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## POLICY APPROACHES TO ENHANCING CONTRACEPTIVE SECURITY IN DECENTRALIZED CONTEXTS

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# Policy Approaches to Enhancing Contraceptive Security in Decentralized Contexts

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## ABBREVIATIONS

|        |  |
|--------|--|
| CS     | contraceptive security   |
| DAIA   | Comités de Disponibilidad Asegurada de Insumos Anticonceptivos |
| DIRESA | Regional Health Directorates                                   |
| HPP    | Health Policy Project  |
| LAC    | Latin America and the Caribbean                                |
| MAIS   | Integrated Health Model  |
| MINSA  | Ministry of Health   |
| MSP    | Ministry of Public Health and Social                           |
| NGO    | nongovernmental organization                                   |
| SRH    | sexual and reproductive health                                 |
| SRS    | Regional Health Services                                       |
| USAID  | U.S. Agency for International Development                      |





# INTRODUCTION

Interventions aimed at improving health outcomes are more likely to be successful when they are customized to local contexts, grounded in strong evidence, and supported by a range of policymakers and stakeholders from different sectors (Pickett and Pearl 2001, Brownson et al., 1999, Lee et al., 1998). The process of decentralization, a type of political reform intended to transfer authority for policy and financing from the central level to lower-level units, presents an opportunity to develop such tailored and effective interventions while also strengthening democratic processes and transparency through greater citizen participation in decision making (Bossert et al., 2000). Decentralization reduces the distance between policymakers and the people they serve, and creates opportunities for smaller, localized civil society organizations to engage in policy dialogue.

Decentralization in health has been in effect for decades, and many countries in Latin America and the Caribbean (LAC) have been pioneers in the process. Within the field of sexual and reproductive health (SRH), countries in the LAC region have achieved several decades of success in meeting unmet need for family planning by increasing contraceptive use through policy reforms, but such progress was largely driven by government agencies and development partners operating at the central level.

At the same time that decentralization has expanded, donors in the LAC region have been phasing out their technical and financial assistance for SRH. As part of this transition, many countries have created contraceptive security (CS) committees to coordinate the analysis, planning, financing, and monitoring of family planning programs across sectors.<sup>1</sup> Known in Spanish as *Comités de Disponibilidad Asegurada de Insumos Anticonceptivos (DAIA)*, CS committees also serve to develop the capacity of national health officials in planning, budgeting, and distributing contraceptive commodities. The committees are typically composed of representatives from the public sector, often the Ministry of Health and Social Security system; the private sector, including nongovernmental organization (NGO) service providers; and international partners (Siman Betancourt, 2007). In the LAC region, members report that CS committees have hastened progress toward contraceptive security and provided an extra boost in prioritizing the issue on national health agendas (Siman Betancourt, 2007).

The parallel shifts toward decentralization and increased country ownership in SRH present a natural opportunity for synergy to strengthen CS at the subnational level, including by adopting the successes of the committee approach. Yet to date there are few examples of such decentralized committees operating in the LAC region, especially with a mandate that includes policy formulation, implementation, and advocacy. In response, the Health Policy Project (HPP) decided to test and share lessons learned about approaches to enhancing contraceptive security in decentralized contexts through policy-focused pilots in two countries, Peru and the Dominican Republic. Over a two-year period from 2010 to 2012, the project revived a weak regional CS committee in Peru and created a new municipal committee and regional committee in the Dominican Republic.

## METHODS

The design and implementation of the programmatic interventions to enhance CS in decentralized settings were highly flexible and iterative. In Peru, the project intended to revive and strengthen an existing regional multisectoral body that could function as a CS committee. In contrast, the program in the Dominican Republic was initially designed to promote the inclusion of SRH in the participatory

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<sup>1</sup> HPP conducted a literature review in Publine, Medline, and gray literature with a set of 20 search terms dating back to 2000. The only articles published about CS committees specifically have been through USAID-funded projects.

budgeting process in one community, but during the early stages of the intervention, stakeholders demonstrated interest in establishing municipal and regional committees.

