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THE EFFECTS OF DECENTRALIZATION ON FAMILY PLANNING

A Framework for Analysis

This publication was prepared by R. Taylor Williamson, Sandra Duvall, Arthur A. Goldsmith, Karen Hardee, and Rebecca Mbuya-Brown.

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The Effects of Decentralization on Family Planning: A Framework for Analysis

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ABBREVIATIONS

CSO	civil society organization
FP	family planning
GHS	Ghana Health Service
HIV	human immunodeficiency virus
HPP	Health Policy Project
ICPD	International Conference on Population and Development
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
JHSPH	Johns Hopkins Bloomberg School of Public Health
LGDF	Local Governance Development Framework
MDG	Millennium Development Goal
MOH	Ministry of Health
NGO	nongovernmental organization
NISR	National Institute of Statistics of Rwanda
OSAR	(Guatemala) Reproductive Health Observatory
PIAT	Policy Implementation Assessment Tool
PPP	public-private partnership
RH	reproductive health
SEED	Supply-Enabling Environment-Demand (Model)
TA	technical assistance
TB	tuberculosis
UNFPA	United Nations Population Fund
UNRISD	United Nations Research Institute for Social Development
USAID	United States Agency for International Development
WGI	Worldwide Governance Indicator
WHO	World Health Organization

1 INTRODUCTION

Worldwide, two trends are converging to place the decentralization of family planning (FP) services at the forefront of policy discussions: (1) the rise of international FP commitments and (2) the expansion of decentralization reforms in developing countries.

Countries pursuing decentralization reforms shift responsibility for various functions from the national government to lower-level entities, such as regional government offices, local governments, independent agencies, state-owned parastatals, and private sector organizations. In the health sector, lower-level actors often assume new roles and responsibilities in financing, governance, human resources, procurement and logistics, insurance, and payments. The implications for FP programs are profound and wide-ranging.

Where decentralized institutions assume responsibility for FP budgets and services, the implementation of international policy commitments—such as the Millennium Development Goals (MDGs) or the FP2020 commitments launched at the 2012 London Summit on Family Planning—ultimately rests with authorities outside the national government.

Within the health sector, proponents commonly argue that decentralization produces more efficient, equitable health services and provides communities with a stronger voice in the programs that affect them. However, the record on family planning and decentralization is mixed. While decentralization opens up the political process to new actors, opportunities for tailoring programs to client needs, discovering and addressing local challenges, and engaging new FP supporters and promoters, the potential for adverse effects is substantial.

FP stakeholders are often excluded from the decision-making processes surrounding decentralization, leading to gaps and weaknesses in policy frameworks guiding FP decentralization. Decentralization reforms may overwhelm the capacity of lower-level organizations to fulfill new functions. Moreover, in some countries, decentralization has led to family planning not being a priority as local-level authorities reallocate resources to other areas. Local authorities may not understand the importance of family planning or may see it as contrary to traditional gender norms or religious beliefs. There is an urgent need to better understand how decentralization reforms impact FP programs and services.

This paper presents a framework to help key stakeholders better understand FP decentralization processes, identify potential challenges and opportunities, and guide decentralization reforms in directions that will benefit FP clients and support the achievement of international FP commitments. Drawing on the latest research literature, the **FP and Decentralization Analytical Framework** provides a way to conceptualize the interactions between different actors in FP decentralization processes, the rules that structure those interactions, and how different models of decentralization can affect FP services. The framework does not seek to draw broad generalizations about the impact of decentralization on FP programs and services. Rather, it (1) offers its target audiences—international donors and technical assistance providers; local and national-level FP advocates; and Ministry of Health (MOH) technical managers—a tool that can be used to analyze the state of FP decentralization reform in individual country contexts and (2) outlines how these three audiences could apply the framework to help them engage more strategically and effectively in policy processes surrounding FP decentralization.

2 ABOUT DECENTRALIZATION

Decentralization is a process of transferring decision-making power, authority, and responsibility from centralized national institutions to decentralized institutions, such as regional and local governments or private organizations. There is no one-size-fits-all approach to decentralization. Decentralization processes vary widely from country to country (Kulipossa, 2004).

2.1 Types of Decentralization

There are four basic types of decentralization (Rondinelli, 1983)—each of which presents particular challenges and opportunities for FP programs and services:

- Deconcentration—National institutions place staff at the local level but retain decision-making power.
- Devolution—Power, responsibility, and budget authority are shifted to locally elected or appointed officials.
- Delegation—Management of public functions is transferred to semi-autonomous or parastatal organizations.
- Privatization—Public tasks are contracted to private sector organizations (including for-profit companies and nongovernmental organizations or NGOs).

A country can adopt one or more of the basic types of decentralization. Decentralization processes often involve a mixture of these types, and countries may shift from one type to another as decentralization processes evolve. Decentralization is best understood as a *process* rather than as a static fact, as approaches must be continually adapted to changing internal and external conditions (Eaton et al., 2010).

For example, Senegal moved from a deconcentration approach, under which regions and district health authorities were accountable to the central MOH, to devolution, under which a portion of the MOH budget passed directly from the Ministry of Finance to local governments. Local officials were given the authority to allocate these funds and were able to spend them on non-health sectors. Similarly, Burkina Faso moved from a system of deconcentration to one of devolution in 2006, with a progressive transfer of responsibilities regarding basic service delivery to regional and local governments (Van der Wal et al., 2006).

The form of decentralization implemented (e.g., deconcentration, devolution, delegation, privatization, or a mixture of these) affects the type of institutional arrangements adopted. This, in turn, determines what types of institutions are involved in FP service delivery (see Section 3.2.).

3 "CAST OF CHARACTERS"

Many institutional actors are involved in decentralization—both in setting and carrying out FP-specific policies and guidelines and in establishing and implementing decentralization policies more broadly. While the specific identities and roles of institutions will vary from country to country, this section outlines some key institutional actors commonly involved in decentralization processes. Understanding this "cast of characters" and the different roles they play will help readers understand and apply the FP and Decentralization Framework (presented in Section 4).

3.1 National Institutions

The national government actors that oversee FP policymaking, planning, and service delivery are critically important. These institutions

- Participate in shaping the lines of responsibility and authority in decentralization reforms
- Set overall FP guidelines and policies

Legislature

Legislative bodies, such as parliaments,[1] are responsible for putting in place and approving laws and policies that affect the provision of FP services and shape the decentralization process itself. They

1. Define decentralization frameworks—assigning specific roles and responsibilities to national and decentralized institutions
2. Establish FP laws and policies
3. Oversee the bodies—such as ministries—responsible for implementing laws and policies
4. Hold the power of budget approval

Parliamentary committees and subcommittees may be permanent standing committees with jurisdiction over areas such as health, budget, or defense, as well as special and/or temporary committees established to address a specific issue such as family planning or decentralization.

In addition to committees established within Parliament itself, informal groups and networks of parliamentarians may also be established. Such groups may advocate for policy change or increased investment in FP programs; reach out to fellow parliamentarians to strengthen parliamentary support for family planning; monitor implementation of FP laws and policies; and/or help hold the government accountable for its FP commitments.

Executive

While systems of government differ, the executive is generally responsible for implementing the laws and policies established by legislative bodies. While specific mechanisms and structures vary from country to country, executive authority is generally exercised through a Cabinet (also referred to as the Council of Ministers, or Government) and ministries. The implementation authority of the executive makes this national institution one of the most important actors in terms of ensuring that FP decentralization does not derail progress toward meeting FP commitments or lower the quality or availability of FP services.

The Cabinet comprises the heads of ministries and other high-ranking executive officials. In some countries, the Cabinet has direct decision-making power—able to approve or reject laws and policies—whereas, in others, it serves in an advisory capacity.

[1] "Parliament" will be used to refer to all legislative bodies, and "parliamentarians" to refer to all legislators.

Ministries are responsible for exercising executive authority in a particular domain. They are often responsible for the development and implementation of policies and guidelines related to their sphere of influence.

In the health sector, for example, executive authority is often delegated to the MOH or its equivalent. The ministry acts as a steward of the health system, depending on the tasks assigned by constitutional and legal frameworks. These tasks often include policy development, data collection and analysis, coordination of services, contracting and procurement, and development of minimum service standards. In some countries, the MOH is also responsible for service delivery.

