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Mobilizing Political Support and Resources for Family Planning in a Decentralized Setting:

Guidelines for Latin American and Caribbean Countries

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EXECUTIVE SUMMARY

This paper presents some case studies of and guidelines for strengthening the policy environment for family planning (FP) in Latin American countries undergoing decentralization. The intended audiences are policymakers, program planners, and specialists in government and civil society organizations, including nongovernmental organizations working in family planning. The guidelines draw on literature on the decentralization of health systems in Latin America and on research findings garnered through key informant interviews in Bolivia and Mexico. The paper also draws on the experiences of USAID's POLICY Project and Health Policy Initiative, Task Order 1 in addressing (from 1995 to the present) issues related to decentralization in Bolivia and contraceptive security in the region.

Decentralization has been a major aspect of overall governmental reform in Latin America for the past 20 years. The goals of decentralization vary by country but tend to focus on three areas: policies, public finance, and services. Decentralization pertains to the shift of power, authority, and responsibility for political, economic, fiscal, and administrative systems from the national government to regional and local governments and agencies. The type of decentralization varies depending on what responsibilities get passed to local governments and how much latitude those officials and managers have in making a range of decisions. The type of decentralization a government chooses is a principal determinant of the changes and adaptations that accompany decentralization.

Although different decentralization types and experiences exist in Latin America, many common problems and solutions can be found among them. Decentralization is largely affected by the policy environment in which the process occurs. Unless the policy environment adapts to account for the continuing need to provide FP information and services to growing populations, decades of progress could be reversed. Countries must make appropriate adjustments in three particular areas of the policy environment to avoid disruptions in FP services: political commitment and advocacy, financing, and access to services.

Strong political commitment, continued advocacy, and good policies and planning are necessary to ensure that national FP priorities and commitments are maintained and expanded during such major transitions. In public finance, for example, decentralization can reduce the proportion of financing for public health activities, so that policy changes mandating support for priority areas such as reproductive health might be required (Ensor and Ronoh, 2005). During decentralization, numerous challenges can directly affect the demand for and quality of FP services. This paper includes examples from Bolivia and Mexico to illustrate some challenging issues in the three policy areas and how the governments and stakeholders addressed them to maintain the availability and quality of FP services.

The paper also provides selected guidelines for policymakers, planners, and other stakeholders dealing with similar decentralization experiences. For example, regarding political commitment and advocacy, the national government should take the lead in building support and understanding for reproductive health within subnational governments. Accompanying this support should be specific policies, directives, operational procedures, and guidelines that specify new roles and responsibilities, clarify the new division of labor among government agencies, and prepare local officials and managers for their new duties.

Regarding financing, to ensure that subnational governments maintain FP programs and scale them up to meet expected demand, national governments can earmark funds and mandate minimum spending levels for such services at the local level. They can also explain to subnational officials and managers the rationale for including family planning as an essential part of the government's development strategy. A key aspect of financing pertains to how contraceptives are paid for and distributed to thousands of service delivery points. Experience shows that the national government is best positioned to set the funding

arrangements and procure and manage the contraceptive supply and distribution, because its economies of scale mean lower prices and it can ensure quality and plan for overall needs.

Regarding access to FP services, increases can be achieved by expanding participatory approaches at the subnational level. These approaches include engaging and enlisting civil society organizations in advocating with governments and the community to make FP services universally available. Such efforts in countries like Guatemala and Peru have had a profound impact on both the national government and the communities, putting family planning high on the policy agenda and improving access to FP services. Participatory approaches can also expand outreach activities related to education and information programs.

ABBREVIATIONS

CEASS	Health Supplies Distribution Center (Bolivia)
CERES	Center for Economic and Social Reality (Bolivia)
CIES	Center for Investigation, Education, and Services (Bolivia)
CNEGSR	National Center for Gender Equity and Reproductive Health (Mexico)
DILOS	local health boards (Bolivia)
FP	family planning
ICPD	International Conference on Population and Development
LAC	Latin America and the Caribbean
MDG	millennium development goal
MEXFAM	Mexican Family Planning Foundation
NGO	nongovernmental organization
PAHO	Pan American Health Organization
RH	reproductive health
SEDES	Department of Health Services (Bolivia)
SUMI	Universal Mother and Child Health Insurance Law (Bolivia)
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

I. INTRODUCTION

This paper presents some case studies of and guidelines for strengthening the policy environment for family planning in Latin American and Caribbean countries undergoing decentralization. The intended audiences are policymakers, program planners, and specialists in government and civil society organizations, including nongovernmental organizations (NGOs) working in family planning. The guidelines draw on literature on the decentralization of health systems in Latin America and on research findings garnered through key informant interviews in Bolivia and Mexico. The paper also draws on the experiences of USAID's POLICY Project and Health Policy Initiative, Task Order 1 in addressing (from 1995 to the present) issues related to *decentralization*[1] in Bolivia and *contraceptive security* in the region.

Latin American countries are committed to improving family planning (FP) and reproductive health (RH), evident by their signature of relevant international agreements such as the Program of Action of the 1994 International Conference on Population and Development (ICPD) in Cairo. This agreement encourages decentralization as a means of promoting community participation in reproductive healthcare services, local management of public health programs, and greater involvement of NGOs and private providers (Hardee et al., 2000). Latin American countries are also committed to achieving, by 2015, the Millennium Development Goals (MDGs) that aim to reduce maternal and infant mortality, improve health, and reduce poverty. On a national level, all Latin American countries have internal policies and laws that aim to guarantee access to FP/RH services to all adult citizens.

Over the past four decades, Latin American governments, NGOs, and private providers have largely lived up to their FP/RH commitments. Contraceptive prevalence has risen dramatically to levels seen in Western European and North American countries. Overall prevalence of modern contraceptive method use in Central and South America is 62 percent. Total fertility rates are moving toward replacement levels—although differences remain within countries. Throughout Latin America and the Caribbean, there is still considerable unmet need for family planning among specific populations, such as the marginalized urban and rural poor, indigenous people, and people with less education.

About 20 years ago, some Latin American countries began implementing governmental reforms that included decentralizing various functions, including social services. Governments and donor partners believed that decentralizing critical government functions such as health and education would increase local autonomy and self-determination; improve the management, efficiency, and quality of local services; increase access for the poor; raise more funds for key services; and make local programs more responsive to *market* forces and local needs and decisionmakers.

The recent performance of Latin American countries in meeting the *demand* for FP services has been affected, in part, by how well they have adapted to these government reforms. Understanding the concepts, structure, operational processes, and impacts of decentralization is critical for governments, donors, and advocates who either want to maintain strong FP programs in high-prevalence countries or strengthen FP programs in low-prevalence countries.

Decentralization in Latin America has been far from a heterogeneous process. The design and degree of decentralization; the type of implementation processes; the levels of local participation; and the systems of financing, personnel, and management, among many other factors differ by country. Some countries have been successful in conceptualizing, preparing, and rolling out decentralized programs but have fallen short when it comes to implementation. The literature on decentralization amply documents the difficulties national and subnational governments have encountered in adapting to changed responsibilities for health services (Ensor and Ronoh, 2005).

[1] See Annex 1 for a glossary of all the italicized terms in this report.

In many countries, national priorities and commitments, which include responding to the ICPD and MDGs, might not necessarily be translated into local government priorities. National health programs can become fragmented as the responsibilities for programs are divided between the national and local levels. Without strong national and subnational political commitment and support, the capacity of local government providers to manage new and expanded responsibilities can be limited. In some cases, programs that are high priorities for the Ministry of Health have been reduced in scope or dropped altogether as local governments assume programmatic and financial management for these programs. Thus, national governments need to establish the policies, directives, operational procedures, roles, responsibilities, and authorities required to ensure that FP programs remain a priority and function effectively at local levels, as well as strengthen regional and local capacity to manage the programs. This paper examines how several Latin American countries have dealt with the challenges of protecting and expanding FP services in a decentralized setting. It also provides some strategies and guidelines that could be useful to other countries encountering similar challenges.

Methodology

The guidelines draw on literature on the decentralization of health systems in Latin America and on research findings garnered through key informant interviews in Bolivia and Mexico. Bolivia and Mexico were selected to illustrate how two types of decentralization provide a diverse set of lessons. Researchers carried out interviews with various national officials from ministries of health; offices of planning and decentralization; and other stakeholders actively involved in family planning and contraceptive security, such as civil society organizations, NGOs, and international and bilateral donor agencies (e.g., United Nations Population Fund and USAID). (See Annex 2 for a list of key informants in Bolivia and Mexico.)

To broaden the perspective on decentralization issues, subnational interviews were also carried out in both study countries. In Bolivia, the project team interviewed regional officials and district officials in three municipalities of different sizes and resource levels. In Mexico, the team interviewed officials in two states and Mexico City. This work is also informed by experience in policy and public finance in the Latin America region during USAID's POLICY Project and Health Policy Initiative, Task Order 1, from 1995 to the present and by a review on logistics supply for contraceptives under decentralization prepared by USAID's DELIVER Project (Sanchez et al., 2006).

Organization of this Paper

This paper summarizes the findings of the literature review and interviews, categorizing them under three components central to maintaining and expanding FP priorities under decentralized health systems: (1) political commitment and advocacy, (2) financing, and (3) demand and access. In addition, for each component, the paper provides case studies from Bolivia and Mexico and selected guidelines. Annex 3 provides chronologies of decentralization and its impact on the health sector in the two countries.

II. DECENTRALIZATION IN LATIN AMERICA: FINDINGS OF THE LITERATURE REVIEW

Goals of Decentralization

Decentralization has been a major aspect of overall governmental reform in Latin America for the past 20 years. The goals of decentralization vary by country but tend to encompass the following:

- **Political goals**, which aim to empower local governments and communities by increasing local participation and autonomy and redistributing authority from the national government to state, departmental, and/or municipal governments.
- **Financial goals**, which aim to increase the *resource flows* to the peripheral levels and improve cost efficiency and fiscal accountability by granting local governments more control over resources, revenues, and allocation decisions
- **Technical goals**, which seek to improve management and administrative oversight, as well as the effectiveness and quality of services, by shifting program decisionmaking to local authorities and officials (UNFPA, 2000; Brinkerhoff and Leighton, 2002).