Still, both programs were intended to build the capacity of civil society and increase citizen participation in policy making, and they followed a similar sequence of design and implementation. The programs were also both heavily invested in building an enabling policy environment for CS, operating with a broader portfolio than the supply chain and regulatory issues that are the focus of many national CS committees. Because health financing and service delivery are relatively new responsibilities for regional and local officials under decentralization, political commitment and leadership are essential to including contraceptive security on the policy agenda.

In addition, the Peru and Dominican Republic programs assumed an expanded scope that addressed several SRH issues related to CS, such as the prevention of maternal mortality and protecting the rights of young people to comprehensive sexuality education. This holistic view was driven by the programs' stakeholders, who viewed family planning as a critical but not independent component of their communities' reproductive health status. While the committee members in both countries maintained consistent attention to challenges such as inadequate funding to transport contraceptive commodities, they also considered related problems, such as low levels of facility-based births, inherently within their mandate.

The program design was informed by a participatory assessment conducted between December 2010 and February 2011. Project staff surveyed a total of 17 government health officials, international donor staff, and program managers, including members of national DAIA committees, in Guatemala, El Salvador, Honduras and Peru. All of the respondents reported that the committees required external technical assistance to improve their ability to promote contraceptive security, and suggested that the committees should be institutionalized within the political and legal framework to provide continual support for family planning policy and financing. Respondents also noted the need to support citizen participation to monitor implementation of public policies in health, as well as review the role and commitment of different political actors in contraceptive security.

In consultation with the project funder, the U.S. Agency for International Development (USAID), HPP elected to work in Peru and the Dominican Republic, based on a history of previous projects on SRH policy in both countries and to align with other projects working in the region. While the two countries both face challenges of geographic and socioeconomic disparities among subgroups of their populations, project staff felt that their distinctions offered an opportunity to test approaches to CS in two different decentralized settings. For example, although decentralization had its legal beginning about 10 years ago in both countries, Peru has made more progress in health sector reform efforts since, while the Dominican Republic has been hampered in part by the influence of politics in the execution of civic functions.

The programs were designed as medium-term efforts that would become increasingly sustainable and could be scaled up to strengthen contraceptive security in other local and regional settings. However, the technical assistance ceased after two years due to funding constraints. Although there was not an opportunity for a thorough endline assessment and evaluation, the programs were extensively documented through monthly reports, meeting summaries, and a series of commitments made by committee members.

To compare and document initial results in the two program areas following the two-year intervention period and their implications for other settings upon completion, we used the programmatic documentation as source material. In our review of the source material, it became clear that the program results applied to the findings of a previous study that identified three elements as critical for SRH programs to be successful within decentralized contexts in the LAC region (Saunders and Sharma, 2008). The discussion section of this paper includes our analysis of the implications of the policy results

achieved in both country programs according to the three elements: political commitment and advocacy, financing, and demand and access.

## PERU: BACKGROUND AND CONTEXT

Contraceptive use increased markedly in Peru between the early 1980s and 2000, due in large part to political commitment to increase the availability of FP services and prioritize financing and human resources in FP programs. Contraceptive services have been offered free of charge since 1995, a budget line for contraceptives was introduced in 1999, and the Ministry of Health (MINSA) has expanded the reach of its facility network, especially in rural areas. Although Peru does not have an official DAIA committee at the national level, since 2004 the MINSA has convened a consultative committee with representation from academic institutions, international partners, and NGOs.

In 2008, all health system services and resources were transferred to regional governments following the 2002 constitutional mandate of decentralization (Rojo Silva, 2010). According to Peru's legal framework, the national government maintains authority for approving national and sectoral policies, regulating public services, and managing the national infrastructure. Regional governments assumed responsibility for regional-level planning, program execution, budget approval, and disbursement of funds. Regional governments, through the Regional Health Directorates (DIRESA), have the authority to prioritize their own health needs, which in turn inform regional health plans that typically cover a five-year period. Planning, service delivery, and budgeting at the district and provincial levels are likewise the responsibility of local governments.