In addition to the MOH, other ministries—such as finance, social welfare, or women's affairs—may also play important roles in FP and decentralization. Key actors within ministries include ministers and permanent secretaries, inter- and intra-ministerial coordinating bodies, and department heads.

National coordinating bodies are also key actors in FP decentralization processes. These multisectoral bodies, such as national population councils, harmonize government policies and approaches across sectors, as well as coordinate the actions of government and nongovernmental actors. The power and authority of national coordinating bodies varies substantially from country to country and from group to group.

Judicial

Courts interpret the legislation passed by legislative bodies and regulations enacted by the executive, ensuring that roles and responsibilities are in accordance with constitutional frameworks. Court decisions often have tremendous impact on FP programs and services—both positive and negative. For example, in 2012, after years of advocacy, the Responsible Parenthood and Reproductive Health Act was signed into law in the Philippines. Yet, shortly thereafter, the Supreme Court issued a restraining order to block implementation of the measure, which guarantees access to medically safe contraceptives. In contrast, in 2010, Mexico's Supreme Court issued a ruling guaranteeing rape victims access to emergency contraception.

Court rulings may also affect the decentralization of health services. Since the introduction of a right to health in the Argentine constitution in 1994, the Supreme Court has taken an active role in defining the responsibilities of federal and provincial governments in the health sector. For example, the Court has decided that the federal government is the "ultimate guarantor of the right to health," regardless of the scope of authority delegated to the provinces. It has also decided that state-organized health insurance for salaried workers (*obras sociales*) must include reproductive health (RH) and HIV services (Abramovich et al., 2008). Court rulings such as these impact the course of decentralization reforms, as well as the delivery of health services at decentralized levels.

3.2 Decentralized Institutions

The type of decentralized institutions involved in FP service delivery differs depending on the type(s) of decentralization adopted in a particular country context.

Branch offices and locally assigned staff (deconcentration)

Where deconcentration approaches to decentralization are used, national institutions may place staff at the regional or district level to oversee their programs, establishing branch offices or locating individual staff members within existing local government offices. In this form of decentralization, national institutions retain decision-making power, and policy development remains centralized, with limited scope for local

modification. Branch office/locally assigned staff remain employees of the national institution, with little scope for autonomous action.

Local governments: mayors, local councils, and other elected units of government (devolution)

When decentralization takes the form of devolution, local governments assume significant decision-making power in the areas of FP budget allocation and service oversight. Normally, however, the authority to determine overall national FP policy direction remains at the national level. Local governments take on a major independent role developing policy for and overseeing service delivery sites, such as hospitals and health clinics. As local governments are accountable to local electorates, this shift theoretically increases citizen input and social accountability.

Semi-autonomous or parastatal organizations (delegation)

Under a delegation model of decentralization, management of public functions is transferred to semi-autonomous or parastatal organizations. Intended to perform a state function free from day-to-day political intrusion, these organizations are operationally independent of the central government. Ultimately, these organizations are accountable to the central government—rather than directly to citizens—for accomplishing their mandate.

In Ghana, the MOH delegated the provision of regional-, district-, and sub-district-level health services to a semi-autonomous agency, the Ghana Health Service (GHS). As an autonomous agency, the GHS is responsible for the public health system throughout Ghana, including hospitals and health facilities. It is overseen by the Ghana Health Services Council, which includes representation from relevant ministries and health worker unions. The independence of the GHS from the ministerial structure allows it to have more flexibility with regards to staffing structures and remuneration for employees, who are no longer part of the civil service. In addition to employment changes, GHS Regional Health Administration offices coordinate district health activities and planning, and GHS manages most health facilities and financial resources in the health sector. Planning and budgeting is structured through GHS Budget Management Centers, which receive public funds and are overseen by the GHS Council (Mayhew, 2003; Couttolenc, 2012).

For-profit companies, charities, and NGOs (privatization)

Under a privatization model of decentralization, private organizations—whether for-profit companies, charities, NGOs, or a combination of these—assume responsibility for FP services. Within this model, the state contracts out for particular services or enters into public-private partnerships (PPPs) in which state and private actors cooperate to supply services, such as contraception. While the private organizations involved may be small-, medium-, or large-scale, this remains “decentralization” in the sense that authority is being transferred away from the central government.

Indonesia encountered challenges when pursuing privatization as part of its decentralization process. Unclear boundaries between the public and private sectors manifested in the leakage of government healthcare products to private vendors for improper distribution. Privatization also led to increased profit seeking as profitable methods of contraception, such as injectables, were promoted more heavily than less profitable, but potentially more appropriate, ones (Sciortino et al., 2010).

4 FP AND DECENTRALIZATION ANALYTICAL FRAMEWORK

Section 3 outlined some of the key actors involved in decentralizing FP programs and services—the "cast of characters." The FP and Decentralization Analytical Framework offers a tool for understanding how these actors relate to each other, how different mechanisms and contextual factors shape their interactions, and how the interplay of these factors influences the design and delivery of FP services. The framework is designed to help stakeholders

- Examine and understand how decentralization processes affect FP services
- Identify, anticipate, and prioritize key challenges and opportunities
- Use lessons learned from country experiences to identify appropriate responses
- Identify potential avenues of influence through which to affect change

This section illustrates the logic of the FP and Decentralization Analytical Framework, using case studies to illustrate the potential opportunities and challenges decentralization processes pose for FP programs and services.

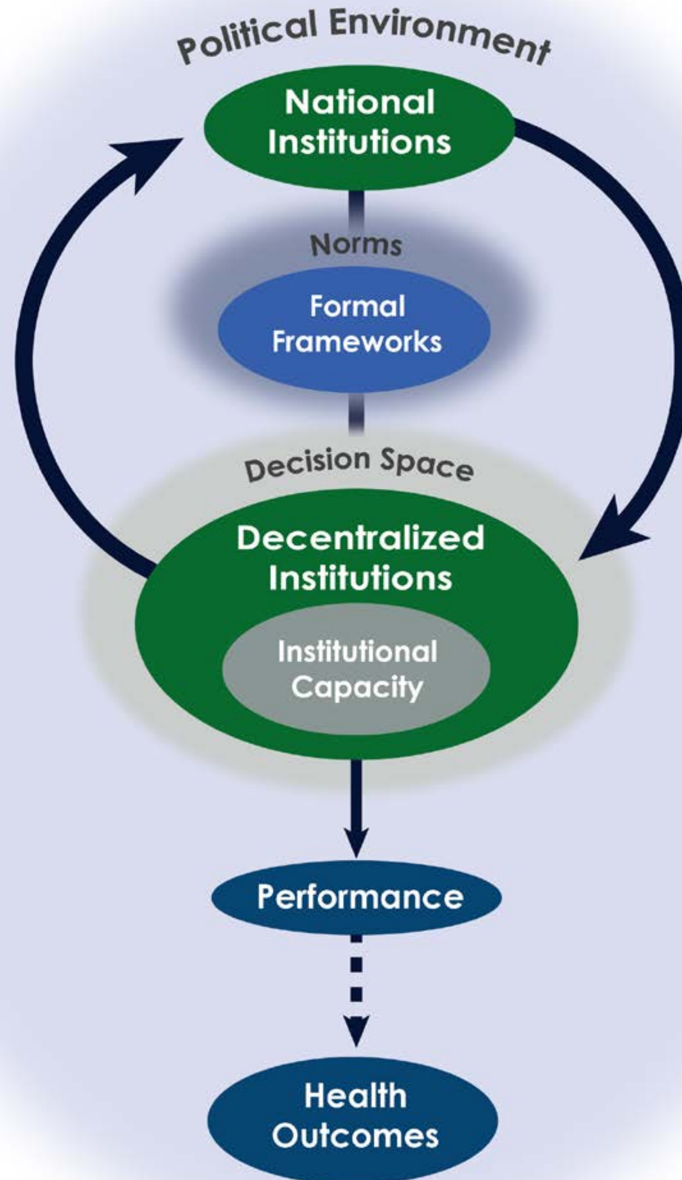
4.1 Logic of the Framework

- Interactions between national and decentralized institutions are governed by written formal frameworks, such as constitutions, laws, policies, and regulations.
- These interactions take place within the broader political environment—key components of which include international agreements, overall governance and political support, the sociocultural environment, and social participation and accountability. The political environment affects all the actors, interactions, and relationships contained within the circle of the framework.
- Interactions between national and decentralized institutions are also mediated by norms—the unwritten "rules of the game" that begin where formal frameworks end.
- Decentralized institutions act within the *decision space*[2] established by formal frameworks and mediated by the political environment and norms.
- The institutional capacity of decentralized institutions (mediated by the political environment) impacts their performance within their allotted *decision space*.
- Decentralized institutions' performance affects the ability of countries to deliver health services to improve overall health outcomes.