Definition and Types of Decentralization

Decentralization is a process that occurs when power, authority, decisionmaking, and responsibility for political, economic, fiscal, and administrative systems are shifted from the center to the periphery. There are four main types of decentralization (Rondinelli et al., 1984). Each type represents progressively greater degrees of decentralization.

- *Deconcentration*: the transfer of authority and responsibility from central to field offices of the same agency.
- *Delegation*: the transfer of authority and responsibility from national agencies to organizations outside their direct control (e.g., regional or local governments, NGOs, or semi-autonomous entities).
- *Devolution*: the transfer of authority and responsibility from national agencies to lower level autonomous units of government through statutory or constitutional measures.
- *Privatization*: the complete or almost complete transfer of a package of government services to private nonprofit or for-profit entities.

This paper mainly focuses on "delegation" and "devolution," as they are the most prevalent types of decentralization in the Latin American region.

Degrees of Control in Decentralization Types

According to Bossert, the fundamental choices in decentralization involve determining which institutions have been identified to take on new authority and responsibilities and how much control should be given to local decisionmakers by national authorities over important functions, such as health finance, service delivery, human resources, access, and governance (Bossert, 2000a). The decision space, or the range of control over different health functions given to decentralized units, is likely to vary by country, according to systematic applied research Bossert and others carried out in Bolivia, Chile, and Colombia. The decision space is categorized by Bossert as either narrow (local decisionmakers pick from a pre-approved menu of decisions), moderate (local decisionmakers make a larger number of decisions), or wide (local decisionmakers make most of the decisions).

The control given to local governments often changes over time. Political and bureaucratic factors might give a narrower range of control over key functions. This is particularly true regarding budget allocations (when central ministries mandate local governments to follow national priorities through earmarks and other directives) and human resources (when there is a backlash over control from unions and professional associations). In any case, understanding that each decentralization decision provides a range of control from narrow to wide is a useful context for considering the operational aspects of the decentralization process and procedures beyond just definitions, types, and policies.

Decentralization Challenges that Affect FP Programs

Decentralization typically has wide-ranging implications for the health sector and especially for family planning and reproductive health. This is because FP programs, with their origins in large-scale donor initiatives spanning several decades, have most often been *vertical programs* and managed from a high-level office in the national government. However, decentralization is often accompanied by the integration of services, and political, fiscal, and administrative decisionmaking power moves from the central to local levels. While the empowerment of local authorities to make their own decisions is viewed as positive, the design and implementation of decentralization has presented some major challenges and problems that affect aspects of health and reproductive healthcare, including access, *equity*, efficiency, quality, and financial sustainability (Bossert, 2000a). For example, with integration, some health professionals may not have the appropriate skills needed to provide FP services, or it may be unclear whether decisions related to human resources and commodity allocations fall under central or local authorities. Hence, it is imperative that as countries adapt to health sector reform, the appropriate *operational policies* are developed and implemented to ensure a commitment to the financial and human resources required to support FP services for the long term. This way, the achievements and improvements in family planning that would have otherwise been realized under more centralized, vertical programming are sustained with the integration of health services.

Policy and planning challenges

Policies on decentralization and integration have often been developed with little or no communication between those designing the reforms and those who manage FP programs. Typically, stakeholders working in the area of reproductive health are not involved in planning decentralization and integration and, as a result, FP and other RH requirements are not taken into account in decentralization and integration plans (Lubben et al., 2002). Without the full involvement of stakeholders, national health programs often become fragmented, as responsibilities for programs are divided between national and regional levels without adequate preparation. This can mean that the capacity of subnational providers to handle new responsibilities might be limited at the time that decentralization goes into effect. National priorities and commitments that include responding to the ICPD and MDGs might not be translated into local priorities. A recent review of decentralization in the health sectors of Colombia and Mexico cites weak and inadequate planning as one of the reasons that reforms have achieved the opposite of original goals (Homedes, 2005 and 2006).

Financing challenges

Decentralization policies affecting finances can have positive and negative effects on the provision of services. For example, the policies often require that local entities contribute local taxes to programs like family planning that were previously totally funded by the national government. Similarly, local governments are given more choices about how to allocate funds to public sector programs. These two factors can reduce

> "When we first decentralized, some municipalities spent all of their money the first year on refurbishing the church. In the second year, some spent all of their money on building bridges. By the third year, they realized they needed to spend money on healthcare, so they did."
>
> ~ Former President of Bolivia
> Washington, DC, 2000

the proportion of financing for FP/RH activities because local governments might not see reproductive health as a priority and thus not raise or allocate funds for these services. Specific mandates from the national government are often required to assure support for priority areas such as reproductive health (Ensor and Ronoh, 2005).

New financing policies can also exacerbate existing deficiencies in the health system if not addressed adequately. In Mexico, Nicaragua, and Peru, health finance reforms magnified already existing weaknesses in the health system. These weaknesses included the lack of trained staff to implement changes at the local level, minimal coordination of financial resource planning and management between local and national levels, and difficulties in developing new local financing sources. Addressing these realities resulted in some improvements in the *health financing* system. These improvements included greater sharing of information between national and local levels; development and implementation of more equitable financial allocation mechanisms; introduction of new techniques, such as per capita adjustment factors to correct for local health needs; and an increase in financial contributions from households and local levels of government (Arredondo et al., 2005).

Organizational challenges

During decentralization, numerous challenges can directly affect the organization of FP/RH programs. *Health sector reform* has proved to be extremely complex. Financial and political considerations have often over-shadowed a focus on improving the quantity and quality of health services, so that "the gap between rhetoric and practice remains wide" (Langer et al., 2000). A literature review on the impact of organizational change on the delivery of reproductive healthcare services notes that three main challenges arise (Ensor and Ronoh, 2005):

- Ensuring that new obligations of decentralization include specific performance requirements for newly empowered local authorities and providers.
- Making sure that local authorities and providers allocate resources and services to the most effective health interventions (e.g., prevention, primary care, etc.).
- Putting in place the supportive systems to manage the greater complexity of health services at the local levels.

Key Aspects Related to Family Planning and Decentralization: Political Commitment and Advocacy, Financing, and Demand and Access

Myriad issues surround the decentralization of FP programs. As we have seen from the challenges that emerged from centralization, it is important to maintain and expand the historical political commitment to FP services in Latin America during times of transition. Decentralization brings new challenges to maintaining the political will for financing and delivering services, because functions can be transferred to hundreds of agencies that might not have the will or capacity to implement them. The first step in expanding and deepening political commitment should be conducting advocacy to educate, inform, and support a range of new stakeholders in decentralizing FP programs.

Political commitment expressed in strong and enduring national policies cannot be translated to action unless the financing arrangements are put in place, ensuring that decentralized services are effectively delivered. Adequate financial sources, flows, and management for subnational services are essential to attain sustainable FP programs in Latin America and the Caribbean. Finally, guaranteeing access for all in a decentralized FP setting cannot be successfully achieved unless efforts are carried out to increase citizen and beneficiary participation at the local level. As local governments theoretically respond to local demand for services, a step in the decentralization process should be to redouble efforts to involve local communities and citizens in understanding and maximizing the benefits of family planning and advocating to ensure equitable access to FP services.

III. POLITICAL COMMITMENT AND ADVOCACY

Strong political commitment, planning, and policies are necessary to ensure that national FP priorities and support are maintained and expanded during major transitions.

National Government Level

National governments play essential roles in strengthening political commitment for FP programs and contraceptive security in decentralizing countries. When a country is decentralizing its health services, the national government's role is likely to transition from direct involvement in service financing and delivery to a role more focused on stewardship and coordination among different levels of government (WHO, 2000). This shift places responsibility with the central ministries (generally the Ministry of Health) for policy development and overall strategic planning, including the setting of priorities for and monitoring and evaluation of national programs. It also requires national authorities to assist local governments with their strategic planning and priority setting.

The national government needs a strategy and plan to strengthen the policy environment and provide support to subnational governments by

- Creating and enforcing standardized policies, regulations, and norms for reproductive health, family planning, and contraceptive security that ensure that local governments carry out national priorities in appropriate and effective ways;
- Encouraging collaboration, developing a common understanding of policy contexts, and linking policy approaches to reproductive health and health sector reforms (Lubben et al., 2002);
- Coordinating FP responsibilities, working with subnational governments on their new roles and responsibilities, and training them to manage and implement policies and programs in the new setting;
- Continuing to advocate for contraceptive security at the national level and expanding advocacy at the subnational level; and
- Managing and coordinating donors whose policies and mandates have a direct impact on decentralization and family planning.

National governments can provide political leadership in various ways. For example, many countries are working toward reaching the MDGs by 2015. Family planning is not included specifically in the MDGs, although the United Nations has recently added an FP indicator for monitoring purposes. Improving access to family planning to reduce the unmet need for family planning can help countries achieve the MDGs. Increased FP use will reduce the size of the target population groups for the MDGs, thereby lowering the costs of meeting the goals. The benefits from meeting unmet need for family planning, as measured by savings in meeting the MDG targets, tend to outweigh the extra costs of meeting unmet need (Moreland and Talbird, 2006; Alkenbrack, 2006; Health Policy Initiative, 2006). More importantly, increased use of family planning has significant and well-documented health benefits for children and mothers. In the

> "The decentralization process was very fast, many municipalities were not prepared, and they did not have the capacity to deal with this process. Because they had few managerial skills, and also the rules were not clear, there were regulations that were not met. At present, these problems are being overcome, but there is still a long way to go."
>
> ~ Executive director of large NGO
> Bolivia, 2007

decentralization process, the national government can ensure that local leaders are knowledgeable about the health goals and national commitments, promote a coordinated approach to achieving national FP objectives, provide technical assistance, and monitor local progress.