In parallel with decentralization, family planning and 13 other health programs that had been administered vertically were combined in 2001 into the Integrated Health Model (MAIS), and contraceptives are managed together with all other medicines in an integrated supply chain. Some regions have continued to administer family planning services vertically, and among those that shifted to the MAIS system during the decentralization process, regions did not always account for the program costs associated with delivering supplies, including logistics management and training. Although family planning was identified as a priority area in the MAIS through the National Sexual and Reproductive Health Strategy adopted by MINSA and has a dedicated budget line item, in practice it was often subsumed into broader issues such as maternal health, and the roles and functions of stakeholders remained somewhat unclear.

One major policy barrier in Peru is the prohibition against delivering contraceptives to adolescents, because sexual relations between young people ages 14 to 18 are penalized, regardless of consent. This has a chilling effect, with providers wary of discussing reproductive health among this age group. The resulting lack of access to information and services is reflected in a high adolescent pregnancy rate, which is a particular concern in the jungle region of Ucayali in eastern Peru. The median age at which young women in Ucayali have their first sexual activity (16.9 years) and first birth (20.4 years) are each nearly two years below the national average (INEI, 2012). Adolescent fertility is twice as high as the national average: In Ucayali, 25 percent of young women ages 15 to 19 are pregnant or already mothers (INEI, 2012).

In recent years, the Ucayali government developed several policies to address maternal health issues, including through the promotion of family planning information and services, which reduce unintended and high-risk pregnancies that in turn contribute to maternal mortality. In 2006, Ucayali defined maternal mortality as a regional priority, with an emphasis on the prevention of unplanned pregnancies among adolescents (Mesa de Derechos Sexuales y Reproductivos, 2012a). In 2009, the government issued Regional Ordinance 11-2009, which affirmed adolescents' right to integrated sexual and reproductive

health information, without prior authorization by parents or guardians. However, this ordinance was not effectively implemented. In addition, the Regional Participatory Health Plan 2005–2010, which frames the political agenda and support for the sector, did not include family planning among its five priorities (Dirección Regional de Salud, 2005).

As part of Peru's decentralization process, Regional Health Councils were formed to facilitate the coordination of health policy between government and civil society. Various thematic roundtables were created to operationalize the work of the Regional Health Councils. In Ucayali, this included the Roundtable on Sexual and Reproductive Health, founded in 2009 to defend and monitor the sexual and reproductive rights of the population (Mesa de Derechos Sexuales y Reproductivos, 2012b). Its organizational members included the regional government and health bodies, national and regional NGOs, and donors.

However, the Roundtable only met irregularly. Its primary achievement was the development of a Regional Strategic Plan for the Reduction of Maternal and Perinatal Mortality 2010–2015, with the aim of reducing maternal deaths by improving sexual and reproductive health. As of 2011, this plan had not been implemented.

## PROGRAM IMPLEMENTATION AND RESULTS

In consultation with USAID/Peru health officials, HPP selected Ucayali as the location of the pilot program due to its supportive political climate and the presence of existing USAID projects. HPP elected to develop capacity for policy development and implementation among members of the Roundtable to motivate a stronger role for sexual and reproductive health, including family planning, on the regional health agenda. Although various actors had been working independently to improve SRH in the region, there was no consistent opportunity for them to come together to reflect on policy barriers and opportunities.

In 2011, the project identified and conducted interviews with the primary social sector actors in the region, including representatives of DIRESA and civil society, to confirm that there was interest and value in reactivating the Roundtable. The participatory approach was pivotal in identifying strategies to address existing health policy barriers that the government had not either identified or acted on previously.

