are exempted from payment of fees. There is also a system for rebates for some children. Of the collected fees, in principle 33% of the revenue is retained in the school (according to FMOE 2006). The Health and Education facility survey found that one third of schools report that all fees are submitted to the locality administration.

Expected and actual revenue collections in the education sector have decreased over the period 2003-2005, but are expected to increase for 2006. At the same time expenditures have increased with the result that revenues collected contribute a decreasing proportion of recurrent expenditures, e.g. Figure 19 for comparison of Chapter Two expenditures.

Figure 19: Planned and actual revenues compared to Chapter Two expenditures, SMOE North Kordofan.



Based on the Health and Education Facility Survey, the average annual fee to be paid per student is 2,354 SDD in basic schools and 4,109 in secondary schools.[2] The average user fee revenues per school amounts 920,000 SDD annually. There is no statistically significant difference between levels of schools. Assuming that the sample is representative for the schools in North Kordofan in terms of number of students, exempted students and fee levels, and that the number of functioning schools correspond to the list provided by FMOE, then the total contribution to operational costs from fees amounts to 1,185 million SDD or on average 740 SDD per capita (corresponding to 3.2 USD). This estimate is higher than estimated public expenditures, suggesting either measurement errors or that a large proportion of school fees are not channelled into the official revenue stream.

In addition, communities collect contributions for schools, mainly for development costs.

Distribution of expenditures

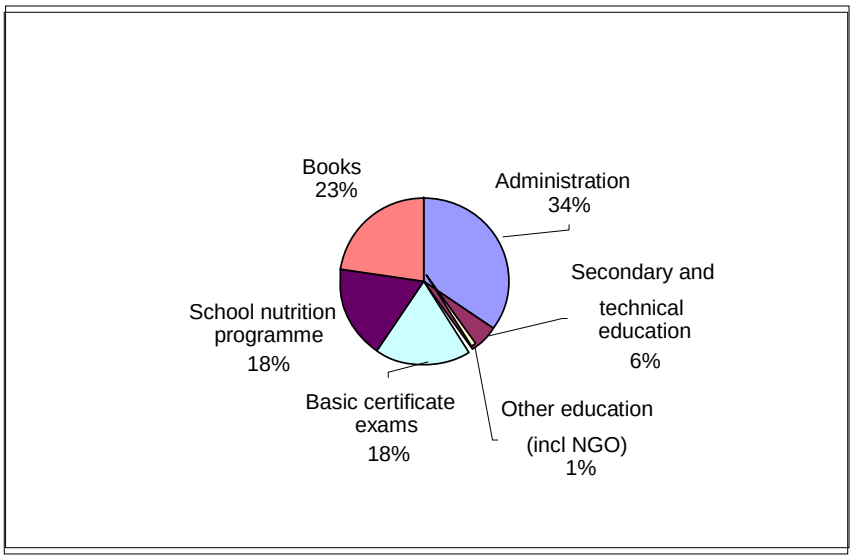
The SMOE budget breakdown does not allow a breakdown by education level of beneficiary group, but gives some indications of the priority given to various levels. It appears that about one third of the budget is used for administrative purposes, i.e. financial and administrative affairs, running costs for the Minister's Office, other administrative issues and a small contingency. Almost a quarter of the budget in 2005, i.e. 23%, was intended for books, 18% each was intended for the school nutrition program and basic certificate exams, while only 6 % was intended for secondary and technical education, cf. Figure 20.

The actual budget release was lower than the planned budget and preference was given to the school nutrition program and the basic certificate exams, mainly at the expense of books, resulting in a distribution of expenditures as illustrated in Figure 20.

The development in the budget by cost category from 2005 to 2006 (Figure 21: Actual and planned Chapter Two expenditures 2005-6, North Kordofan SMOE.) shows increasing budgets for administration, basic certificate exams and the school nutrition programme, whereas the budgets remains unchanged for books and for secondary and technical education.

[2] Data set adjusted: It is assumed that reported fees above 100,000 SDD are mistakes, likely representing figures in pounds rather than dinars.

Figure 20: Distribution of actual and planned recurrent education sector expenditures, SMOE, North Kordofan 2005.