Subnational Government Level

The role of subnational governments might change dramatically in a decentralized setting. As a result of increased autonomy, subnational governments can be requested to participate in policy formulation processes to establish or reform national policies taking into account local priorities and realities. As noted above, where there is weak political commitment at the subnational level, local authorities have been known to reduce the proportion of financing for public health activities (Ensor and Ronoh, 2005). Just as national governments might need to mandate support for priority areas, so might state and departmental officials need to bolster political commitment and appreciation for reproductive health "down the line." Thus, support to regional and local governments in countries with weak institutions is important—including training for mayors, local health officials, and civil society on key FP and contraceptive security issues, consensus building, and conflict resolution (Bossert, 2000b).

Advocacy and Information Dissemination

Advocacy is central to increasing political commitment for family planning. Decentralization not only increases the need for continued advocacy but also expands the types of advocacy required. Advocacy strategies should reflect the different approaches needed over time at different levels, as the decentralization process moves from design to implementation. A list of key steps for implementing a comprehensive approach to advocacy during decentralization can be found in Annex 4. Similarly, decentralization requires that subnational governments be informed of the laws, policies, and regulations surrounding their new obligations to oversee and provide FP services. National-level authorities that oversee FP programs should

- Advocate to ensure that FP priorities are maintained and that commitments to family planning and contraceptive security are reflected in programs and mandates;
- Employ initiatives to share information with state, municipal, and local leaders on the importance of family planning to ensure that family planning and reproductive health are viewed as priorities;
- Raise awareness with regional, municipal, and local officials about the potential impact of decentralization, their obligations in terms of accountability for family planning and meeting national health priorities, and the steps that need to be taken to ensure adequate resources and broad support for family planning;
- Advocate on the importance of family planning and reproductive health among decisionmakers in local community groups, the private and commercial sectors, and civil society and train them to be advocates for family planning and to use available data showing that family planning saves lives; and
- Involve the broader community by raising awareness about the importance of family planning and contraceptive security and by encouraging social participation initiatives.

IV. CASE STUDIES: POLICY, ADVOCACY, AND INFORMATION ISSUES DURING DECENTRALIZATION IN BOLIVIA AND MEXICO

Decentralization and the Health Sector in Bolivia and Mexico

This section begins by detailing some of the salient characteristics of health sector decentralization in Bolivia and Mexico. To understand how decentralization affects the management and delivery of health and FP services, it is essential to know the political and economic context that frames the decentralization process in each country (Birn et al., 2000).

Bolivia

Type of process: In Bolivia, the move toward decentralization was abrupt and rapid, with the passage of the Popular Participation Law 1551 in 1994.

Type of decentralization: Deconcentration/devolution. Authority, responsibilities, and ownership were shifted from the central government to 314 newly created municipalities with financial and administrative autonomy. Human resources were deconcentrated to regional Ministry of Health units.

Transition process: The process itself was applied unevenly, particularly in rural areas, due to a lack of information and capacity building and a lack of clarity on the development objectives under the new system.

In Bolivia, interviews carried out for this paper (in smaller towns) confirmed the critical need to develop local capacity. Lack of administrative and managerial capacity is a major barrier to the effective provision of FP services. A lack of regulations and standards for decentralization compounded the difficulties in determining roles, obligations, and responsibilities, as functional guidelines for programs had not been prepared. Regulations and standards have since been developed, and there are now instruments to clarify the responsibilities of municipalities, regions, and the national government. However, the provision of training, technical support, and sharing of best practices has not been sufficient to support small municipalities and needs strengthening. Healthcare coverage is still poor. In 2004, 45 percent of the population still had no access to healthcare, and 73 percent had no *health insurance* (PAHO, 2007).

Mexico

Type of process: In Mexico, decentralization was an incremental process, carried out in two phases spanning the period of 1994–2000.

Type of decentralization: Delegation. Power was delegated to states and some municipalities. Priority areas were the transfer of resources and the definition of operational lines of social services.

Transition process: The central government gradually transferred responsibilities to the states. In the first phase, states were given the option to decentralize or to continue operating under the federal government. The government did not hand over decisionmaking powers on all levels. In the second phase, states already decentralized requested greater power to plan, budget, execute, and allocate resources. States that had not previously decentralized began to decentralize.

Local capacity was limited in Mexico due to years of concentrated management at the national level. Decentralization was initially carried out gradually, with local states assuming greater control in a phased process. Mexico developed a framework for the divisions of labor between the federal government and

the states and subsequently developed uniform regulations and standards for service provision at the various provider levels. The Health Secretariat signed a framework in 1996, allowing federal entities to operate autonomously in states, identify priorities at the local level, and commit the state to participating in managing and taking responsibility for service provision at the municipal level. By 2006, 95 percent of all Mexicans were covered by some type of public health or social security plan (PAHO, 2007).

Table 1 briefly summarizes the characteristics of decentralization in Bolivia and Mexico, its impact on the health sector, and the opportunities and challenges it created. More detailed information on the key characteristics of decentralization in Bolivia and Mexico, along with summaries of the impact of decentralization on the health sectors, is available in Annex 3.

Table 1. Decentralization: Characteristics, Impact on the Health Sector, Opportunities, and Challenges in Mexico and Bolivia

Country	Characteristics and Impact on health sector	Opportunities and Challenges
Bolivia	**Characteristics** • Abrupt, rapid, no transition • Reorganization of government into three levels of decisionmaking and resources **Impact** • Decentralization of health sector functions to municipal governments • New political and administrative regional boundaries • Implementation through a series of health insurance programs • As insurance program evolved, family planning sometimes included, sometimes excluded	**Opportunities** • Gains for autonomy at local levels • Increased access to services • New sources of financing • Institutionalization of popular participation in resource allocation **Challenges** • Considerable confusion and uncertainty in governance issues • No clear definition of responsibilities of different levels of government • Weak planning and management capabilities at the local level • Ineffective coordination and linkages • Insufficient resources in some municipalities; inequities still exist
Mexico	**Characteristics** • Incremental process in two phases: Phase 1, option to decentralize or to continue operating under a centralized system; Phase 2, national government transfers resources and defines social services responsibilities for all states **Impact** • Establishment of a framework for state and municipal control of the planning and management of health services • New rural poverty relief program introduced with maternal child health components (Opportunities Program); FP limited to distribution of condoms • Medical insurance programs introduced (Popular Insurance covers family planning and Medical Insurance for the New Generation; covers children ages 0–5)	**Opportunities** • Development of more responsive health planning and service delivery • Shared responsibility for financing health services **Challenges** • Problems related to efficiency due to a lack of local capacity to effectively allocate, manage, and use resources • Imprecise definition of responsibilities • Limited implementation capacity at the local level • Inequities in the distribution of the federal budget

The Role of Contraceptive Security Committees in Bolivia

During decentralization, Bolivia introduced a series of *social health insurance programs* directed at improving maternal and child health for the poor. In 1996, the original program covered only medical services for poor pregnant women and children up to five years of age. A second version of the program, Basic Health Insurance, expanded the package to include broader FP/RH services. The third version of the program, the Universal Maternal-Child Health Insurance (SUMI), did not initially cover family planning and contraceptives.

The National Committee on Contraceptive Security was established in 2003 and functioned until 2006. Comprising key stakeholders in the government as well as donor representatives and international agencies, the committee played an important role in advocating with Congress and other policymakers for the inclusion of contraceptives in the SUMI package. Advocacy focused on the importance of reproductive health, family planning, and contraceptives for reducing maternal and infant mortality and in achieving the MDGs. As a result, Congress extended SUMI benefits in 2005 to include a "reproductive and sexual health" package (with contraceptives) in the national insurance plan.

During the interviews for this paper, committee members stated that advocacy is needed among departments and municipalities to promote family planning and contraceptive security. Other interviewees stated that the 2006 change in government has once again removed family planning and reproductive health from the list of national health priorities. Thus, there is now an even greater need in Bolivia for advocacy activities—at both the local and national levels. Committee members are seeking technical assistance and capacity building to reactivate the CS committee and improve its strategic approach at the national level and to strengthen its capacity to advise on contraceptive security at the local level.

The Role of States in Mexico

Prior to decentralization, the Mexican national government had a strong legal foundation to support the FP program, with laws granting free access to contraceptives for public health institutions and defined government responsibilities for ensuring access to services and supplies. During decentralization, the state-level decisionmakers who became responsible for family planning generally did not view FP service provision as a priority even though the national government's commitment was quite strong at the time (Alkenbrack and Shepherd, 2005).

The states' lack of support might also have stemmed from the integration of family planning into the larger health sector framework. In some states, integration meant that FP services were lumped in with the hundreds of other basic health services. Due to the possible lack of awareness of the benefits of family planning as well as competition with demands for other health services, many states did not allocate sufficient funding to family planning and contraceptive security when they took over responsibility for budgeting, forecasting, and procurement in 1998.

At the same time, donors were phasing out all their financial and commodity support for the FP program in Mexico. To counteract these two trends (donor phaseout and lower state priority for family planning), government agencies and donors began to implement advocacy activities with state authorities and local stakeholders to mobilize support for family planning during the decentralization process. These efforts were ultimately successful, as noted later in this paper.

Prior to decentralization, advocacy efforts in Mexico had focused on raising awareness and improving the policy environment for family planning. In the late 1990s, advocacy efforts began to focus not only on raising awareness but also on ensuring the adequate allocation of resources to state FP programs. While this advocacy was eventually effective, stakeholders have suggested that a more strategic approach to

state-level advocacy would have accelerated the process. Such a strategy could have focused on (1) helping officials make the link between investing in family planning and improving overall health and development and (2) clarifying the potential effects of an inadequate supply of contraceptives, including unintended pregnancies and abortions (Alkenbrack and Shepherd, 2005).

Improving Inter-institutional Coordination, Information Sharing, and Networking on Family Planning during Decentralization in Mexico

In Mexico, coordinating institutions played a critical role in setting priorities and standards and influencing the budgeting process for newly decentralized state health authorities. In addition, these groups helped keep states up-to-date on FP information as well as convene regular coordination meetings between federal and state health officials.

The Inter-institutional Reproductive Health Group was created in 1995 to coordinate the implementation of and follow-up to actions that integrate distinct programs in reproductive health. Members come from 19 public sector institutions, civil society groups, and the private sector. The group has the support of federal representatives—particularly from the national Commission on Equity and Gender of the Chamber of Representatives (lower house of Congress)—who are dedicated to promoting and securing additional funds for reproductive health.