The Roundtable was formally reconvened in September 2011, and meetings continued on a monthly basis. Its members agreed to track the implementation of the Maternal Mortality Strategic Plan and Regional Ordinance 11-2009 as their primary strategy, with working groups formed for each. HPP provided technical assistance by orienting Roundtable members to the status of SRH in Ucayali and the policy environment, and identifying entry points to improve policy implementation.

The Roundtable's efforts to ensure that existing policies were well-implemented addressed a range of SRH issues, including but not limited to contraceptive security. Its accomplishments included

- Providing political pressure for authorities to award resources to the Maternal Mortality Contingency Plan, developed in late 2011 to address an increase in the number of maternal deaths in the region. During a November 2011 Roundtable meeting, members reviewed the fact that funding had been obligated from the regional government and the DIRESA, but not received due to budget shortfalls. In response, the Manager of Social Development of the government of Ucayali and the director of the DIRESA committed to allocating the necessary funds, which were used to strengthen the human resource capacities of eight health facilities in the region and distribute emergency obstetric kits to the facilities.

- Convening a Sexual and Reproductive Health Dialogue in June 2012 to analyze how the legal framework affected adolescents' access to SRH services and propose strategies to improve SRH in the region. At the end of the meeting, more than 30 representatives from government, civil society, and international organizations, including the Ucayali representative in Congress, signed a commitment promising to implement policies that ensure access to high-quality reproductive health services for the whole population and to ensure financing.
- Compelling the regional government and Regional Directorate of Education to begin rolling out the comprehensive sexuality education curriculum, which had been developed in 2008 but was not implemented in many regions. The curriculum includes material about the right to high-quality contraceptive information and services. In September 2012, the Manuela Ramos NGO, a member of the Roundtable, began training 70 teachers from five districts in Ucayali.

Simultaneously, the project initiated an effort to strengthen capacity at the district level to design, implement, and monitor policies that contribute to the reduction of maternal mortality and the adolescent pregnancy rate, including through the provision of contraceptive services and information. This initiative was intended to ensure that district officials are equipped with information about SRH challenges and how to overcome them as they assume greater authority and responsibility through the national decentralization process, and to train community civil society organizations on how to increase citizen participation in policy making.

Project staff, including a team from the USAID-funded Healthy Communities and Municipalities II (Spanish acronym MCS) project, selected the Campo Verde district of Ucayali, where MCS was already active. The mayor convened a meeting of 17 local officials about local reproductive health issues, during which officials expressed their concern about the high rate of adolescent pregnancy in the district, which the local health network reported at nearly 25 percent. In response, the officials committed to including a public investment project in the 2012 budget to improve SRH of the local population, especially adolescents. A similar meeting with three neighborhood groups from the district was held to discuss how adolescent pregnancy and maternal mortality could be reduced through interventions such as implementing SRH curricula in schools and providing trainings for parents, teachers, and healthcare providers about adolescent SRH and family planning.

In March 2012, 18 representatives of the district committee and local government met to review indicators related to maternal mortality and adolescent pregnancy. After this meeting, the Campo Verde health network, a member of the district committee, delivered a presentation on raising the share of facility-based births to the Health Sector Reform Support Fund (PAR SALUD) Competitive Fund. Their proposal was funded for 40,000 Peruvian soles (US\$15,500), which was in turn supported by a grant of 120,000 soles (US\$46,500) from the local government to construct a birthing center.

In April 2012, the project convened a workshop on public policies in reproductive health and citizen participation for members of the local government and the district committee. Participants drafted two ordinances, one related to preventing unintended pregnancy in adolescents and the other to improving access to culturally appropriate services among pregnant women in Campo Verde. The ordinances were combined as a single proposal to the Local Council and approved in August 2012. The ordinance designates the months of May, June, and July of every year as priority action months for maternal health and the prevention of adolescent pregnancy and mandates that coordinated actions to address these issues be included in the annual workplans to implement the district's strategy for healthy communities.