[2] "Decision space" refers to how much autonomy decentralized institutions have to develop policy, allocate resources, and define programs and services (Bossert, 1998). See Section 4.5 for details.

FP and Decentralization Analytical Framework

The FP and Decentralization Analytical Framework depicts how various health system actors shape family planning in decentralized settings by highlighting (1) how these actors relate to each other, (2) how different mechanisms and contextual factors define their interactions, and (3) how these factors influence the design and delivery of FP services. This framework is a starting point for conceptualizing the various processes, challenges, opportunities, and avenues of influence through which stakeholders can affect FP services in a decentralized setting.



4.2 Formal Frameworks

- *Interactions between national and decentralized institutions are governed by written formal frameworks, such as constitutions, laws, policies, and regulations.*

Formal frameworks are the constitutional arrangements, laws, policies, and guidelines that govern both decentralization reform processes and the design and implementation of FP programs and services. Formal frameworks relevant to family planning and decentralization constitute two elements:

1. Broad constitutional and legal structures—define interactions and relationships among different governmental institutions—such as courts, ministries of health, Parliament, parastatals, and local governments—and assign broad responsibility to each of these actors.
2. Health and FP-specific policies and guidelines—outline FP service standards, commodity procurement mechanisms, and financing flows in a more detailed way than broader constitutional and legal structures, setting the stage for working relationships between national and decentralized government institutions.

Formal frameworks are not set in stone; rather, they structure the breadth of *decision space* currently available to decentralized institutions and provide the backbone for FP-related decisions at national and decentralized levels. Formal frameworks are periodically renegotiated based on new information, shifting political realities, or lessons learned during implementation. For example, the literature shows a history of national governments using formal frameworks to exert influence on local governments to counterbalance the lack of support for family planning at local levels that sometimes occurs as a result of decentralization (see Section 4.5.1).

4.2.1 Gaps in formal frameworks for FP decentralization

Many countries pursuing FP decentralization reforms lack formal frameworks to guide the decentralization of FP programs and services. In the absence of a formal framework that includes FP priorities, these priorities may well be overlooked. Gaps in FP decentralization frameworks are often a result of the mixed motivations driving governments' decentralization reforms, which may range from a desire to promote democracy, to provide security and stability, to be consistent with major development assistance agency preferences, or to quell regional or separatist disputes.

Gaps in formal frameworks also result from the exclusion of FP/RH stakeholders from policy and planning processes. Decentralization reforms are typically driven by politics rather than evidence that changes will improve services and deliver greater benefits to clients (Kolehmainen-Aitken, 1998). Health sector stakeholders, including those focused on FP/RH, are rarely included in decentralization planning processes. As a result, FP/RH priorities and considerations are often overlooked or not incorporated into decentralization plans, leading to gaps in formal frameworks (Lubben et al., 2002, Saunders and Sharma, 2008).

In Kenya, for example, where decentralization reforms were undertaken as a response to electoral violence, no framework was outlined for decentralizing the health sector (including FP services) during the 2010 decision-making process on decentralization. As a result, discussions on health sector decentralization were held by the two ministries of health as part of a post-ad hoc process of determining how to fit FP services into decentralization plans that have already been decided by political elites (HPP, 2012).

The ambiguity of decentralization policy frameworks is another common challenge. Decentralization policy frameworks often fail to clearly delineate the responsibilities of actors at national and decentralized

levels. While this ambiguity may be helpful in securing political support at the outset of decentralization reforms, it often causes problems later on. For example, in Jamaica, vague roles hampered the integration of family planning with other health services and have led to accusations of duplication and waste (POLICY Project, 2005). As a result, the 2011 Public Sector Master Rationalization Plan includes a recommendation to re-centralize project management, human resources, and internal auditing (Jamaica Public Sector Transformation Unit, 2011). In Tanzania, the integration of family planning into the decentralized health system was significantly delayed because of confusion at the district level concerning the policy frameworks under which they operated vis-à-vis the national government (Oliff et al., 2003, Patykewich et al., 2007).

Developing a formal framework to guide FP decentralization reform, which includes a carefully planned, phased-in approach; clear policies with well-defined roles and responsibilities; and institutional capacity strengthening can help avoid some of these challenges (see the Rwanda case study below).

The case of Rwanda

Between 2000 and 2010, modern contraceptive use in Rwanda increased from 3 percent to 45 percent (National Institute of Statistics of Rwanda et al., 2012). This success can be partially attributed to the successful combination of a clear fiscal decentralization framework coupled with community-based health insurance (*mutuelles*) and performance-based financing within a broader reform of management of human resources for health (Sekabaraga et al., 2011). In 2006, the central government developed a formal decentralization framework to define policies and standards—including the degree of authority delegated to local levels—using a three-phase approach. This framework gives local-level decentralized units the authority to manage the flow of funds and delivery of health services and enables health facilities to autonomously manage financial and human resources. Accountability of local governments is maintained through inspections, audits, and performance contracts with regional and district governments to ensure the implementation of measures outlined in annual plans. Performance-based financing strengthens the accountability of providers to the government to ensure high-quality services. The government established health insurance funds (*mutuelles*) to increase access to services, generate revenues for health facilities, and ensure health provider accountability to clients.

Rwanda's development of a formal framework with a planned, incremental approach provided the opportunity to lay out roles and responsibilities and build institutional capacity at the local level for each phase of decentralization. Phase 1 (2001–2005) focused on administrative and political decentralization. Under Phase 2 (2006–2010), local government roles and responsibilities were reorganized, and district authority was strengthened to facilitate resource allocations to local governments. To give greater autonomy to health facilities, Phase 3 (2011–2015) transferred fiscal responsibilities, financial resources, and administrative authority from the central and district governments to sectors—the level of government below districts. While this carefully planned approach strengthened the capacity of the health system to meet high demand for services, including family planning, rigid implementation meant that low-capacity districts received authority before they were ready, while high-capacity districts were unable to take advantage of this capacity.

4.3 Political Environment

- *Interactions among national and decentralized institutions take place within the broader political environment—key components of which include international agreements, overall governance and political support, the sociocultural environment, and social participation and accountability. The political environment affects all the actors, interactions, and relationships contained within the circle of the framework.*

While the institutional arrangements for decentralizing FP services are established by formal frameworks, the details of who has power and how it is exercised are affected by the overall political environment, as well as by norms. The outer circle of the framework represents the political environment surrounding FP decentralization processes. Political environment factors affect all the actors and relationships involved in FP decentralization and must be taken into account to accurately forecast the potential impact of policy decisions and developments.

Five aspects of the political environment are particularly relevant when considering family planning and decentralization:

1. International agreements
2. Governance quality
3. Political support
4. Sociocultural environment
5. Social participation and accountability

4.3.1 International agreements

Recent years have seen an increase in international agreements related to family planning, including the MDGs and the FP2020 targets established at the 2012 London FP Summit. International agreements can help spur action by raising the profile of FP issues; encouraging donors and governments to increase investment in FP programs and services; furnishing advocates with compelling arguments in support of expanding access to FP services; and strengthening political commitment and leadership. However, to achieve their objectives, these agreements must be translated into action at the service delivery level.