The functions of the group are to

- Promote the development of inter-institutional and inter-sectoral actions that contribute to increasing the coverage and quality of reproductive health information and services;
- Propose, develop, and promote the monitoring of policies, official norms, and procedures in reproductive health; and
- Promote research in FP-related areas in close collaboration with academic and research institutions.

The National Health Council is a government entity that introduces, debates, formulates, and evaluates health policies. It works across federal government agencies and with state agencies in a shared federalist system. The council includes 32 state secretaries of health and relevant federal health officials and is presided over by the Minister of Health. Formed in the 1980s, it meets four times a year (Interviews in Mexico City, 2007). Resolving policy and program issues during decentralization has been at the center of the council's work over the last two decades. The council plays an important role in keeping FP services and contraceptive supplies a priority for state health programs even though it is just a tiny fraction of the overall health budget (National Health Council, 2007).

V. GUIDELINES FOR STRENGTHENING POLITICAL COMMITMENT

The experiences in Mexico and Bolivia, as well as in other countries in Latin America, reveal that advocacy and policy dialogue are needed before and during decentralization to ensure that family planning and contraceptive security are addressed in policy and planning deliberations at national, regional, and local levels. The national government should take the lead in increasing political commitment and create a national policy environment supportive to subnational governments and their FP programs. Below are some recommended guidelines related to strategic planning, policy development, advocacy, data analysis, and information sharing.

National governments should

- Gain a full understanding of the characteristics and potential challenges and impacts associated with decentralization before it begins;
- Devise a strategic approach for informing local levels about decentralization policies and processes at the early design and implementation stages; change often takes place at the national level without local-level involvement in the process;
- Prepare strategic advocacy plans to promote reproductive health and family planning at regional and local levels to ensure a comprehensive approach to advocacy; capacity building for advocacy at decentralized levels has been shown to be effective in Peru and other countries of Latin America;
- Lead strategic planning and coordination efforts among the national, regional, and local levels;
- Improve local capacity in management, administration, monitoring, and evaluation to increase the effectiveness of planning and management at the local level;
- Collect information on the impact of decentralization on family planning at the local level to inform the development or revision of an advocacy strategy;
- Include family planning as an important complementary strategy for achieving the MDGs and the objectives outlined in countries' poverty reduction strategy papers; FP use leads to significant health benefits and lower maternal and infant mortality and a reduction in the costs of achieving the MDGs;
- Include family planning in public health insurance programs to provide access to FP education and services by the poor and vulnerable populations that constitute the primary target group for social insurance programs; and
- Design contraceptive security strategies that account for the local environment, financial resources, and demand for contraceptives.

National and subnational governments should

- Identify local priorities based on information and data collected through using analytical tools such as the framework of the Strategic Pathway for Achieving Reproductive Health Commodity Security (Menotti and Sharma, 2007);
- Encourage contraceptive security committees and other focused working

"The Contraceptive Security Committee should return to work, because it has enabled the inclusion of contraceptive benefits in the SUMI health insurance program. This committee could operate in different areas of the health system, especially in the municipalities."

~ Senior Official, SUMI
Bolivia, 2007

- Establish technical committees that can provide assistance at the national and subnational levels, advising on priority setting and addressing the duplication of functions;
- Promote social participation as a key element of decentralization—engage civil society in FP-related policymaking, programming, oversight, ongoing advocacy and evaluation; and
- Support policies of inclusion of gender diversity, indigenous groups, marginalized groups, women, adolescents, youth, and civil society in strategic planning and program monitoring and oversight.

VI. FINANCING

A major goal during decentralization is to maintain or preferably increase the amount and type of financial resources throughout the health system. This section of the paper presents some key financial issues and challenges around family planning and decentralization at the national and subnational government levels and also illustrates how Mexico and Bolivia have dealt with the impacts of decentralization on the financing of FP services and commodities.

National Government Level

Decentralization usually results in significant changes in financing mechanisms for family planning and contraceptives. Even if the national government remains the principal source of funding for reproductive health, resources can be directly allocated to local governments in various ways, with local governments then determining how to spend funds and manage the programs. Without establishing specific mandates and operational policies prior to decentralization, funding for family planning can decrease, local governments can experience an uneven flow of funds and FP supplies, and subnational agencies can lack information about how to access and program funds and supplies—thus making it difficult to maintain FP programs at pre-decentralization levels. Another financial constraint can be local officials' lack of understanding of budgeting requirements or even what the local funding needs are.

Additional financial constraints are organizational and cultural. The lack of clarity about the roles and responsibilities of decentralized government authorities can bring fund flows to a halt. On the cultural front, there are many examples of local leaders being biased against or not understanding family planning and therefore opposing the allocation of any funds to FP programs (Interviews with SUMI, 2007). These kinds of issues can generally be addressed in advocacy initiatives and in overall policy development activities. However, the following specific steps can be taken to ensure that funding for family planning is not disrupted or halted.

Fortify national government financial support for family planning

In taking the following steps, the national government can play a stewardship role to ensure adequate financing for family planning:

- Develop financial mechanisms to ensure that FP priorities are addressed at the local level.
- Set mandates such as line items for family planning and contraceptives in state, county, and municipal budgets.
- Put national government conditions on financial resource transfers that earmark them for family planning, such as *formula-based transfers*.
- Conduct advocacy (led by the national government) at state and regional levels to financially support family planning as a national priority.
- Increase attention to financing contraceptives centrally and distributing them locally, as in most cases, the national government will set the related policies and purchase the contraceptives for the entire public sector.

Identify alternative financing mechanisms

Decentralization offers the opportunity to explore *alternative financing mechanisms* for family planning, thus diversifying funding and increasing the overall financial base. The following are some common examples of alternate mechanisms:

- *Supply-side financing*
  - Establish *user fees* for services and contraceptives for wealthier segments of the population.
  - Include FP commodities in the Essential Drug List.

    - Reimburse for family planning in public sector health insurance programs.
    - Promote community-based health insurance programs or microfinance programs that include coverage for family planning.
    - Establish incentives to increase the private sector's provision of services.
- *Demand-side financing*
    - Create *conditional cash transfer programs* that include family planning and contraceptives for the poor.
    - Establish matching grant awards for programs aimed at providing FP services to poor populations.

Improve equity outcomes in financing

One key issue highlighted in literature on decentralization is the extent to which decentralization alleviates gross inequities in the use of public health services in Latin America (Homedes, 2005). Targeted actions might be necessary to achieve greater equity in financing for family planning. Equity is attained by ensuring that FP and contraceptive information and services are financially accessible to all who are interested in planning their families, including the poor and underserved populations. The following are some specific steps for addressing equity concerns in a decentralized environment (Levine et al., 2001):

- Distribute national funds to subnational units with proportional allocations to lower income populations.
- Require that a minimum percentage of national government transfers be allocated to rural FP programs.
- Use matching grants to encourage local authorities to allocate funds to priority programs directed at underserved populations.
- Make per capita allocations based on need, as successfully done in Bolivia, Colombia, and Chile.
- Create *equalization funds* that redirect some funds from wealthy municipalities to poorer ones based on per capita and *municipal poverty formulas* (Bossert, 2000b).

Subnational Government Level

Decentralization raises important issues concerning the degree of autonomy at subnational levels—in terms of the control of revenue and the responsibilities for revenue allocations and transfers to reproductive health. In addition, decentralization raises myriad issues around the new division of labor among the national government, the local and state governments, and the national government agencies located in the states. It is clear from the interviews conducted for this paper that the lack of clarity about financial roles and responsibilities in both Mexico and Bolivia led to confusion about and a slowdown in the decentralization of reproductive healthcare services. National and subnational authorities, as well as FP stakeholders, can deal with these issues by considering the following steps:

Insist on clear roles, responsibilities, and financial guidance

- Define new roles and responsibilities for financial decisionmaking, allocation, budgeting, management, and reporting. Clear guidance and training on financial management should be provided to subnational officials.

Help subnational governments to identify supplemental sources of health revenues

- Under decentralization, subnational governments can have the power to identify and assign local sources of funding at the state or municipal level for health and FP services; the national government might have to provide technical assistance and guidelines to support this process.

New partners (NGOs, business, civil society groups) might be interested in supporting family planning and willing to contribute resources, if they are aware of its importance.

Address contraceptive financing as a whole

- Because the central procurement of contraceptives has been shown to be cost-effective and efficient, the national government should consider the contraceptive needs of states, counties, and municipalities; and help subnational governments to forecast financial requirements.

VII. CASE STUDIES: FINANCING AND DECENTRALIZATION IN BOLIVIA AND MEXICO

National and Subnational Support for Financing Family Planning in Bolivia

Before decentralization in Bolivia in 1994, all governmental decisions were made at the national and departmental levels. With the creation of municipal governments, the national government imposed conditions to ensure that national priorities were addressed. Municipal governments receive about 20 percent of total public healthcare funding and are responsible for health services, supplies, and health infrastructure. The central Ministry of Health and its regional offices in the departments receive about 80 percent of total public healthcare funding and finance all of the human resources for the public health sector, including in the municipalities. Bolivia's basic health indicators did substantially improve with the implementation of this new system. Nevertheless, Bolivian municipalities still lack adequate funds to address all their health needs.

Municipalities can turn to other funding sources for additional income—some of which could be spent on health services. In addition to funds received from the national *tripartite co-participation fund*, municipalities now retain taxes on rural property, urban apartments, and vehicles instead of transferring these funds back to the national level. Additional local sources of funding can be identified if health issues are a local priority or advocacy and civil society groups convince local leaders that it is a priority to supplement federal funding.[2] Several departments and municipalities, including Tarija and El Alto, have launched health insurance programs over the past several years.

Tarija

Decentralization allowed Tarija and several other departments to establish a universal health insurance program as a social services priority. The program initially covered health needs for children from 5–19 years old and served as an extension of SUMI. The program was then expanded in 2007 to include all citizens up to age 59 for a total of 362,000 beneficiaries (*Noticias Departamentales*, 2007). Citizens age 60 and over are covered by national insurance for elderly citizens (called *Seguro de Vejez*). These health insurance programs are approved by the national government; and therefore, the programs' sources of revenue are determined in La Paz. The national government designated 14 percent of all departmental hydrocarbon taxes derived from provincial oil and gas operations to pay for these expanded insurance programs. Note that this diversion of substantial resources from the department revenues to support health insurance has brought considerable protests from local authorities who are loath to redirect their funds (*La Razon*, 2007).