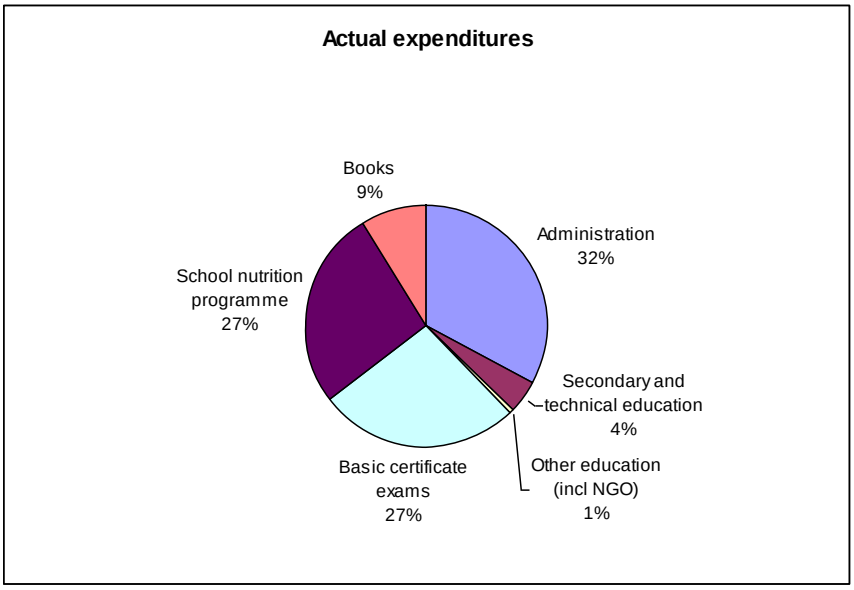
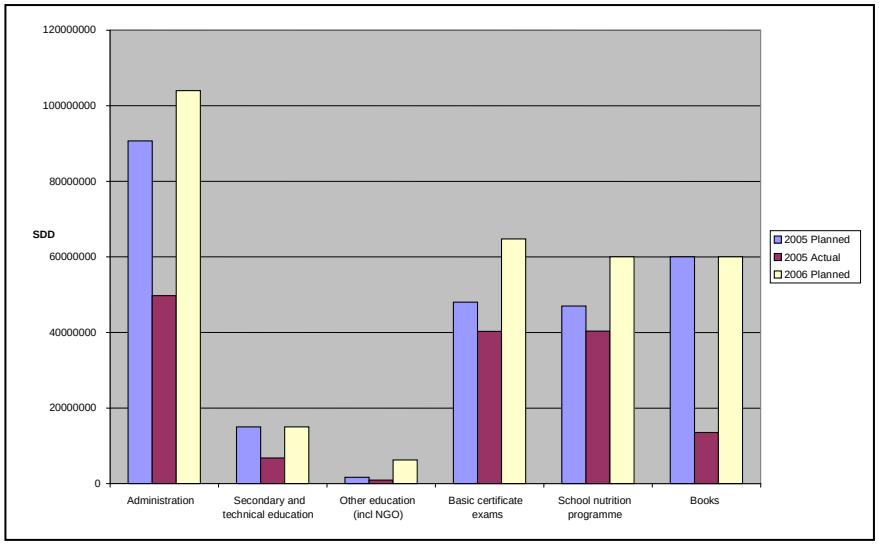


Figure 21: Actual and planned Chapter Two expenditures 2005-6, North Kordofan SMOE.



5. Main issues and recommendations

5.1. Availability and adequacy of financial resources

Financial resources for health and education service delivery at the locality level are generally fairly low at an estimated 1.6 USD per capita for recurrent costs for health services and an estimated 1.0 USD per capita for recurrent expenditures for primary and secondary schools.

While including the estimated user fees paid for government health and education services, the estimate does not include user fee financing of private sector health care and education services – nor user fees paid in public facilities that are not channelled through the official revenue stream. Especially for health there are likely to be considerable private sector expenditures. Drugs are often not available in the public sector and medicine purchases are therefore largely outside the estimate. Thus, there are likely to be considerable resources available that are currently, being direct out-of-pocket payment, prioritised by individual citizens for health in spot market purchases. Estimating the size of such resources would require a population survey. A National Health Accounts exercise may contribute to an estimate of these various sources including of the scope for pooling of risks, in small pools (micro-credits, drug revolving funds), medium sized pools (local health insurance schemes) or large pools (National health insurance for the formal sector).

There appears to have been an increase in the funding for health and education services, at least at state level. Much of the increase appears to have been devoted to salaries and incentives, although some may be associated with transfers of responsibility for some staff (and their salaries) from federal to state level.

5.2. Inequitable distribution of financial resources

Equitable and affordable access is a declared objective in both health and education. The distribution between socio-economic population groups cannot be determined on the basis of the present data, but there appears to be large differences between the localities with Sheikan Locality having most resources.

It does not seem to be clear to localities on what basis resources are allocated and there seems to be no monitoring and consequent accountability of whether resources were directed to the intended purpose. It is therefore difficult to assess the equity of the distribution of resources.