Accomplishing this requires strong national commitment. However, in the context of decentralization, national commitment alone may be insufficient to ensure that international agreements deliver on their promises. As political systems are decentralized, operational responsibility for implementing international agreements ultimately rests with authorities outside the national government, and a broader set of actors are involved in key decisions, such as resource allocation and program design. While most national governments are notionally supportive of family planning and have signed the major international commitments on population and RH, there may be less awareness of and support for such commitments at regional and local levels. Moreover, it can be difficult to maintain a cohesive national FP program as decentralized actors assume responsibility for FP services (Saunders and Sharma, 2008).

The case of Mexico

Following the 1994 International Conference on Population and Development (ICPD) in Cairo, the Mexican government agreed to increase federal funding for contraceptives and increase service availability, as international funding was scaled down (Saunders and Sharma, 2008; UNFPA, 2000). By 1999, the federal government was the sole purchaser of contraceptives for the public health system (Saunders and Sharma, 2008). However, as states began accepting more responsibility for commodity procurement through a local government decentralization process, problems emerged. Local leaders reallocated funding to other priorities, states were unable to forecast either supplies or budgetary resources, and purchasers lacked economies of scale (Alkenbrack and Shepard, 2005). As a result of these

problems, the federal government created a system of pooled purchasing, re-centralizing purchasing, forecasting, and supplier negotiations under a new federal mechanism. Flowing from their commitments at the ICPD conference in Cairo, the Mexican government purposefully tracked progress and made adjustments in state-level responsibility and authority to achieve its agreed on funding and service goals, changing the relationship between the federal and state governments to ensure that those goals were achieved.

4.3.2 Governance quality

The overall governance environment, both at national and decentralized levels, is an essential factor in how FP services are delivered, affecting how international agreements are translated into service delivery (Sheng et al., 2007, Safaei, 2006). Good governance, defined as a "capable state that is accountable to its citizens and operating under the rule of law" (Kaufman and Kraay, 2008), can help facilitate improvements in FP service delivery, ensure broad access to government services, and provide a voice for citizens in political processes. The World Bank's Worldwide Governance Indicators (WGIs) (see Box 1) provide an excellent dataset for examining national-level governance factors that affect family planning at the national level. While the WGIs and Demographic and Health Surveys only collect data for national-level review, governance quality is a critical component for health outcomes at decentralized levels (Charron, 2013; Nannyonjo, 2012), and the concepts underpinning the WGIs can also be used to examine governance quality at decentralized levels (Kaufmann et al., 2010).

Box 1. Worldwide Governance Indicators

- Voice and accountability
- Political stability and the absence of violence
- Government effectiveness
- Regulatory quality
- Rule of law
- Control of corruption

One challenge faced by countries pursuing decentralization reforms that involve transferring authority to local governments is how to foster good governance at local levels. A country's success in improving local-level governance impacts FP service delivery; for example, poor governance—as manifested by limited effectiveness, weak security, and high levels of corruption—can negatively impact access to health services (Sheng et al., 2007, Safaei, 2006).

The case of Uganda

Since the late 1980s, Uganda has gradually decentralized authority to district governments. Though the current local government structure was only defined in 1997, by 2006, local government employees accounted for 75 percent of the public workforce, and 38 percent of the national budget was spent through local government (Okidi, 2006). A 2012 study, however, found that governance challenges were hindering health service delivery: poor accountability, transparency, and information sharing, coupled with insufficiently qualified personnel and weak infrastructure, contributed to inefficient health services at the district level (Nannyonjo and Okot, 2012). Health service provision was most efficient in districts where local governments had strong citizen participation mechanisms, management oversight, and regulation and engagement of alternative service providers (Poku, 1998).

4.3.3 Political support

Political support, in addition to effective governance, is an important factor in the success of FP decentralization. Unlike other components of the political environment, political support for family planning is difficult to assess due to the need to evaluate the intent and motivation of political actors. While political support can be seen in policy statements and speeches, local government officials must provide more than moral support to improve FP programming (Brinkerhoff, 2010). Political support at

decentralized levels can be strengthened through top-down incentives, sanctions, and rules; or it can flow from the bottom up, through local government engagement with civil society organizations (CSOs), citizens' groups, and the private sector (Brinkerhoff, 2010).

As described in Box 2, lack of political commitment at local levels often becomes a barrier to successful FP decentralization. In contrast, as seen in the case of Mexico above, when family planning is deprioritized at local levels, strong political commitment at national level can help get FP programs back on track. Where responsibilities are devolved to local governments, cultivating local-level political support is crucial.

Box 2. Lack of Support for Family Planning at Local Levels

Lack of support for family planning among decisionmakers at local levels is one of the risks posed by FP decentralization. Local elected leaders often fail to prioritize resources for FP services (Ensor and Ronoh, 2005) and place a higher priority on sectors with higher visibility to the electorate (ACQUIRE Project, 2006; POLICY Project, 2000).

In **Malawi**, researchers found that, "Implementation of the country's SWAp and decentralization have made it more difficult to mobilize champions and leaders to fund family planning as there are so many competing demands" (Health Policy Initiative, Task Order 1 and DELIVER Project, 2008, p. v).

In some circumstances, decentralization may even be a purposeful strategy to avoid confronting issues in a meaningful way, for example by moving decision making for family planning out of the national limelight to localities where interventions that were announced at the national level can be quietly neglected (Buse et al., 2006).

National governments have used various methods to circumscribe the decision space of local governments to counter lack of support for family planning at local levels (see Section 4.5.1).

4.3.4 Sociocultural environment

Sociocultural factors should be taken into account when seeking to understand the effects of decentralization on FP programs and services, as these may affect the political will of local policymakers to fully fund and provide FP services.

Decisionmakers and leaders at local levels often enter the policy arena with little experience of policymaking or exposure to international agreements that national governments may have signed in support of family planning. As Sharma and Saunders (2008) have noted, "there are many examples of local leaders being biased against or not understanding FP and therefore opposing the allocation of any funds to FP programs" (p. 14, citing Interviews with SUMI, 2007).

Family planning can also fall victim to "local centralization"—a situation in which local elites set aside or ignore public policies that are not agreeable with them, particularly those that threaten "traditional norms and structures that served their interest" (Siahaan, 2002). These religious and patriarchal norms at the community level can exclude women, who are beneficiaries of FP services, from participating in local government decision-making processes (Myers, 2002).

Saunders and Sharma (2008) found that the attitudes of local governments toward family planning can be favorably influenced by knowledge of international agreements, advocacy by civil society and citizen

groups, and the dissemination of national policy frameworks and guidelines. This finding points to the importance of social participation and accountability for ensuring that decentralization does not draw attention and support away from FP services.

4.3.5 Social participation and accountability

One common justification for decentralization is that it offers communities a stronger voice in shaping the programs and services that affect them. Multiple avenues for citizen participation exist at different levels, and different avenues for participation may be used throughout the FP decentralization process (see Box 3; Slevin and Green (2013), which provide excellent guidance for CSOs on ensuring good governance, transparency, and accountability; and Appendix A, which offers a list of resources for advocates):

- In Ethiopia, where responsibilities such as setting policy and mobilizing and managing resources have been partially devolved to regional and district levels, citizen advocates for RH commodity security influenced the reallocation of regional funds to address contraceptive stockouts (DELIVER Project, 2012).
- Advocacy efforts by women's and youth organizations in Bolivia, with support from Centro de Investigacion, Educacion y Servicios (CIES) and International Planned Parenthood Federation (IPPF), influenced three Bolivian regions to incorporate sexual and RH rights into their autonomous bylaws (IPPF/WHR, 2012).
- The National Network for the Promotion of Women in Peru formed and supported local surveillance teams to monitor compliance of national RH norms (POLICY Project, 2006).

Box 3. Mechanisms for Social Accountability

Advocacy: A set of targeted actions directed at decisionmakers in support of a specific policy issue (Policy Project, 1999).

Health policy monitoring: Monitoring of government and healthcare facility regulations, rules, and standards to influence availability of services and quality of care. Civil society can also serve as a watchdog to "monitor how policies are actually rolling out and affecting communities" (HPP, forthcoming).

Community scorecard: A tool for providing service users the opportunity to monitor and evaluate services provided by local governments (World Bank, 2011).

Public Expenditure Tracking Survey (PETS): A tool to monitor public spending in targeted districts and regions to influence greater budget accountability (World Bank, 2010).