El Alto

Near La Paz, the municipality of El Alto, chose to extend health insurance to all young people up to age 21—including for reproductive health education and referrals for services—through a program called Mandatory School Health Insurance. To finance this program, the municipality uses leftover funds from SUMI, supplemented by whatever funds it can raise locally, or accesses nationally available funds targeted for special municipal activities (Interviews in El Alto, 2007).

[2] Prior to decentralization, health centers were able to charge a co-pay fee that the health center could keep and pay for personnel, equipment, or other costs. After decentralization, health centers lost their right to collect fees.

In many countries, the lack of financial resources for services is not merely a result of those resources being unavailable but also largely a result of the health officials' and managers' lack of capacity to access them. The municipality of El Alto has learned how to access local and national tax funds to pay for its expanded health insurance programs. However, according to interviewees, many municipalities do not have the knowledge or capacity to access funds that are normally readily available for health-related programs. In Bolivia, two sources of funds are the co-participatory tax funds, available at the municipal level, and the National Solidarity Fund, which redistributes funds from wealthier departments to poorer ones. This situation strongly suggests that the capacity to access funding is equally important as the existence of additional funding sources.

> "Many municipalities do not use all funds they have potentially available for health programs. Some use only 85 percent of what they could obtain from the municipal participatory tax. The National Solidarity Fund is also underutilized by municipalities who have financial shortfalls in health. So the problem is not a lack of funding but the inability of many municipalities to access financial resources properly."
>
> ~ Senior Official, SUMI, Bolivia, 2007

Social Insurance and Poverty-Reduction Programs in Mexico

Starting in the 1980s and continuing into the 1990s, Mexico undertook a major decentralization process in which the federal government redistributed authority, responsibilities, and resources to the states in the areas of health, education, and poverty reduction, among others. The redistribution included a transfer in financial resources deemed adequate to pay for service provision and a transfer in taxing authority to both state and municipal governments. Under this new system, the federal government retained most of the regulation and control functions and left policy implementation to the states. Because the federal government and its policymakers were concerned that population programs could digress with decentralization, this division of responsibilities between the federal and state authorities suited those national stakeholders concerned about the future of the FP program.

In practice, the federal government set the budget line items for FP services, and the states, in turn, oversaw implementation in the municipalities. Interviewees in the states suggested that the federal funds were insufficient to implement all the FP programs. In turn, some states did not allocate enough funds for family planning, and thus, shortfalls in local funding and services occurred. The government and donor organizations eventually alleviated this problem through extensive advocacy and the training of local officials (Alkenbrack and Shepherd, 2005). However, shortfalls in FP funding still persisted. Consequently, states searched for other sources of funds and financing mechanisms. Several government insurance programs provided the opportunity to secure additional FP funding, as evident by the case of Tabasco state.

Tabasco state

Under the new decentralized system, the federal government left the purchase of contraceptives up to the states. Tabasco, like many other states, was unprepared for this new responsibility but was eventually able to manage the procurement. Tabasco participated in the federal training program to learn how to procure all types of contraceptives (pills, intrauterine devices, injectables, condoms, and implants) and manage service provision. Training was provided by the National Center for Gender Equity and Reproductive Health (CNEGSR) and the United Nations Population Fund (UNFPA). However, with the growing demand for FP education, services, and contraceptives, federal government funding (through the federal government transfer system) was not adequate to meet all of the FP needs, especially contraceptives.

To broaden the base of its health financing and reach low-income groups, Tabasco pursued funding through two recently launched federal health programs. The two programs, Popular Insurance and a social development program called Opportunities, provide financial resources for service programs and

commodities, including contraceptives. The Popular Insurance program provides health coverage, including FP/RH, for a large segment of Mexico's population that has little access to services. It is more than 90 percent subsidized by the federal government and funds the states to reimburse providers. The program's essential drugs list includes four types of oral contraceptives, four injectables, and one implant (*Seguro Popular: Medicamentos*, 2008). The Opportunities program provides the poorest population in the state with access to FP and contraceptives, education, and limited services. The program encourages demand for health and education services, and when the requirements for these services are filled, economic assistance is allocated to women to be spent on improved nutrition and family needs. Families are required to attend talks about reproductive and other health issues and must have health check-ups and regular health visits.

Challenges and Opportunities for Financing Contraceptives under Decentralization in Bolivia and Mexico

A key challenge around family planning in Latin America and the Caribbean is funding contraceptive supplies. This issue became critical in the 1990s when donors signaled their intentions to phase out the supply of free contraceptives for most (but not all) Latin American and Caribbean countries. During decentralization, some countries considered also decentralizing the procurement of contraceptives. In the end, most countries maintained the central procurement of contraceptives but used mixed systems for financing them.

Studies have shown that key functions of the contraceptive procurement and logistics system, such as bulk procurement, logistics management, quality assurance for products, among others, should remain centralized since this arrangement leads to better system performance (Sanchez et al., 2006). Centralized procurement makes sense because of the lower prices in bulk purchasing, the efficiency gains, the improved quality of contraceptives in comparison with local purchasing, and the guarantee of national coverage at a very low cost. Interviews conducted in Bolivia and Mexico affirm that the process of purchasing contraceptives should not be decentralized but should follow the same process used to procure and purchase vaccines (Interviews with UNFPA, and all other interviews, 2007).

The current situation in Bolivia illustrates that contraceptives can become much more expensive and difficult to manage if procurement is decentralized. When each municipality has autonomy to procure contraceptives separately and locally, they do not benefit from economies of scale or consistency in supply and quality (Sanchez et al., 2006). Contraceptive availability is a chronic problem in the country due to the unreliable nature of international donations, lack of commitment by the current national government to establishing contraceptive security as a priority, and weaknesses in management and administration. The Health Supplies Distribution Center (CEASS) is the main, official contraceptive provider at the state level, but it is irregularly stocked. Municipal governments buy from CEASS, and the only other provider (through different distributors) is PROSALUD (except for condoms). Some revolving funds are available in the municipalities to finance contraceptives, but they sometimes function erratically, mainly because local capacity for managing procurement is weak. Non-profit *social marketing* groups that provide low-cost, high-quality contraceptives and FP services, such as PROSALUD and the Center for Investigation, Education, and Services (CIES), continue to play an important role in providing contraceptives to municipalities.

In Mexico, contraceptives were mainly financed by international donors up until the mid-1990s. Following the 1994 ICPD, the Mexican government agreed to gradually increase federal funding for contraceptives while donors gradually reduced funding. In 1999, the federal government became the sole financier of contraceptives for the public health system. As part of the decentralization process, state

secretaries of health started to assume responsibility for procuring contraceptives through their state budgets. This shift meant that states needed to manage the entire process (Alkenbrack and Shepherd, 2005).

Problems emerged at the state level in the same manner they emerged in Bolivia. When faced with decisions about funding contraceptives or other local health priorities, officials chose what they saw as more immediate needs. Besides having other priorities, states did not have the capacity to forecast financial requirements, budget for different types of contraceptive, or make procurement arrangements for contraceptives. Thus, many states failed to budget for contraceptives. As a result, the national government included a line item in state budgets to earmark funds for contraceptives and hold state government officials accountable for maintaining the supply of contraceptives. When states did carry out procurement and manage the logistics, their reduced purchasing and negotiating power led to price increases, systematic under-funding of contraceptives, and deterioration in services.

To remedy this situation, the Federal Secretariat of Health, the UNFPA, donors, and state secretaries of health developed a system of pooled purchasing. For this system, the federal government negotiated overall prices and quantities with preferred providers, who, in turn, can provide contraceptives to the states when requested. At the same time, sponsors of the pooled purchasing system strengthened logistics and management capacity in the states by providing training and assistance for states.

Twenty-three states, along with four civil society organizations, have voluntarily participated in the system through their secretaries of health and signed an Agreement on Participation and Financing of Expenses. The program is a success and is still the basis for public sector contraceptive financing today.

VIII. GUIDELINES FOR INCREASING AND ALLOCATING FINANCING

There is an optimal division of labor between national and subnational governments when it comes to financing and managing contraceptive supplies in decentralized settings. National governments are generally best positioned to oversee contraceptive procurement and financing systems, as they can ensure cost effectiveness, control the quality of contraceptives through establishing uniform standards, set earmarks, negotiate financing arrangements, assess overall needs, and carry out detailed planning. The following are some recommended guidelines for financing contraceptive procurement and logistics systems in decentralized environments.

National governments should

- Allocate funds for contraceptives equitably among states or departments according to need and monitor financial expenditures of subnational governments on contraceptives to ensure that the funds are used for the intended purpose;
- Ensure that subnational government health personnel are trained in all aspects of contraceptive planning, financing, distribution and operations; and
- Define new roles and responsibilities for financial decisionmaking, resource allocation, budgeting, management, and reporting.

Subnational governments should

- Institutionalize budget line items for contraceptives (especially in countries where the entire financial burden falls on the subnational government);
- Identify additional sources of funding and allocate money to guarantee sufficient supply; and
- Design and implement a comprehensive supply- and demand-side financing approach for FP services and contraceptives.

National and subnational governments should

- Work collaboratively with private providers such as social marketing programs, NGOs, and pharmacies to define complementary goals and sources for contraceptive provision; the roles of each sector should be defined through *market segmentation* studies and incentives for the private sector to get engaged in contraceptive security should be created, allowing local governments to focus on reaching the poor (Alkenbrack, 2006).

IX. DEMAND AND ACCESS

Political commitment and financing in a decentralized environment affect the "supply side" of FP services and commodities—that is, they are essential components in ensuring the funding and implementation of services at all levels of government. This section examines the "demand side" of FP services and thus focuses on maintaining and increasing the demand for and access to services in a decentralized environment. Educating the population and developing local ownership of programs can receive less attention as responsibilities are passed to subnational policymakers and managers.