Resource allocation criteria define the flow of financial resource from the centre to regions and districts and to providers. The main purpose of designing resource allocation formulas is usually to address equity issues. Pro-poor resource allocation includes reallocation across levels of care or levels of schools as well as geographical reallocation.

It should be emphasized that using fair resource allocation criteria targeting priorities may be a pre-condition for improved equity, but does not in itself lead to equitable spending or outcomes. Constraints in the budgeting and spending process as well as lack of monitoring or guidance on the performance may result in inefficient as well as inequitable outcomes. If management is poor, more poorly managed funds may contribute only little to address the strategic objectives. It is therefore important also to consider strengthening the management systems and reconsider the incentive structures in the system.

5.3. Do funds trickle down?

Sudan is facing a challenge to ensure that increased transfers from the federal level to the states are allocated to health and education and that growing transfers translate into basic services.

In fact, aside from the salary payments to health and education workers, no government funds go directly to the facilities in the form of cash and most often facilities and schools are not aware of any particular budget for them. In-kind resources are, however, received, although often not recognised for their financial value. Non-salary expenditures are in any case very low for both schools and health facilities. A number of services such as immunisation campaigns, school books etc. are still vertically funded. These resources are likely to flow to the lower levels in the form of in-kind benefits to the population.

Lack of accountability and transparency in decision-making and lack of monitoring and follow up on spending according to planned activities and outcomes further makes it difficult to assess the extent to which the limited resources available reach the beneficiaries at the lowest level of health care and schools.

It is recommended that planning, financial management and monitoring capacity at locality level be strengthened, including feedback systems to facilities and schools. Introduce simple financial monitoring systems that can be used by facilities and schools, as well as communities, could be introduced to increase accountability. The government could consider (in the longer term) an accreditation system, in which health facilities and schools can be accredited to manage funds.

5.4. Inefficient use of funds?

The available data do not allow very firm assessments of the efficiency in use of resources. There are very few resources available for operational expenditures beyond salaries, which definitely makes the staff less effective in their work.

With the low population density, large distances and few resources available it is important that the health care delivery system focus on health promotion and prevention. It will take a long time and be relatively expensive to reach all of the population with curative services. The recent organisational integration of health services with the engineering departments responsible for water and sanitation has the potential for a strong focus on promotion and prevention, if collaboration is developed in the area of rural water and sanitation and health education.

The incentive structure entails a risk that funds will be used inefficiently. Budget and management of locality health services are separated between PHC services (managed by the localities) and first referral hospitals (managed by the SMOH). Thus, the state government, which commands much greater resources, has little incentive for investing in PHC.

There is considerable gap between budgets proposed, budgets approved and actual releases. This provides a poor environment for planning. Lack of clear prioritisation combined with ad hoc reprioritisation as budget releases are lower than planned budgets also increases the risk of inefficient use of funds, which is further exacerbated by the lack of follow up and evaluation.

5.5. Lack of planning and management capacity

Increased funding does not necessarily result in more and better services. If a health care system is performing poorly due to poor management, the solution is not necessarily more resources. In fact, more resources in a poorly managed system may result in only limited improvement in performance. In the medium term this could prove damaging to future resource mobilisation efforts.

The localities appear to be under-resourced in terms of management capacity and furthermore the state ministries appear to be weak in their capacity to support the localities in planning and financial management. There appears to be insufficient supervision in the area of planning, management and finance.

Lack of capacity may relate to numbers of staff, skills and culture of staff and absence of adequate systems. Localities are under-resourced in these aspects. There is a high turnover of staff. Staff have little or no training in health or education administration and there is no defined career in this area. State and federal ministries are not recognised as resources for technical support.

Furthermore, the motivation for serious planning is understandably low as there is no predictability or stability in the resource flows, and, as mentioned above, a considerable gap between budget proposed, budget approved and actual releases.

Finally, in the health sector the integration with the engineering departments, does not seem to have stimulated localities to reorient to take on the responsibility for management of health service delivery at locality level.

Training and strengthening capacity of managers at the locality level could be accompanied by defining a clear career path for public administration in health and education (in resource scarce situations administrators do not necessarily need to be doctors or teachers). Supervision, technical support and back-stopping functions need to be developed at the state level – higher-level administrations need to be assisted to adapt to their new stewardship role. Accountability, feedback, and monitoring mechanisms need to be developed. There are currently no mechanisms for holding service units (facilities, schools) accountable.

5.6. Poor information systems

There is also a lack of data on which to base rational planning and management. The availability of relevant and timely information of good quality is a problem. This is due to manual accounting systems, lack of separation of budgets between departments and lack of financial information for monitoring and follow-up by higher administrative levels as well as for lower levels to follow up requests and demands with higher administrative levels.