To build sustainability for future advocacy directed at Campo Verde's increasingly supportive local officials, the project held a citizen participation workshop with representatives of 13 neighborhood groups in August 2012. Although the neighborhood groups have a "watchdog" function as part of their founding resolutions, they often lack knowledge about how to effectively monitor policy development and

implementation. The neighborhood groups developed vigilance plans to verify that health facilities adhere to their designated hours of operation, that teachers are present when schools are open, and that adequate supplies of supplementary nutrition are provided through public assistance programs.

## **DOMINICAN REPUBLIC: BACKGROUND AND CONTEXT**

Contraceptive prevalence has risen in the Dominican Republic, with 70 percent of women in union using modern family planning methods, and fertility has declined steadily, to 2.4 children per woman in 2007 (CESDEM and Macro International Inc., 2008). However, there are significant geographic disparities, compounded by the fact that the country shares its island location with a neighbor that has much lower levels of socioeconomic development. Provinces in the west and south of the Dominican Republic, next to and near Haiti, face special challenges due to migration across the porous border. The region of Enriquillo in the southwest, also known as Health Region IV, and Health Region VI directly to the north, have the highest fertility rate in the country, 3.1 children per woman (CESDEM and Macro International Inc., 2008).

Although guidelines exist for adolescent-friendly services, education about sexual and reproductive health is limited and confidentiality and cost concerns inhibit use of services among young people (Miller et al., 2002). The median age at which young women begin sexual activity in Health Region IV (17.1 years) is one year younger than the national average, and the region has the highest rate of adolescent childbearing in the country—29 percent of young women ages 15 to 19 are already mothers or pregnant.

Health sector reform in the Dominican Republic is governed by the General Health Law (42-01) and the Social Security System Law (87-01) mandating a national health insurance scheme, both passed in 2001. As part of this reform initiative, the health sector was deconcentrated, a specific form of decentralization with functions, responsibilities, and resources transferred to regional and provincial levels (Miller et al., 2002).

Decentralization was operationalized through the creation of a system of Regional Health Services (SRS), autonomous health providers that must adhere to criteria defined by the Ministry of Public Health and Social Welfare (MSP). Each SRS is composed of Provincial Health Directorates (DSP), that serve as local representatives of the MSP and manage the supply chain for family planning commodities. Still, governance of the health sector is a major challenge, with services distributed inequitably and management fragmented. In 2009, only 40 percent of the population was covered by the health insurance program that had been mandated nearly a decade earlier (Rathe, 2010).

As decentralization was introduced, the evolving political context created new opportunities for policy dialogue at the community level. Community participation in local-level decision making was formalized in a 2007 Dominican law (176-07), which states that municipal governments are responsible for soliciting the collaboration of their citizens in local management (Consejo Nacional de Reforma del Estado, 2007). The resulting participatory municipal budget model mandates formal community participation throughout the municipal budgeting process, especially for the 40 percent of municipal budgets that are provided from national resources. This law also requires that 4 percent of municipal budgets be dedicated to gender and health education programs.

Yet after the law was approved, governments and civil society alike lacked understanding of how its mandates would be handled in practice. In the decentralized context, capacities for democratic governance and health policy implementation were weak at the local levels. Government authorities and civil society organizations were unaware of the municipal framework that would support implementation

of their policy priorities, or did not know how to navigate the mechanisms available to facilitate their participation in planning and budgeting.

The Dominican Republic's national DAIA Committee was formed in 2004 (Siman Betancourt, 2007), the same year that the government began purchasing contraceptives with domestic resources (Olson et al., 2010). The committee has a large and active membership and has contributed to an expansion of family planning coverage and reduction in commodity costs (Siman Betancourt, 2007). In 2009, the DAIA Committee facilitated a purchasing agreement between MSP and the NGO PROFAMILIA that alleviated a significant contraceptive shortage in the public sector (Olson et al., 2010).