The form of decentralization adopted affects the extent to which citizens are able to influence FP programs and services and the avenues through which they can exert that influence:

- Devolution—As local elected bodies assume greater responsibility for FP policy, the potential for bottom-up engagement and influence may increase.
- Delegation—Opportunities for citizen involvement in policy and decision making are generally more limited than they are when locally elected bodies assume responsibility for FP services. However, this arrangement does bring civil servants to local areas, which may make them more accessible and responsive to citizens.
- Privatization—Accountability is enforced by the terms of government contracts, with private actors responsible to the government, rather than directly to citizens. Citizens' input is indirect, as it must flow through votes for elected officials and then through executive bodies. Citizens also have some limited power to "vote" through their actions in the marketplace.

The case of Guatemala
Citizen engagement at the local level can enhance family planning by increasing community knowledge and government responsiveness. In the mid-1990s, Guatemala underwent a program to deconcentrate the health sector, as local directorates and regional offices of the MOH gained budgetary authority and responsibility for service delivery, including the ability to contract to an increased number of NGO and private partners to provide services. As this authority was deconcentrated, there was little focus on FP services due to significant political opposition. In the absence of a coordinated civil society response to this opposition, government policies and programs relating to FP services were either ambiguous or non-existent, and FP services were de-emphasized in favor of politically neutral services, such as antenatal care and delivery (Duarte, 2000; POLICY Project, 2000).

However, by the late 1990s, women's networks, NGOs, and other civil society groups mobilized to increase women's participation in policy making, put family planning on the policy agenda, and advocate for legislation protecting FP services. In April 1999, the Guatemalan congress passed the "Law for Advocacy and Fundamental Dignity of Women," reaffirming not only the right of women to access government health services, but also the responsibility of government to provide family planning through public facilities. Increased engagement of civil society also led to greater awareness of family planning among local decisionmakers, as political and social leaders began speaking in favor of improving health access for women (POLICY Project, 2000).

Guatemala continues to demonstrate strong civil society participation in FP/RH monitoring and accountability. Civil society advocacy has led to numerous laws and policies that impact reproductive health, including a 2004 law mandating that 15 percent of alcohol tax revenues be directed to RH programs and a 2005 law on universal access to family planning. Advocacy by two civil society organizations, the Women´s Network for Building Peace and the Women´s Health and Development Organization, led to the creation of a civil society RH observatory (OSAR) in 2008. By 2012, 19 out of the 22 departments in Guatemala had an OSAR. Additionally, the President of Congress and civil society leaders signed a political agreement to expand access to RH services (Merino, 2012).

4.4 Norms: The Unwritten "Rules of the Game"

- *Interactions between national and decentralized institutions are also mediated by norms—the unwritten "rules of the game" that begin where formal frameworks end.*

Political, cultural, or social norms guide the various behaviors of people and institutions in different environments. They are informal and not written down (as formal frameworks are), yet they affect FP decentralization processes by defining how national and decentralized institutions (including elected officials, technical and managerial staff, and service providers) interact with one another and with citizens and advocates.

Interactions among national and decentralized institutions are mediated by societal norms. Therefore, the unwritten rules that govern hierarchies, power dynamics, and obligations—played out within the broader political environment described in Section 4.3—are a key factor in determining how FP services are delivered and should be taken into account by those seeking to understand and influence FP decentralization processes (Department for International Development, 2009). While inter-governmental relationships must fit within the broad confines of formal frameworks, local governments may have more or less power depending on the norms that govern how local authorities interact with the national government.

The potential impact of norms on FP decentralization is made clear by experiences in Kenya and Tanzania. In Kenya, an official national policy on contraceptive distribution was unofficially reversed by many health providers. Contrary to national policy, they directed women toward less permanent methods or did not discuss condom use with potential clients—either because they did not understand or were personally opposed to the government's guidelines (Ndhlovu, 1995). In Tanzania, national-level managers side-stepped health sector policies on decentralization by maintaining policymaking and budgetary authority and thus keeping the direction of FP services under their purview rather than under the formal authority of district staff (Oliff et al., 2003).

4.5 Decision Space

- *Decentralized institutions act within decision space established by formal frameworks and mediated by the political environment and norms.*

The scope of authority transferred from central to decentralized institutions varies widely from country to country. "Decision space" refers to how much autonomy decentralized institutions have to develop policy, allocate resources, and define programs and services (Bossert, 1998). Responsibilities transferred may be few or comprehensive—ranging from broad authority over policies and finances to much more constrained decisions about the administration of services.

Appropriately aligning central and decentralized roles is crucial to successful FP decentralization. Certain government functions related to family planning (e.g., finance, planning, and budgeting) may be suited to decentralization, while others (e.g., inventory control, logistics management, storage, and product selection) may be better retained by central governments (Bossert et al., 2004). However, these functions are likely to vary from country to country depending on the capacity of local governments and other decentralized institutions.

Aligning central and decentralized roles is not a one-time proposition. Rather, it is an iterative process, as the appropriate alignment of central and decentralized roles tends to change over time as political conditions and capacities shift (see Section 2.1 and the case of Rwanda, p. 7). Moreover, as stated in Section 4.4, whether decentralized institutions actually obtain the decision space allotted to them in formal frameworks partially depends on norms ("the way things are done"), as well as the broader political environment.

Available literature demonstrates that the decision space available to institutions and the degree of local independence are rarely fixed over time (Eaton et al., 2010). Rather, they change as decentralization processes are adapted to meet shifting conditions. Sri Lanka, for example, began decentralizing health services in 1952, but it was not until 40 years later that the central government handed over full responsibility for maternal and child healthcare to the districts (Dmytraczenko et al., 2003).

Senegal went through a similar shift in the structure of decision space. Under the 1996 Decentralization Code, Senegal moved from a health system of deconcentration of planning and management authority—with regions and districts accountable to the central MOH—to one of devolution, under which a portion of the MOH budget passed directly from the Ministry of Finance to local government units comprising locally elected officials. Although they were provided with budgetary guidance on the health sector, these officials were given the authority to allocate funds and spend them on non-health sectors. Health personnel were paid and supervised by the MOH, but many of the healthcare facilities were under the financial control of locally elected officials (ACQUIRE Project, 2006).

The literature shows a history of national governments circumscribing local governments' decision space to counterbalance lack of support for family planning at local levels (see Box 2). National governments must balance the goal of providing greater autonomy to local authorities with the need to maintain focus on priority services, such as family planning. To achieve this balance, formal policy frameworks are often renegotiated based on the perceived success or failure of previous frameworks (Lackshminarayan, 2003).

National governments have used numerous policy tools to help strike this balance:

- National policies or directives that regulate minimum service packages or funding levels can attempt to limit the discretionary authority of decentralized institutions in nationally identified priority areas (Lakshminarayanan, 2003; Saunders and Sharma, 2008) (see the case of the Philippines below).
- Legislation may be used to maintain certain vertical programs or logistics management tasks at the central level (Bossert and Beauvais, 2002).
- Oversight of local governments can be carried out by placing national government staff at local levels—although recreating vertical programs at subnational levels creates the possibility of overstaffed bureaucracies at every level.
- Quotas, affirmative action, or other measures can be used to ensure that women—who are the key beneficiaries of FP services—are able to participate in local government decision-making processes. Measures used to promote women's involvement include frameworks for ensuring participatory budgeting, planning, and auditing; gender-sensitive budgeting; and incentives to encourage bureaucrats and elected officials to respond to the concerns of women (UNRISD, 2005).

In practice, these methods of limiting the decision space of decentralized institutions have mixed records. Mexico's national government was successful in adjusting state-level authority and responsibility to achieve national FP commitments (see the case of Mexico on p.8). The Philippines was less successful in managing decision space to support FP priorities during the decentralization process (see below). Efforts to counterbalance lack of local-level support for family planning by manipulating decision space have been most successful when central governments include sanctions and/or incentives that allow them to hold local governments accountable.

The case of the Philippines

The Philippines has a great deal of experience with health sector decentralization, going back to the mid-1980s. In accordance with the Local Government Code of 1991, service delivery responsibilities and budgetary authority for primary care were transferred to provinces, municipalities, and villages, while the Department of Health retained responsibility for policy development, regulation, quality assurance, health worker training, technical supervision, and tertiary care.