There appears to be no standard presentation of financial data at locality level and current practice does not provide a level of detail that is useful for planning purposes. Standardised financial data that are accessible to managers would improve the potential for more efficient and equitable use of funds targeted for prioritised objectives.

Experiences with data collection for this particular study was not very encouraging. The data tables to be filled by respondents were too complex. Furthermore, while the accompanying questionnaire were translated into Arabic, the tables were not, which may have resulted in some misunderstandings. Furthermore, it would in retrospect have been an advantage to use interviewers with a background in financial administration. Alternatively, financial staff from the localities could have been called for a workshop, been given the data tables and asked to submit the information at a later stage.

Annex 1: Structured questionnaire

Guidelines for structured interview on Locality financing of health and education services

- **<u>TO BE READ TO ALL RESPONDANTS:</u>**

  " **I represent FMOH/FMOE-Sudan. We are interviewing concerned financing personnel in North Kordofan State for a research study. We hope we can ask you some questions today. All answers will be seen only by the research team and will be kept confidential. Please be as accurate and truthful as possible, since your answers will help us to understand the current financial situation. If you have any questions about what is asked, please ask me to explain. Thank you in advance for your cooperation**".

A. Details of the interviewed person(s)

Place:
Date:
Name:
Designation:
Area of responsibility:

B. Size and sources of financing

1. What are the main sources of funding for health facilities/schools?
(Federal government, state government, locality, user payment, in-kind contributions, donors, NGOs, others)

2. **Does the locality administration keep track of all funding for health facilities/schools in the locality? If yes, how?**

3. **Does the locality administration provide guidelines for user fees (level, how they can be spent and exemptions – does the locality refund exemptions or is it at the expense of the facility/school)?**

4. What is the overall financial framework for health/education in the locality?
Ask for data as well – see checklist

6. C. Flow of funds by source

5. Which of the funding sources are channelled through the locality administration?
(Be aware that government funding is often channelled in several ways, i.e. salaries directly to staff from central level and other running costs to locality or facility/school directly)

6. How are user fees managed? Are user fees retained at facility/school level or submitted to the locality or state for redistribution? Principles for redistribution?

7. Who has the authority to spend, i.e. who has to approve spending at health facility/school level? Any limitations?
(Be aware that this may differ by source as well as by type of institution, e.g. hospitals often have more authority than dispensaries)

8. If approval to spend is needed from the locality, what are the steps (list) and how long does it take?

9. Do health facilities/schools receive physical money e.g. do they manage their own funds?

10. If not, do they receive an “imprested accounts”/advances?

D. Budgeting and planning process

11. Is a comprehensive budget, including all sources, developed for the health/education sector in the locality?

12. Which sources are included in the budget?

13. Is the locality provided with an indicative budget ceiling for planning purposes?

14. Who approves the budget?

15. In last financial year, was there discrepancy between the budget proposed and the final approved budget allocated to the locality?

16. If yes, how much and were the revisions to the budget discussed with the locality? How did you manage the deficit?

17. On what basis is the budget allocated to the health facilities/schools?
(historical, based on catchment area, based on number of attendants…)

18. Who develops the budget for individual health facilities/schools?

19. Are the health facilities/schools provided with an indicative budget ceiling?

20. Were there discrepancy between the proposed budget and the final approved budget (in the budget book?)?

21. If yes, how much and did the locality administration discuss with the facilities/schools

E. Actual expenditures

22. Do budget releases for the year correspond to the approved budget? If no, what proportion of the approved budget had been released by the end of the year?

23. Did budget releases come on time? If not, what are the delays? Which proportion of the approved budget had been release by the second quarter?

24. Were funds spent according to the budget? If released funds were less than the budget, what were the principles adopted for allocating the funds received? Were these principles discussed with the facilities/schools?

25. What were the actual expenditures for health and education in the locality, by level of facility/school and by input category (personnel, running costs, investments)? *Ask for documentation, see checklist.*

26. Who is doing the accounting for the facilities/schools?

F. Monitoring and evaluation

27. What is the flow of financial reporting? Who sends financial reports to whom and how often?

28. Do you receive regular feedback from the state on expenditures against budget?

29. Do you receive and support supervision from the state level in the financing area?

30. Do the facilities/schools receive regular feedback on their expenditures against the budget?

31. Is the financial information used for management (comparing inputs and performance for example)? Does the locality discuss this with facilities/schools?

G. Other issues: your opinion.

32. What do you perceive as strengths and weaknesses in the financing system in the locality?

33. What do you perceive as the bottlenecks that need to be addressed to make the financial flow more efficient?

34. What do you think could be done to improve the use of existing funding to get more value for money?

35. What do you think is needed to improve financial management at facility/school level as well as at locality level?

Annex 2: Figures