Although the Dominican Republic has secured a well-functioning logistics system for contraceptives at the central level, barriers remain in delivering supplies to the lowest levels of the supply chain. A study by the DELIVER Project (Sánchez et al., 2008) and reports by community members during project design reported several problems in the delivery of contraceptives that contribute to regular shortages in many communities. Local-level staff require additional training on analyzing and evaluating stock levels, and facilities are often delayed in their preparation of monthly consumption reports, so the quantity of supplies ordered is often insufficient to meet demand. Local facilities also receive supplies erratically due to inadequate transportation budgets.

## PROGRAM IMPLEMENTATION AND RESULTS

HPP's initial goal was to build capacities for democratic governance and health policy implementation at the local level by working with one municipality to include SRH and family planning in the participatory budgeting process. In designing an intervention, USAID recommended that the project work in Paraíso, a town of 15,000 in Barahona province within the Enriquillo region (Health Region IV). Paraíso was selected because of the level of stakeholder interest demonstrated in the previous program, its location near the Haitian border, and its demographic characteristics, which include poverty and illiteracy rates above the national averages. Furthermore, the mountainous terrain around Paraíso isolates its communities and makes transportation to regional-level facilities challenging, a problem that the municipal committee would later address directly.

Beginning in April 2011, the project worked with the mayor and other local government authorities in Paraíso to design the program and build consensus for working with the community. HPP conducted a rapid situation assessment that included individual and group interviews, observational tours with community leaders, and workshops.

The project convened five focus group sessions with members of the community representing diverse backgrounds. The participants used "tortilla" diagrams and mapping to identify the powers and responsibilities of local government agencies as well as barriers related to information and service delivery across the health sector, including family planning. For example, community members faced delays in seeing medical specialists due to overcrowding of health facilities, incurred transportation costs to seek care at higher-level facilities in the provincial capital because the local hospital only functioned intermittently, and experienced frequent commodity shortages.

During these discussions, a group of people emerged as interested in the program and the approach of forming a new committee, although not explicitly included in the original workplan, emerged organically. The focus group participants decided to create a health working group, which chose as its name the Paraíso Family Health Committee. The Committee's goals were to compile evidence on key health problems in the community, generate proposed interventions, and present these solutions to policymakers. While contraceptive security at the subnational level was a primary focus for the Committee, the members

also elected to consider policy challenges related to adolescent pregnancy and gender-based violence. Its seven organizational representatives included local government authorities and the local hospital, representatives of the national health and education ministries, and civil society. It was formally inaugurated by the municipal government in a January 2012 resolution.

The Committee's activities over the subsequent year focused on capacity building for its members and on strengthening social participation at the community level, including:

- Training seminars provided by HPP on data use and analysis, participatory citizenship, governance, and social leadership within health;
- Informal meetings in schools to discuss reproductive health services with students and teachers; and
- Meetings with providers at local health centers to suggest simple techniques to improve the quality of care, such as closing the door to ensure privacy when meeting with patients.

The single year of activity in Paraíso produced major results in alleviating the community's regular contraceptive shortages. In April 2011, during a stockout that lasted four months, members of the nascent Committee informed the mayor that medical staff often paid out of their own pockets to purchase supplies due to shortages. In response, the municipal government quickly organized a trip for health officials to travel to the regional store to pick up family planning commodities and distribute them to facilities in Paraíso. With municipal officials among the leaders of the Committee, their exposure to ongoing discussions about CS issues generated even stronger commitment. In November 2011, the municipal government committed to adding a line worth 36,000 Dominican pesos (US\$920) to the 2012–2013 budget to pay for the transport of commodities from the regional level, thus preventing future shortages. By mid-2012, the project judged the Paraíso Committee to be self-sustaining due to its established activities and support from local policymakers.

## Forming a Regional CS Committee

The creation of the Paraíso Committee spurred interest in a similar mechanism at the regional level. Beginning in June 2011, HPP held several conversations with the Regional Director of Health and his staff to explain the role of DAIA committees and explore the possibilities of implementing one at the regional level.