Strong political and religious opposition to family planning exists in the Philippines. With the advent of stronger local control of health services, well-organized opposition to family planning in some local governments led to a reduction in FP services, as local governments had the freedom to decide which services they would provide.

To ensure that priority services, including for family planning, continued to be provided, the national government attempted to constrain decision space at the local level by developing comprehensive care agreements, which required negotiation between the Health Department and local governments on priority health investments. In reality, however, these agreements provided neither incentives to comply nor sanctions for non-compliance. When some local governments stopped offering contraceptives in public facilities, the Health Department had no recourse to compel them to offer the services, even though

they were identified as priority services in the comprehensive care agreements (Lakshminarayanan, 2003; Bossert and Beauvais, 2002).

4.6 Institutional Capacity

- *The institutional capacity of decentralized institutions impacts their performance within their allotted decision space.*

As policymakers determine how much decision space to provide government institutions at various levels, it is useful to consider not only the amount of latitude a decentralized institution has to make decisions, but also the decentralized institution's capacity to implement those decisions. Lessons learned from country cases and information from existing frameworks and tools show a clear need to focus on the capacity of a decentralized institution as part of a framework to assess how decentralization affects FP services.

Moving authority for family planning from national to decentralized institutions does not automatically create the capacity to execute those tasks. Decentralization reforms may overwhelm the capacity of lower-level organizations to fulfill new functions. This is particularly true in the case of devolution, when power and responsibility is being shifted to local governments.

Country experiences demonstrate the capacity challenges posed by FP decentralization, as well as pointing to opportunities to overcome those challenges. A review of the literature suggests that national governments and donors can support local governments to ensure uninterrupted provision of FP services during decentralization by

- Properly aligning centralized and decentralized roles (see Section 4.5 Decision Space)
- Focusing on building the capacity of decentralized institutions
- Minimizing disruption to health workers
- Supporting a mandate for continued financing for family planning
- Allowing for a gradual shift in responsibilities to decentralized institutions

Madagascar's experience illustrates how strengthening capacity and properly aligning centralized and decentralized roles can significantly improve management of FP commodities. In 2007, a nationwide health-supply management software program was introduced to manage FP commodities through the public health distribution system. This centralized software program allows decentralized individual warehouses to track their supply stock in real time and generate simple reports and requests. Following the shift to the new software, stockouts of contraceptives dropped dramatically (UNFPA, 2011). A technique that has been applied in many other countries, use of the software highlights the importance of flexibility and experimentation with regards to the allocation of tasks to decentralized institutions, as well as the need to find innovative ways to strengthen capacity to improve access to commodities and services.

4.6.1 Capacity building of decentralized institutions

FP service delivery is administratively intense, demanding high-level technical and managerial skills to deliver services and oversee ongoing processes of commodity procurement, storage, and distribution (Crichton, 2008). Institutional capacity constraints in a number of areas, including financing, planning, procurement, logistics, and training, can adversely impact FP programs (Bossert et al., 2004). Addressing these constraints requires a combination of individual, institutional, and system-level capacity building. Common areas in need of strengthening include the following:

Systems

- Healthcare financing systems
- Commodities and logistics systems
- Human resource management systems (recruitment, deployment, productivity, retention)

Institutional

- Quantity and quality of available resources
- Commodities and logistics management capacity (e.g., forecasting, inventory control, procurement)
- Administrative and management systems
- Planning and budgeting capacity (including ability to manage resources)
- Monitoring and supervisory capacity, including management of integrated services
- Operationalization of policies and adaption of strategies
- Citizen and civil society mobilization and support for FP programs and services

Individual

- Human resource management
- Leadership
- Commodities, logistics management, and financial systems
- Strategic planning and policy development
- FP service provision
- FP policies and guidelines
- Advocacy and awareness raising

Bolivia's experience demonstrates the importance of decentralized institutional capacity in determining the impacts of decentralization on FP services. Decentralization in Bolivia began in 1994 and was applied unevenly due, in large part, to weak capacity at the decentralized level (Saunders and Sharma, 2008). FP services were hampered by a lack of administrative and managerial capacity at the local level. Inadequate provision of training, technical support, and sharing of best practices to support small municipalities posed a major barrier to accessing services. In general, municipalities in Bolivia did not know how to access available funds and did not have the capacity to manage the funds that they were able to access.

The municipality of El Alto serves as an example of what can be accomplished with adequate capacity to access and manage funds. Unlike other municipalities in Bolivia, El Alto learned how to access and manage available local and national tax funds to support an extended health insurance program. The municipality's leaders used their knowledge and capacity to extend broad-based health insurance to young people up to age 21 that covered RH education and referrals for services for enrollees.

Lack of local-level capacity to accurately estimate the need for contraceptive supplies and operate logistics systems is one example of a capacity bottleneck affecting the implementation of FP programs in decentralized settings. In Bolivia, this was addressed by incorporating a training module on the logistics system in the national nursing and medical school curricula, so that upon graduation, doctors and nurses would be conversant with the system and able to order commodities (Egan, 2013).

India's experience demonstrates the potential of developing innovative approaches to build management capacity. In India, recognition of the need to strengthen the capacity of district civil servants led to the creation of the Public Health Resource Network (Krishnamurthy et al., 2007; Kalita et al., 2009). The network is a distance-learning course that disseminates technical resources to strengthen district-level capacity in public health planning, management, and implementation.

A number of frameworks and tools exist for broadly measuring the implementation and administrative capacity of institutions (see Box 4 for details). These tools could be applied or adapted to identify priority capacity needs to strengthen FP provision at decentralized levels.

4.6.2 Minimizing of disruption to health workers

Decentralization often results in disruptions for individual health workers, as their roles and responsibilities shift. For example, as part of the decentralization process, personnel may be shifted from the national to local level to address capacity gaps. Shifting personnel from one administrative unit to another needs to be done smoothly to avoid lowering staff morale and productivity.

In the **Philippines**, efforts to address lack of skilled personnel at decentralized levels by transferring staff from the national to local level demonstrate the need to ensure that transfers are equitable and do not adversely affect performance. Local governments in the Philippines often lack trained personnel to deliver services and manage health financing in their jurisdictions. Skilled workers who were transferred from the National Department of Health to the municipal level saw their benefits erode and their career paths disappear, which lowered morale and adversely affected the quality and effectiveness of all health services, including family planning (Lakshminarayanan, 2003).

4.6.3 Securing of uninterrupted FP financing

Fiscal decentralization refers to the location of revenue generating and spending powers within the overall government framework. In the standard, centralized model, financing is generally done through line budgets for the major categories of input such as staff, medicines, and operating expenses, with little scope for reallocation among line items. Under decentralization, this can change quickly. In Mexico (a federal system), state responsibility for managing healthcare budgets rose significantly over just five years in the 1990s—with major impacts on the acquisition and distribution of contraceptives. In 1994, the federal government managed more than 75 percent of healthcare budgets. By 1999, states' had assumed responsibility for managing 70 percent of their healthcare budgets (Alkenbrack and Shepherd, 2005). As financial authority is passed from the MOH to local governments, oversight responsibilities may become clouded, as a separate ministry is often responsible for overseeing local governments.

When fiscal decentralization is not aligned with the decentralization of roles and responsibilities, interruptions and shortfalls in FP financing can result. Staff at decentralized institutions find that an increase in responsibilities is not always matched by an adequate increase in resources, resulting in inadequate staff numbers, training gaps, and poor management—all leading to service disruption. Financial resources are often distributed by percentage or formula-based allocations from the central government, which may not take into account actual needs or past expenditures or even population changes.

In **Nigeria**, funding—based on historical percentages—is transferred from the state government to local governments using block grants. Therefore, even though all health workers are employees of the state government, local governments must pay their salaries from the block grants, leading to a situation where local governments have no ability to pay for health workers allocated by the state government (Ohadi et al., 2012).