Three important aspects of maintaining and expanding demand and access in decentralizing settings include (1) engaging civil society, (2) broadening social participation in strategic planning and management, and (3) developing targeted outreach for the poor.

Civil Society Engagement through Information, Education, and Advocacy

Decentralization was introduced in the Latin American and Caribbean region at a time when civil society involvement was increasing. The decentralization process encompasses a strong element of support for increasing the role of civil society in governance and the provision of services (Hardee et al., 2000). To further strengthen FP and contraceptive security programs, it is important to demonstrate to civil society the need for these programs and the benefits of FP education and information. Ideally, these efforts should occur concurrently with broader decentralization processes, but too often, they are not considered until after decentralization has occurred (Sanchez et al., 2006).

Networks and coalitions for sharing information can be effective in broadening support for family planning and in disseminating effective strategies at the national and local levels. In Guatemala, decentralization and participatory planning in health emerged gradually after years of civil war. Challenges in decentralization in Guatemala included a lack of tradition of civil society participation, low status of women, cultural diversity and discrimination, lack of advocacy skills, and government resistance (Merino et al., 2000). The Women's Network to Build Peace received training in advocacy and use of information, as well as educational programs on reproductive health. Participants used their newly learned skills to increase the number and effectiveness of women participating in subnational reproductive healthcare activities. In addition, they attended workshops on creating opportunities for government and civil society to interact at the municipal level. Women's networks have been successful in mobilizing political support and resources for family planning and removing barriers to access to FP services and information among indigenous women.

Social Participation in Strategic Planning and Management

To be successful, decentralization requires promoting participation at subnational levels in strategic planning and the management of local programming. Ensuring local participation in governance means engaging multisectoral groups representing a broad spectrum of society to foster more democratic approaches and protect the process from domination by a single interest group. Increasing participation in the decentralization process often means bringing marginalized groups into health planning and management processes by improving gender balance; increasing the representation of indigenous groups; and involving adolescents, youth, and other under-represented groups. The needs of women, particularly indigenous women, might not be reflected in local priority setting without a concerted effort to include them in decisionmaking processes.

In Peru, there have been many challenges in implementing decentralization and promoting effective collaboration between government and civil society, including the following:

- Local elected officials had little understanding of the issues or needs in their communities.
- Civil society groups lacked the skills to participate effectively.
- Local authorities in the Ministry of Health and other sectors did not value civil society participation.

To overcome these challenges, USAID and others worked with local women's groups to build their advocacy skills and design and carry out advocacy campaigns in support of reproductive health. Strengthening the capacity of civil society groups to participate in decisionmaking processes in Peru resulted in proposals to improve municipal policies, form inter-sectoral committees, develop key strategies for coordinating with local officials to improve policy implementation, and collaborate with the media.

Targeted Outreach for the Poor

Decentralization provides an opportunity to expand outreach programs and FP service availability, raising demand for services by poor and underserved populations. Expanding and improving outreach and services requires training and placing extension workers and possibly developing incentives to encourage staff to re-locate in rural areas.

Another means of expanding access to health services is through *contracting out* service delivery from local governments to NGOs. Although collaboration between governments and NGOs is often informal, contracting out services is becoming more common. To succeed, contracting requires an appropriate legal and regulatory framework, minimal transaction costs and appropriate incentives, continuity in service provision and minimal delays in payments, and reliable management information systems (Levine et al., 2001). The PROSALUD program in Bolivia is an example of an NGO that is under contract by the government to provide high-quality education, health, and reproductive healthcare services, with a focus on community outreach and participation.

X. CASE STUDIES: RAISING DEMAND AND IMPROVING ACCESS

Supporting Health Networks in Bolivia

Bolivia created a new management model, including municipal health networks that integrate community health services. These networks link primary care facilities with secondary and tertiary service providers. Departmental health networks include municipal health networks and higher levels of care facilities. Local health boards (DILOS) and these autonomously managed health networks create a framework for shared management of health services (World Bank, 2004). The DILOS include representatives of the Ministry of Health, the municipal government, and civil society. Each municipality has its own DILOS for strategic decisionmaking. Local municipal health networks that include more than one municipality manage health services. As a result, information and education on family planning is an important strategy for communities, their leaders, and DILOS members, including municipal authorities.

Supporting Participatory Decentralization in Bolivia

Even though laws and regulations authorize and support reproductive healthcare services, it has been difficult to maintain and expand these services during decentralization in Bolivia. Communities were unfamiliar with the laws and their rights to participate in decisionmaking and priority setting. They lacked the skills to participate and, in many cases, did not view FP issues as priorities. There were few advocates of reproductive health at the municipal level, particularly for family planning and contraceptive security (Kincaid et al., 2000).

Actions were taken to educate newly elected local officials on decentralization laws and disseminate information on best practices in implementing local health initiatives to prepare municipal leaders appropriately (Bossert and Ruiz Mier, 2000). An approach taken by USAID's POLICY Project included

- Creating workshops on participatory planning;
- Providing extensive follow-on technical assistance to draft municipal development plans;
- Working with a network of women's NGOs to develop participation, advocacy, and leadership skills; and
- Supporting advocacy efforts and the collection and use of information on FP programs for more informed decisionmaking (Pinto et al., 2000).

Strengthening Reproductive Health Education, Integrating Gender Issues, and Improving the Inclusion of Indigenous Populations in Mexico

In Mexico, youth brigades, comprising youth champions, have been mobilized to bring reproductive health education to youth in underserved areas. These outreach services are designed to be more culturally appropriate to indigenous groups. A culturally appropriate, special educational program has also been designed to integrate a gender equity perspective, with attention to preventing family violence. The program has four essential components:

1. Training and sensitization for better cultural understanding among health service providers and communities.
2. Community participation to establish co-responsibility in decisionmaking on health services, with the aim of providing health education to indigenous youth through youth brigades.
3. Workshops on reproductive health for youth in different communities, municipalities, jurisdictions, and states.
4. Follow-up to strengthen the introduction and continuity of the education model.

A pilot project for an integrated and intercultural approach to reproductive health and preventing family violence is being implemented in nine marginalized indigenous communities in the states of Chiapas, Puebla, and Veracruz. If successful, it will be extended to all states with marginalized indigenous communities.

The specific objectives of this pilot project are to identify the key necessities in addressing reproductive health, employing a gender perspective; to account for cultural diversity of the population; and to increase the participation of men in decisionmaking on reproductive health, maternal health, and prenatal health matters. The program focuses on family planning, breast and cervical cancer, care for high-risk pregnancies, emergency obstetrical and neonatal care, gender equity, and family violence (Interviews in Mexico City, 2007).

XI. GUIDELINES FOR RAISING DEMAND AND IMPROVING ACCESS

Engaging civil society, broadening social participation in strategic planning and management, and developing targeted outreach for the poor are central efforts in increasing demand for and access to FP services. The following are some recommended guidelines for stakeholders to consider in implementing these efforts:

- Promote multisectoral participation at subnational levels in strategic planning and the management of local programming.
- Demonstrate to civil society the need for these programs and the benefits of FP education, information, and services.
- Form and/or support networks and coalitions to share information and disseminate effective strategies at the national and subnational levels, thus broadening support for family planning.
- Ensure local participation in governance by engaging groups that represent a broad spectrum of society, including marginalized populations such as indigenous women and youth.
- Expand outreach and increase access to services by training and placing extension workers and possibly developing incentives to encourage staff to re-locate to rural areas.
- Consider increasing access to health services through contracting out service delivery from local governments to NGOs.

XII. CONCLUSION

Decentralization in Latin America and the Caribbean has an important influence on how FP programs are supported politically, how they are financed, and how they operate. While the experiences and types of decentralization differ from country to country, there are nevertheless many commonalities in the problems faced and solutions adopted.

All countries have faced challenges in maintaining political commitment and a supportive policy environment for family planning at the national level while at the same time expanding subnational government and community support for family planning. Countries have also dealt with some new issues around financing FP programs. Decentralization began while international donors were phasing out financial support for programs and commodities. Thus, while governments and key stakeholders had to identify new sources of funding to replace donor monies, they also had to establish new systems, regulations, and guidelines for distributing national funds as well as seek additional funding to support increasing needs.

Furthermore, decentralization required that subnational governments, local communities, and organizations play a greater role in formulating, financing, and managing FP and reproductive healthcare programs. This change has spurred subnational governments to engage more with civil society, implement participatory processes for planning and management, and expand their educational and service outreach programs.

This paper reviewed a variety of challenges faced by FP programs during decentralization in Latin America and the Caribbean. It also discussed how governments have responded to these challenges by taking steps to ensure that decentralized systems can adequately manage and fund FP programs. In conclusion, below are some of the major guidelines that emerged from the study.

Select Guidelines for Supporting Family Planning in Decentralized Settings

Overall

- Gain a full understanding of the concepts, structure, operational processes, and potential impacts of decentralization before its implementation.
- Establish policies, directives, operational procedures, roles, and responsibilities before decentralization is initiated.

Strengthening political commitment and advocacy

- Strengthen political commitment at all levels of government and create a national policy environment supportive of subnational governments and their FP programs.
- Build local capacity in management, administration, and monitoring and evaluation.
- Devise a strategic approach for sharing information at subnational levels and prepare strategic advocacy plans.
- Encourage contraceptive security committees or other focused working groups to play important advocacy roles during times of health reform, executive and legislative change, and program revision.

Increasing and allocating financing

- Develop funding mandates for subnational governments and put conditions on financial resource transfers that earmark them for family planning.
- Implement advocacy programs with subnational government officials and managers focused on the demand for and financial costs and benefits of FP programs.
- Introduce alternative sources of support and funding, such as FP benefits under insurance plans and user fees for high-income clients.
- Include FP commodities on the Essential Drug List.
- Use financing mechanisms to improve equity, such as earmarking funds to low-income groups or employing equalization funds to shift revenues from wealthier to poorer areas.
- Keep oversight of the contraceptive procurement and financing systems at the national level, as national governments can ensure cost-effectiveness, control the quality of contraceptives through establishing uniform standards, set earmarks, negotiate financing arrangements, assess overall needs, and carry out detailed planning.
- Train subnational officials and managers on how to identify national and regional funding sources to supplement local FP budgets.