Meetings between the Regional Director of Health, the Regional Director of Logistics, and civil society organizations then defined the composition of the subnational committee. With representation drawn both from both the national and municipal levels, the Enriquillo Committee was designed to bridge the gaps between successes in enhancing contraceptive security at the national level and the relatively high unmet need for SRH services at the local level. Its members included regional, provincial, and district government officials; regional hospitals and associations; development and women's empowerment NGOs; local neighborhood groups; and a representative from the Paraíso Committee.

The Committee members created a workplan for the 2012–2013 period that was informed by interviews with nearly 40 stakeholders representing the regional government, SRS, three local governments, nine civil society organizations, and two international agencies. The workplan's objectives included defining policy guidelines and plans related to SRH; developing strategies to strengthen the social participation of vulnerable groups; and developing criteria to ensure funding and a functional supply chain for contraceptives.

After several delays, the launch of the Enriquillo Committee occurred in January 2012 with the Vice Minister of Planning and Development and the Minister of Public Health in attendance to represent the national government. On International Women's Day in March, members of the Committee formally



introduced its activities to more than 100 representatives of the community. Next, its members, including representatives of the regional government and civil society, made visits to schools and health facilities to discuss the importance of providing sexual education.

Unfortunately, the political climate surrounding the May 2012 presidential campaign slowed the pace of the Committee's activities. Delays in naming new political appointees in the health system continued into the autumn. The prospects of the Enriquillo Committee remained uncertain in the post-election transition period, and by September 2012, it had not yet held its first official meeting.

## **DISCUSSION: APPLYING LESSONS LEARNED**

The approach of promoting a favorable policy environment for contraceptive security in a decentralized context through multisectoral committees is still novel, and can be applied in many other settings both within and beyond the LAC region. Given the lessons learned in these programs, family planning and reproductive health can be positioned as key components of regional and local development, as they have been at the central and global levels. Our assessment confirmed that three components are critical to maintain prioritization of family planning during decentralization: political commitment and advocacy, financing, and demand and access (Saunders and Sharma, 2008).

### **Political Commitment and Advocacy**

Although national governments have developed policies and regulations for SRH service delivery, such documents do not necessarily exist at the subnational level. Furthermore, policy implementation is weak at the subnational level, where there is often inadequate planning for supervision and monitoring. Local government officials who assume responsibility for SRH programs may have never advocated, or been targets of advocacy, on behalf of contraceptive security. They may also have never liaised with international partners and donors who support or prioritize contraceptive security. In situations with scarce resources, family planning, which lacks the tangible curative ability of commodities like vaccines, is sometimes viewed as important but not urgent.

Given this context, issues related to SRH may not be part of the political agenda for local and regional officials, due not necessarily to opposition but simply to a lack of awareness of their relevance for health and development. In a decentralized setting, political commitment for contraceptive security often must be constructed and nurtured, largely through advocacy, from the ground up. With a multisectoral approach, such programs can also generate a cadre of civil society champions whose dedication to advocacy increases the likelihood of sustainability even in times of political transition.

In Peru, the regional Roundtable emerged as a space for coordination of policies to improve reproductive health in the region. Even more importantly, its reactivation ensured that the political agenda moved beyond policy development to address implementation. In its first year of existence, the Roundtable's commitments resulted in enhanced training for health and education staff and improved supply distribution to and linkages between health facilities, directly advancing the implementation of two neglected policies.

In both countries, the committees introduced the concept of governance into health at the decentralized level, enabling members to hold policymakers accountable for their commitments by showing how services were not meeting the needs of all citizens and providing a channel of communication between the authorities and civil society. In Paraíso, committee members regularly informed the mayor and other local officials of their discussions, providing information about the effects of supply shortages that made leaders' priorities, such as reducing adolescent pregnancy, more concrete. The members' active

engagement in advocacy demonstrated that brief but intensive policy outreach at the community and regional levels can have a quick impact.