To provide flexibility for staffing and accountability for results, conditional grants can be used. These grants are made from national to decentralized institutions with "strings" attached (e.g., requirements that a portion of the funds be used for priority services or functions such as family planning, that certain standards be met, and/or that the decentralized institution reports regularly to the central government). By "attaching strings," conditional grants can be used to ensure that decentralized institutions have sufficient financial resources to meet their new responsibilities and that decentralized institutions focus their

spending on priority areas and remain accountable to the central government. Kenya, for example, is exploring how conditional grants could be used as part of the health sector devolution process to improve equity, efficiency, and service quality (Chen et al., 2014).

4.6.4 Gradual shifting of responsibilities to decentralized institutions

A study of 20 countries (UNFPA, 2000) concluded that many moved too fast to decentralize their health systems—doing so before local officials were ready to take on new responsibilities or central government officials were willing to relinquish their authority over decentralized functions. Organizational structures were often not ready for the new demands placed on them, resulting in confusion over roles and responsibilities and causing a decrease in morale and performance among health workers. Decentralization can be phased in gradually to allow institutional capacity to catch up with administrative reform. Rwanda's experience points to decreased service disruption when decentralization occurs in phases (see the case of Rwanda, p.7).

4.7 Performance and Health Outcomes

- *Decentralized institutions' performance affects the ability of countries to deliver health services to improve overall health outcomes.*

As described in Section 4.6, the institutional capacity of decentralized institutions affects their performance within their allotted decision space. Decentralized institutions' performance, in turn, affects the delivery of FP programs and services, which affects whether the desired health outcomes, such as reduced maternal and infant morbidity and mortality, are achieved.

Ultimately, the success of FP decentralization will be gauged by its impact(s) on health outcomes—how it affects key FP indicators, such as contraceptive use and unmet need. The inclusion of health outcomes within the FP and Decentralization Analytical Framework is intended to maintain a focus on this end goal and to help users understand how health outcomes fit in with the other institutions, actors, and influences outlined in the framework.

Box 4. Capacity Measurement Tools

HPP Capacity Development Framework
(Jorgensen et al., 2012)
The framework provides insight into the role of decentralized institutions in managing, implementing, and monitoring FP programs. Addresses the following:

- Issues of ownership of FP services by decentralized institutions
- Decentralized institutions' ability to manage commodity logistics
- Decentralized institutions' ability to generate and retain the support of citizens and civil society for their FP policies through citizen forums, provider committees, and other systems for enhancing accountability

Policy Implementation Assessment Tool (PIAT)
(Bhuyan et al., 2010)
Developed under the USAID | Health Policy Initiative, Task Order 1, PIAT analyzes how health policies are linked to program action, focusing on seven dimensions of policy implementation, within which capacity components are embedded. Identifies five key capacity areas for decentralized institutions:

- Ability to plan for and manage resources
- Ability to translate guidance from decisionmakers into action
- The quality and quantity of resources available
- The flexibility to adapt strategies to diverse and changing needs
- Progress monitoring

Supply-Enabling Environment-Demand (SEED) Model
(EngenderHealth, 2011)
The SEED Model takes a comprehensive approach toward providing FP services, analyzing the supply of commodities and staff, demand generated for FP services, and the enabling environment for service provision (including social and gender norms and health systems). Identifies key capacities for program managers at any level:

- Service organization and integration
- Administrative, financing, and management systems
- Community outreach mechanisms
- Infrastructure to support commodity availability

Local Governance Development Framework (LGDF)
(Minis, 2012)
RTI International's LGDF addresses broad local government capacity issues. This framework uses performance standards and characteristics to measure capacity across seven functional areas for local government:

- Strategic policy and planning
- Project planning and implementation
- Institutional and personnel development
- Assets and infrastructure management
- Financial management
- Service delivery
- External relations

The framework provides a comprehensive list of local government functions and performance expectations that inform operational planning. Adapting these functions from broad local government services to a more narrow focus on FP services could provide a starting point for conceptualizing decentralized institutional performance for delivering FP services.

5 USING THE FRAMEWORK

"[t]here is no one best way to approach decentralization… It is difficult to generalize from experience [with FP] and provide 'how to' advice, especially across the various national settings involved." (McGirr et al., 1994, p.6)

Drawing generalizable conclusions on the impact of decentralization reform on FP programs and services is difficult, and the FP and Decentralization Analytical Framework is not intended to serve that purpose. Rather, it provides key stakeholders with a tool that can be used to analyze the state of FP decentralization reform in individual country contexts. By helping stakeholders identify and apply relevant lessons learned from other country experiences, the framework can help them engage more strategically and effectively in the policy processes surrounding FP decentralization.

This section outlines how three key audiences could apply the framework:

1. International donors and technical assistance (TA) providers
2. Advocates at local and national levels
3. MOH technical managers

For each audience, a few key questions and issues raised by the framework are highlighted, using country examples to describe possible responses.

5.1 International Donors and Technical Assistance Providers

5.1.1 Role

Strengthening national FP programs and supporting the achievement of FP2020 and other international FP commitments.

- Fostering high-level commitment on FP issues
- Providing strategic guidance and funding to national governments
- Building policy, planning, and implementation capacity

5.1.2 Use of the framework

The framework can help donors and TA providers

- Conceptualize and articulate the relationship between family planning and decentralization
- Identify and prioritize existing challenges and opportunities
- Anticipate potential future challenges and opportunities
- Identify avenues of influence and policy approaches available to respond to these challenges and opportunities
- Facilitate conversations and strategy sessions with key stakeholders to chart strategic direction for engaging in FP decentralization issues

5.1.3 Key considerations

Gaps and weaknesses in the formal policy frameworks governing FP decentralization reform often hinder effective decentralization of FP programs and services (see Section 4.2.1). Consider the following:

- What formal frameworks are in place to guide decentralization reforms?

- How clearly do these frameworks define the roles and responsibilities of actors at national and decentralized levels?
- To what extent do these frameworks include FP priorities?

Properly aligning centralized and decentralized roles is key to successful FP decentralization (see Sections 4.5 and 4.6). Consider the following:

- To what extent are centralized and decentralized roles properly aligned?
    - What scope of authority and responsibility has been transferred to decentralized institutions?
    - Do decentralized institutions have the capacity to perform the roles and responsibilities assigned to them?
    - If not, how can capacity gaps be identified and addressed? (Box 4 offers an overview of tools that could be used to assess decentralized institutions' capacity to deliver FP programs and services)
    - What mechanisms are in place to revisit the division of centralized and decentralized roles based on lessons learned as the decentralization process unfolds?

Countries have often moved too fast to decentralize health systems—with reforms outpacing the capacity of decentralized institutions to carry out their expanded roles (see Section 4.6.4). Consider the following:

- Could a gradual phased-in approach, as pursued in Rwanda (see the case study, p.7) be used to decrease service disruptions during FP decentralization?
- What plans and/or interventions are in place to assess and build the capacity of decentralized institutions?

Many countries undertaking decentralization reforms have found family planning deprioritized at local levels (see Section 4.3.3).

- Consider fostering a more favorable policy environment at decentralized levels by raising awareness of international agreements, supporting advocacy by civil society and citizen groups and/or facilitating dissemination of policy frameworks and guidelines (Saunders and Sharma, 2008).
- Consider counterbalancing lack of support for family planning at local levels by
    - Adopting national policies or directives regulating minimum service packages or funding levels. (As mentioned in Section 4.5.1, this method is most successful when policy mechanisms include sanctions and/or incentives that allow national governments to hold local governments accountable for meeting FP commitments.)
    - Retaining certain vertical programs or logistics management tasks at the central level.
    - Placing national government staff at decentralized levels to provide oversight. (As mentioned in Section 4.5.1, this method may lead to an overstaffed bureaucracy at all levels.)

FP and decentralization processes do not always deliver on their promises of greater citizen participation and accountability.

- Strengthening social accountability mechanisms and fostering evidence-based advocacy in support of FP priorities can help ensure that decentralization processes deliver on this promise. Consider the following:

- Encouraging local governments to actively engage citizens to better understand their preferences and ensure that FP policies and programs address their needs. Local governments can use a variety of tools for engaging citizens, including community scorecards and other surveys, citizen advisory committees, and public forums (see the case of Guatemala, p. 11, and Box 3).
- Supporting the engagement of women and women's groups in the policy development process, program design, and implementation.