Raising demand and improving access

- Promote multisectoral participation at subnational levels in strategic planning and the management of local programming.
- Demonstrate to civil society the need for these programs and the benefits of FP education, information, and services; initiate advocacy efforts to educate, inform, and support a broad spectrum of groups, including marginalized populations.
- Expand outreach and increase access to services by training and placing extension workers and possibly developing incentives to encourage staff to re-locate to rural areas.

ANNEX 1. GLOSSARY OF TERMS

Alternative financing mechanisms: Different ways of funding FP/RH programs and services, such as through charging fees or making FP/RH services part of health insurance.

Conditional cash transfer programs: Provide money to poor families on the condition that investments in human capital are made, such as sending children to school or bringing them to health centers on a regular basis.

Contraceptive security: Contraceptive security exists when every person is able to choose, obtain, and use high-quality contraceptives whenever s/he needs them.

Contracting out: The government hires private entities for a specific service rather than doing it within the government structure. (One example is a laundry service in health facilities that can be "contracted out" to a private company, which can sometimes do the job at a lower cost to the government than if the government did it themselves.)

Decentralization: A process that occurs when power, authority, decisionmaking, and responsibility for political, economic, fiscal, and administrative systems are shifted from the center to the periphery.

Deconcentration: The transfer of authority and responsibility from central to field offices of the same agency.

Decision space: The range of control over different health functions given to decentralized units; according to systematic applied research by Bossert (2000a), it is likely to vary by country. The decision space is categorized by Bossert as either narrow (local decisionmakers pick from a pre-approved menu of decisions), moderate (local decisionmakers make a larger number of decisions), or wide (local decisionmakers make most of the decisions).

Delegation: The transfer of authority and responsibility from national agencies to organizations outside their direct control (e.g., regional or local governments, NGOs, or semi-autonomous entities).

Devolution: The transfer of authority and responsibility from national agencies to lower level autonomous units of government through statutory or constitutional measures.

Demand: The desire, ability, and willingness of an individual to purchase a product or service. (Demand for healthcare is influenced by the prices and quality of services, convenience of location of health facilities, income and education levels of consumers, as well as religious and cultural factors.)

Demand-side financing: Puts the purchasing power in the hands of consumers to spend a certain amount on specific services (often at specific facilities).

Equalization funds: The term "equalization" refers to an accounting methodology, designed to ensure that not only the investment manager is paid the correct incentive, performance, or profit sharing fee, but also that the incentive fees are fairly allocated among each investor in the fund. In this paper, the creation of equalization funds is suggested to redirect some funds from wealthy municipalities to poorer ones based on per capita and municipal poverty formulas.

Equity: Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this

potential, if it can be avoided. Equity is therefore concerned with creating equal opportunities for health and bringing health differentials down to the lowest level possible.

Formula-based transfers: Formula-based transfers are applied to achieve a systematic and equitable allocation of local government resources. Use of a population-based formula adjusted for poverty and other indicators for intergovernmental funding transfers can help increase the equity of allocations among rich and poor and urban and rural populations.

Health financing: The ways in which money is generated and spent as well as how it flows to and within a health delivery system.

Health insurance: A system of funding that pools money from many individuals or organizations as a means to pay for unexpected and usually large healthcare expenditures required by some individuals in the contractual arrangement.

Health sector reform: A process to reorganize and improve healthcare systems, usually involving changes in national priorities, policies, laws, regulations, and financing. The overall goal of health sector reform is usually to improve access, equity, quality, and efficiency, and to ensure that the system is sustainable in the long term.

Inputs: Goods or products, services, personnel, and other resources needed to conduct an activity or service and for achieving program objectives.

Market: The market for a specific product or service is defined by its consumers and the providers. For FP services, the market usually includes people ages 15–49 who are currently using a contraceptive method or may be potential users. Providers are disaggregated by three categories: government, private for-profit (commercial sector), and not-for-profit (NGOs). How these components of the FP market fit together is referred to as the FP market structure.

Market segmentation analysis: This analysis examines how the market for family planning is structured and helps to identify the extent to which different providers serve various population segments (with identifiable contraceptive method and provider choice behaviors). The FP market is the interaction of contraceptive methods, consumers (women of reproductive age, between 15 and 49), and providers that belong to the FP sector.

Operational policy: Operational policies are the rules, regulations, codes, guidelines, plans, budgets, procedures, and administrative norms that governments use to translate national laws and policies into programs and services. Operational policies govern the "operating system" for public health programs.

Privatization: The complete or almost complete transfer of a package of government services to private nonprofit or for-profit entities.

Resource flows: Analysis of resource flows identifies the sources and uses of money for FP/RH goods and services. The primary sources of funding for FP/RH typically include the government (central and local); donor agencies; insurance programs; out-of-pocket spending by individuals; and private groups (NGOs, for-profit entities, and philanthropic organizations). The funds generated from these sources are used to pay for different services, such as those related to family planning, birth delivery, postabortion care, HIV/AIDS, reproductive tract infections, and so on.

Social health insurance programs: Social contributions are paid by employees or others, or by employers on behalf of their employees, in order to secure entitlement to social insurance benefits in the current or subsequent periods for the employees or other contributors, their dependants, or survivors.

Social marketing: The use of commercial marketing techniques to achieve a social objective. Social marketers combine product, price, place, and promotion to maximize product use by specific population groups.

Supply-side financing: Supply-side financing is a type of financing mechanism in which the public/donor money goes directly to suppliers/providers.

Tripartite co-participation fund: Funds received from the central government at the municipality level are referred to as "co-participation funds."

User fees: Charges levied at the point of service for use of healthcare and products. Fees may be configured in different ways depending on the facility or the health system. A client may be charged one fee per visit to the facility, which would include all services and treatment provided at that time; one fee for an illness episode, which would include all services and treatment associated with the illness across several visits; or separate fees for each service and treatment provided during a single visit. The employment of user fees is also referred to as cost sharing, cost recovery, or co-payment.

Vertical programs: In the context of family planning, vertical program structures refer to organizations or programs with the single purpose of providing family planning services.

ANNEX 2. LIST OF KEY INFORMANTS

Bolivia

Name	Position/Area of responsibility	Institution
USAID		
Dr. Rocio Lara	Health Programs Officer	USAID/Bolivia
Magui Morales	Decentralization Specialist	USAID/Bolivia
Roberto Tejada	Decentralization Specialist	USAID/Bolivia
Central Government		
Alejandro Vargas	Decentralization Specialist	Vice Ministry of Decentralization
Ademar Esquivel	In charge of health	Social and Economic Policy Unit
Dr. Margarita Flores	Director, Social and Health Insurance	Ministry of Health and Sports
Lourdes Peralta	Executive Director, CEASS	Ministry of Health and Sports
Dr. Ruth Calderon	Director, General Unit of Health Services	Ministry of Health and Sports
Dr. German Crespo	Planning Director	Ministry of Health and Sports
Municipalities		
Dr. Víctor Conde	In charge of reproductive health	SEDES, La Paz
Dr. Honorato Calderon	Director	CERES, El Alto
Dr Angel Veizaga	Chief, Reproductive Health	CERES, El Alto
Dr. Miguel Flores	Chief, Planning	CERES, El Alto
Dr. Rosa Medina P.	In charge of SUMI	SEDES, Potosí
Dr.Juan Carlos Lacustre Siacara	SEDES Potosí Director	SEDES, Potosí
Dr. Roberto Vargas	Director	SEDES, Santa Cruz
Edgar W. Gutiérrez Apaza	Advisor, Departmental Secretariat of Social Development	Potosí Prefecture
Health Services		
Dr. Mario Vera Mendoza	Hospital Director	Daniel Bracamonte Hospital
Dr. Luis Fernandez	Executive Director	PROSALUD
Dr. Haydee Cabrera	National Marketing Director	PROSALUD

NGOs and International Agencies		
Patricia Sáenz	Medicines and Supplies Logistics Coordinator	Management and Quality, John Snow, Inc.
Dr. Oscar Viscarra	Health Officer	UNFPA
Dr. Oscar Cruz	Regional Director, La Paz	PROSALUD
Dr. Johnny López	Executive Director	CIES
Independent Consultants		
Dr. Victoria de Urioste	Ex-director	Chamber of the Bolivian Pharmaceutical Industry

Mexico

Name	Position/Area of responsibility	Institution
Ministry of Health		
Dr. Patricia Uribe Zúñiga	General Director	CNEGSR
Dr. Alba Moguel Ancheita	General Deputy Director of Reproductive Health	CNEGSR
Dr. Marco Olaya Vargas	Family Planning Director	CNEGSR
NGOs and International Agencies		
Dr. Vicente Díaz	General Director	Mexican Foundation for Family Planning (MEXFAM)
Esperanza Delgado Herrera	Information, Evaluation, and Research Director	MEXFAM
Gabriela Rivera Reyes	Reproductive Health Supplies Officer	UNFPA/México
Dr. Javier Domínguez del Olmo	Reproductive Health Services Quality Advisor, Country Technical Services Team for Latin America and the Caribbean	UNFPA/Mexico
States		
Dr. Sara Carmina Armenta Meneses	Director, Health Delegations	Secretariat of Health, Sinaloa
Olga Martínez	Director, Priority Programs	Secretariat of Health, Sinaloa
Dr. Manuel González Bon	Chief, Reproductive Health Department	Secretariat of Health, Sinaloa
Dr. Rubén Sinagua Acosta	Ex-chief of Family Planning	Secretariat of Health, Sinaloa
Dr. Jesusa Ofelia Cárdenas Medina	In charge of the family planning program	Secretariat of Health, Sinaloa

Da. Ana Cecilia I. Ávila Guzmán	Chief, Reproductive Health Department	Secretariat of Health, Tabasco
Dr. María Juana López Martínez	Family Planning Coordinator	Secretariat of Health, Tabasco
Dr. Francisco Ugalde Beaxuregard	In charge of the *Arranque Parejo en la Vida* program	Secretariat of Health, Tabasco

ANNEX 3. CHARACTERISTICS AND IMPACTS OF HEALTH SECTOR DECENTRALIZATION IN BOLIVIA AND MEXICO

Key Characteristics of the Decentralization Process in Bolivia

Decentralization process: An abrupt and rapid national transition initiated by the national government to shift responsibilities from a centralized form of government to subnational government units.