## Financing

Changes in financing mechanisms are among the hallmarks of decentralization, which typically incorporates a shift in some degree of budgetary control to lower-level authorities. This change can affect family planning programs in various ways, creating problems when there is a lack of data about local funding requirements and projections, insufficient training in budgetary timelines and processes, or cultural biases against support for family planning (Saunders and Sharma, 2008). More optimistically, it can present an opportunity to increase equity in the allocation of resources.

In response, many decentralization frameworks incorporate some form of earmarking or mandatory allocations from the central government to decision-making bodies at the regional and local levels, as the Dominican Republic does with a regulation that 4 percent of local budgets be devoted to gender and health education. This presented both a challenge and opportunity in matters of funding. Communities have typically largely devoted their budgets to infrastructure issues or short-term cash transfers. Concerted advocacy is required to ensure that SRH and family planning are identified by the community as a priority and necessity and awarded adequate budget allocations and disbursements. In Peru, funding had been promised for the Maternal Mortality Contingency Plan but not delivered until Roundtable members were able to directly impress its urgency on regional officials.

Logistics are a key component of the decentralization process, and inextricably linked to financing. In both countries, the new committees piqued interest among government officials in the value of coordinated capacity development for logistics at lower levels of the health system. Officials working primarily at the national level had succeeded in improving stock levels, logistics, and procurement and funding mechanisms, but did not realize that the system was not working as well at lower levels. Meanwhile, regional and local officials were unaware of problems in contraceptive supply because such issues became part of their purview only recently through decentralization, and they did not know how to seek recourse. The networking and accountability functions of decentralized committees can both inform policymakers of problems in the supply chain and motivate sustainable resolutions, such as the new annual budget allocation in Paraíso.

## Demand and Access

The programs in both countries chose to work at the community level to strengthen social participation and engage citizens in governance for policy decisions that directly affect their health services. Training to local civil society organizations, including neighborhood groups, positioned them for effective advocacy by developing vigilance plans for close monitoring. In Campo Verde, Peru, workshops with the local authorities and technical teams informed officials that poor quality of care and lack of information inhibited people from accessing reproductive health services and therefore contributed to unacceptably high maternal mortality and adolescent pregnancy rates. In response, officials solicited funding and designated three months of the year as priority action months for these issues.

The increased citizen participation generated by these programs aligned with the opportunity decentralization presents to motivate civil society representation, especially among smaller groups, in the policy process. This can particularly benefit representatives of marginalized or underserved populations, such as adolescents and those living in poverty. In Peru, the Roundtable secured a commitment from stakeholders, including the local congressional representative, to revise laws that inhibited the dissemination of information about SRH to youth. In the Dominican Republic, the Paraíso Committee,

representing a geographically isolated area, raised awareness among local officials of the additional challenges in accessing services faced by Haitian immigrants living in the hills outside the community.

## CONCLUSION

The findings from these pilot programs demonstrate the value of a localized, multisectoral, policy-focused approach to contraceptive security in a decentralized context. Multisectoral committees can address a host of policy issues, from human resources and financing to quality of care. In addition to funding for contraceptives, such groups can ensure that decentralized budgeting processes, especially when designed to be participatory, include funding for training, supervision, community outreach, transport of commodities, and improvements to infrastructure and basic equipment. They can also promote improvements in the quality of service, for example by pressing for adolescent-friendly services to help reduce high rates of unintended pregnancy among young people.

In the Dominican Republic and Peru, project staff and committee members were approached by several other local, regional, and national stakeholders who expressed interest in creating other committees in the same mold. Although the duration of the project was short, the successes and enthusiasm generated by the Paraíso, Enriquillo, and Ucayali committees will hopefully ensure that these potential new committees come to fruition, and that the lessons learned in these pilots can be applied to the many other settings where decentralization and efforts to improve contraceptive security overlap.

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