Goals: Reorganization of the structure of government into three levels of decisionmaking (central, departmental prefectures, municipal governments)—each with specific responsibilities and resources.

Key national policy changes:

- 1994: Popular Participation Law 1551 redefined local political relations for the purpose of promoting democracy and local government. Specified financial, management, and administrative authority is devolved from the national level to 314 municipalities.
- 1995: Administrative Decentralization Law 1654 established departments as coordinating bodies between national and municipal levels. Prefects are named by the President of the Republic to head departments, but as of 2006, prefects are elected directly by popular vote.
- 1999: Municipal Law 2028 established norms and standards for municipal control.
- 2001: National Dialogue 2000 established the management of the Poverty Reduction Strategy to guide the state in improving equity, reducing poverty, and increasing participation.
- 2006: Special Law Convoking a Constitutional Assembly established the Constitutional Assembly with democratically elected representatives to create a new more inclusive constitution. This process has been at a stalemate due to lack of political clarity on how to create a new all-inclusive constitution.

Financing and resource allocation: 20 percent of national income is transferred from the national government to municipalities through a tri-partite co-participation fund. Disbursements are made on a per capita basis.

Issues of autonomy: Local governments experienced significant gains in financial authority and management of local infrastructure.

Access: Decentralization increased access to basic social services, particularly for the rural poor.

Social participation: Creation of entities and mechanisms for popular participation and decisionmaking and social control; decentralization of social services.

Challenges: Rapid change created some confusion regarding roles, without the clear definition of responsibilities among different levels, and created uncertainty surrounding matters of governance (Garcia Pimentel, 2007; Pinto, 2000; Alcalde, 2004).

Impacts of Decentralization Bolivia's Health Sector

Changes in health policy: Significant impact on the organization, management, and implementation of the health sector.

Municipal governments assuming responsibility for

- Property of local public health services;
- Decisionmaking about new investments in health;
- Coordination with the Ministry of Health and Sports on decisions regarding the allocation and use of resources generated locally for health services;
- Management of health services in each municipality in line with national health policy and priorities; and
- Health networks (municipal and departmental networks).

National and departmental governments assuming responsibility for

- Regionalization of the health administration based on new political and administrative boundaries;
- Changing the role of the Ministry of Health and Sports to one of stewardship, with principal responsibilities for strategy, policy, planning, and program oversight; and
- Changing the role of SEDES to articulate national policy and help manage municipal health.

Health insurance: Along with the process of decentralization, a series of social health insurance programs have been adopted to improve maternal and child health of the poor. Related legislation includes the following:

- 1996: Supreme Decree No. 24303, National Maternal and Child Health Insurance, designed to improve maternal and child health and established to cover medical services for pregnant women and children up to 5 years of age. Financed by the tripartite co-participation fund transfer to municipalities.
- 1998: Supreme Decree No 25265, Basic Health Insurance, established to improve maternal and child health and relevant conditions of the poor by targeting them with a basic package of services of high-impact and low-cost services, including FP/RH. Financed by tripartite co-participation funds allocated to a Compensatory Health Fund in each municipality to cover additional costs of *inputs*.
- 2002: SUMI Law No. 2426 increased the number of services covered and the number of beneficiaries (to include all children and women of reproductive age) to lower maternal mortality. Did not cover all services (e.g., contraceptives and other services). Human resources financed by the National Treasury. Ten percent of resources from Popular Participation funds (taxes on goods and services). Up to 10 percent of resources from a Special Account (goods and services).
- 2002: Supreme Decree No 26873, Unique System of Logistics, established norms for a national logistics system.
- 2007: Universal Health Insurance announced by the President of the Republic to cover all children through age 21 in the first phase. The second phase will cover all people through age 51. Laws, norms, and regulations governing the new program are still in Parliament.

Impact of health insurance programs: Increased access to prenatal care and institutional deliveries and lowering of maternal mortality; but differential implementation, with limited operational capacity, infrastructure, and supplies in poorer municipalities. Still required are technical assistance, training, better diffusion of norms and standards, improved training in FP/RH and the use of contraceptives, and support for improved management.

Changes in health financing: New sources of financing for health services established at the municipal level.

Changes in access: Significantly increased access with the establishment of health insurance.

Changes in social participation: Institutionalization of popular participation through incentives in control over the allocation and use of tripartite co-participation funds. Establishment of mechanisms for popular participation in planning.

Challenges: Poor capacity in planning. Ineffective coordination among national, prefecture, and municipal agencies. High turnover of health personnel. Insufficient financial resources in some municipalities. Extremely limited management capacity in small municipalities (Garcia Pimentel, 2007; Pinto, 2000; Alcalde, 2004).

Key Characteristics of the Decentralization Process in Mexico

Decentralization process: Incremental in two stages.

- The first stage, 1984–1988, laid the foundation for decentralization. States were given the option to decentralize or continue under the federal government. Fourteen of 32 states decentralized.
- The second phase, 1995–2000, was initiated by the states, requesting the power to plan, budget, execute, and allocate resources. The national government gradually transferred responsibilities to the states, but without handing over decisionmaking power on all levels. Priorities were the transfer of financial resources and the definition of operational lines for social services.

Key national policy changes:

- 1983: Presidential Decree established decentralization.
- 1984: General Health Law on health rights established to modernize services and promote decentralization and deconcentration.
- 1997: Presidential decrees outlining the "new federalism" and the role of "decentralized public institutions."

Financing and resource allocation: Pattern of financial devolution.

Issues of autonomy: Mexico is a federal system. Each jurisdiction has its own sovereign power to establish decisionmaking mechanisms, as allowed by the federal structure.

Social participation: Social participation in rural areas was introduced with decentralization but was not a principal focus.

Challenges: Incremental approach eased the transition to decentralization, but balancing the power of the national government, states, and local government has been difficult (Egremy, 2007; Alfaro, 2000).

Impacts of Decentralization on the Health Sector in Mexico

Changes in health policy: Mexico moved to accelerate the decentralization of its health sector under the Health System Reform Program of 1995–2000.

- 1996: Health Secretariat signed agreements allowing federal entities to operate autonomously in states, identify priorities at the local level, and commit the state to participating in managing and taking responsibility for municipal levels. The specific agreements were the National Agreement for the Decentralization of Health Services and the Agreements for Coordination for the Complete Decentralization of Health Services.
- 1997: Reforms to the National Health Law and the Social Security Law, in conjunction with presidential decrees on "new federalism," and the role of "decentralized public institutions" reinforced earlier agreements.
- By 1999: States were responsible for managing more than 70 percent of their healthcare budgets.

Health financing: The federal government remains the main source of funding. State governments and local elected officials are responsible for local planning, program implementation, ensuring that resources are directed to local health needs, and presenting plans and budgets to respective state legislatures. The state legislatures then approve or amend plans and budgets. National, state, and municipal levels share responsibility for funds and sources of financing for health services. In 2004, Mexico spent 6.6 percent of the gross domestic product on health.

An amendment to the National Health Law mandated two budget line items—one for contraceptives and the other for FP services—to ensure that state governments adequately fund family planning. In 2000, this regulation was revised, and line items for contraceptives and family planning were incorporated into a more general category of medical services, giving state governments more flexibility with their budget allocations.

The recent sub-analysis of FP/RH spending according to the National Health Accounts has shown an average annual spending increase of 2.4 percent in real terms between 2003 and 2005. This was primarily due to an increase in public health spending related to the Popular Insurance and the new Fund for Protection against Catastrophic Costs. While public health spending on reproductive health increased, household out-of-pocket spending decreased.

Health insurance: Development of the Popular Insurance as part of the system of social protection in health. Mexico is also launching Medical Insurance for a New Generation to cover all children. The poverty relief program, Opportunities, also has a strong health component. FP services are limited to condom distribution only.

Access: By law, Mexico guarantees access to free contraceptives. Mobile health caravans have been deployed to reach less accessible sites.

Social participation: Community involvement and coordination needs strengthening, particularly NGO involvement in poor, rural states.

Challenges: The Program of Health System Reform aimed to address deficiencies in the decentralization process. These deficiencies include a limited local capacity for decisionmaking about the use of resources, the imprecise definition of responsibilities, and inequities in the distribution of the federal budget (Egremy, 2007; Alfaro et al., 2000; Alkenbrack and Shepherd, 2005).

ANNEX 4. KEY STEPS FOR IMPLEMENTING A COMPREHENSIVE APPROACH TO ADVOCACY DURING DECENTRALIZATION[3]

Step 1: *Form strategic working groups* at national, state, and municipal levels, with diverse representation from public and private sectors, NGOs, civil society groups, and community leaders.

Step 2: *Conduct a situation analysis* that covers key factors on FP/RH and access to services; population factors and likely future demand for FP/RH; the impacts of decentralization and integration, if applicable; the identification of new decisionmakers and stakeholders; gender norms, roles, and inequalities; and the roles of different sectors and the local policy environment.

Step 3: *Establish clear goals, objectives, and performance indicators,* specifically for advocacy at different levels that sufficiently narrows the focus to reposition FP/RH.

Step 4: *Identify target audiences* at the national, state, and municipal levels.

Step 5: *Build support and strengthen relationships* through networking tactics, civil society partnerships, and links with the Ministry of Health and other government organizations.

Step 6: *Develop messages* targeted to the specific audience to address its concerns and the information gaps, and develop an appropriate approach for the audience.

Step 7: *Select communication channels* to deliver the messages, with products tailored according to the best way to reach and hold the attention of the target audience.

Step 8: *Develop plans of action* that outline activities, responsibilities, timeframes for completion, support needed, and accountability for tasks.

Step 9: *Monitor and evaluate* to determine progress, revise the strategies as needed, and identify lessons learned and impact to provide evidence for next steps.

[3] Adapted from POLICY Project. 2005. Strengthening Family Planning Policies and Programs in Developing Countries: An Advocacy Toolkit. Washington, DC: The Futures Group, POLICY Project.

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