5.2 MOH Technical Managers

5.2.1 *Role*

Decentralization transforms the roles and responsibilities of national government agencies, including ministries of health, which generally take on responsibility for overall policy development and strategic planning, as well as for supporting local governments in strategic planning and priority setting (Saunders and Sharma, 2008; WHO, 2000). Navigating this transition can be difficult for MOH staff at all levels.

5.2.2 *Use of the framework*

The FP and Decentralization Analytical Framework can help MOH technical managers

- Better understand the decentralization processes, including the roles of key actors and institutions within these processes
- Identify potential impacts of decentralization on FP programs and services
- Identify avenues of influence and levers through which to guide decentralization processes in directions that support the effective provision of FP programs and services
- Identify and prioritize existing challenges and opportunities
- Select applicable lessons learned from other country experiences, and use these to inform strategic planning, policy development, and implementation

5.2.3 *Key considerations*

One of the greatest challenges in the context of FP decentralization is how to maintain unified, coherent national FP strategies and meet national FP commitments as ministries of health become less involved in the direct delivery of FP services.

Successfully maintaining progress on FP priorities requires national governments to hold decentralized institutions accountable for following through on those priorities. However, this is often challenging, as decentralization may entail yielding partial or complete control over resource allocation and priority setting to decentralized institutions. Consider the following:

- What avenues of influence are available to hold decentralized institutions accountable for implementing national FP strategies and policies and meeting international commitments—especially when national government control over budgets and priority setting may be limited?
- There are a variety of potential avenues of influence available—some are directly accessible to the MOH, while others may require working in partnership with legislators, other ministries, and civil society to affect change:
    - Formal frameworks within the MOH can be used to manage the decision space of decentralized institutions and help hold these institutions accountable for implementing national policies and strategies—for example, legislation, policies, or directives requiring a minimum service package or funding levels or mandating that certain responsibilities (e.g.,

logistics and procurement) be retained at the centralized level (see Section 4.5.1; the case of Mexico, p.8; and the case of Rwanda, p.7).

- Conditional grants from the national-level MOH can be used to ensure that decentralized institutions focus their spending on priority areas and remain accountable to the central government (see Section 4.6.3). Dissemination and awareness raising can help ensure that officials and health staff at decentralized levels are aware of national FP commitments and policies (see Section 4.3.3).
- Involving officials and health staff from decentralized levels in FP policy and decision-making processes can help ensure their support and "buy-in" for national FP policies and strategies—and ensure that policies are in alignment with local-level needs and priorities.
- Gaps in the institutional capacity of decentralized institutions can be assessed, and appropriate capacity-building initiatives undertaken, in collaboration with international partners, management consultants, and civil society to ensure that decentralized institutions have the capacity necessary to carry out their new FP-related roles and responsibilities (see Section 4.6.1).
- Relationships between individuals within national and decentralized institutions can be used to facilitate communication, generate support, gather information, and strengthen accountability.
- Partnerships with civil society can be explored to help build political support for family planning at decentralized levels and hold decentralized institutions accountable for FP service provision and resource use.

The division of responsibilities between central and decentralized institutions may affect the success of decentralized FP programs.

- Consider, within existing policy frameworks, which responsibilities are most suitable for delegation to decentralized levels and which should be retained at the central level.
- Consider whether there is a need to revise policy frameworks to realign responsibilities at central and decentralized levels, and, if so, how the MOH could help bring this about.
- Consider the extent to which public health sector staff at both central and decentralized levels are supportive of the new division of power and responsibilities (see Section 4.4).
  - What norms and habits may prove to be obstacles to the successful decentralization of FP programs?
  - If norms and beliefs are hindering FP decentralization, what could the MOH do to help shift these norms and beliefs?

The political nature of decentralization reform often leads to the exclusion of RH stakeholders from decision-making processes and consequently to a lack of clear and appropriate policy frameworks to guide FP decentralization (see Section 4.2.1).

- Consider the extent to which all FP/RH stakeholders are involved in decision-making processes surrounding decentralization reforms and what opportunities may exist to ensure that FP/RH concerns are taken into account.
- Consider the extent to which all FP/RH stakeholders are aware of policy decisions on decentralization and the potential impact of these decisions on FP programs and services. If there is a lack of awareness of understanding, what actors and avenues could offer insight, updates,

and/or advice (e.g., donor agencies, advocacy NGOs, connections/communication with those involved in decision-making processes)?

5.3 Advocates (national and community levels)

5.3.1 Role

Decentralization, by changing accountability structures and diffusing responsibility, can significantly affect FP services. Strong citizen advocacy, however, can put family planning back on the policy agenda at decentralized levels and impact political decisions about FP services, including those related to resource and service availability. For example, motivated grassroots women's organizations—often with strong national networks, effective leadership, and ties to local political, social and religious leaders—can play an important role in increasing policy attention and priority for FP services at the local level (see the case of Guatemala, p.11; and Annex 1, which provides a list of resources to support FP advocacy efforts).

5.3.2 Use of the framework

The FP and Decentralization Analytical Framework can enable advocates to engage more effectively on FP decentralization issues by helping them

- Understand decentralization processes, including the roles of key actors and institutions within these processes
- Identify and prioritize advocacy objectives
- Identify potential avenues of influence for achieving the change they seek
- Facilitate strategic conversations to guide their engagement on FP decentralization issues

5.3.3 Key considerations

Decentralization often diffuses responsibility and authority among multiple actors, making it more difficult for advocates to determine who is making what decisions about family planning and at what level—and therefore where to engage to bring about the changes they are seeking. The pathways to influence for advocates may be clearer when the central government sets major policies for FP services.

While the framework provides a general overview of the actors and institutions involved in FP decentralization, avenues of influence will differ from country to country depending on the overall political environment and policy frameworks. Avenues of influence will also change within countries over time as the policy landscape shifts. Moreover, they may differ from issue to issue within countries, as certain avenues of influence will be more useful than others depending on the specific change being sought.

- Consider how best to map the scope of decision-making authority, influence, and responsibilities of key actors in the FP decentralization process to effectively engage in policy dialogue and advocacy.
  - Advocates can use the framework to identify roughly which actors have the power/influence necessary to achieve the desired change in policy or practice. However, as described in Section 4.3, the details of who exercises power and influence are determined by a combination of factors, including formal frameworks, overall political environment, and norms. To be effective, advocates should keep all these factors in mind as they plan and execute their advocacy strategies.
  - Which organization(s) or networks have the capacity and expertise necessary to conduct this type of mapping? If none do, what other sources of technical assistance could be mobilized?

    - Once generated, how can this information be shared widely and be used to develop and carry out advocacy strategies—with particular attention paid to local-level advocates who may have limited capacity in the area of policy analysis.
- Consider joining forces with other advocates and groups to identify the strongest possibilities for influence and which individuals or groups have access to these "levers," and then develop joint or aligned advocacy initiatives.

Decentralization may lead to the fragmentation of advocacy efforts, making it more difficult to mobilize unified, effective advocacy campaigns. National advocacy organizations may have a weaker presence at decentralized levels, while local advocacy organizations may be hampered by lack of skills or information necessary to engage effectively in the policy process.

- National advocacy groups should consider to what extent they have linkages to the local level and how these linkages can be strengthened.
- National advocacy groups should consider involving local-level advocates in the identification of priority issues and the development of national advocacy campaigns.
- National advocacy groups should tailor their campaigns to make them relevant and useful for local-level advocates, enabling the development of unified messages and campaigns across multiple localities.
- Local advocates/advocacy groups should consider how they can magnify their influence and gain knowledge and capacity through partnerships with national groups and/or by collaborating with other local groups.

6 CONCLUSION

The spread of decentralization reform has the potential to profoundly affect the provision of FP programs and services and countries' ability to meet their FP2020 commitments. Decentralization presents many opportunities, but poses substantial risks—erosion of service quality, lack of local-level support for family planning, and fragmentation of national FP programs and strategies. As more and more countries pursue or expand decentralization reforms, those concerned with ensuring access to high-quality FP services must grapple with the ramifications of decentralization. The FP and Decentralization Analytical Framework is designed to help ministries of health, donor agencies, advocates, and other key FP stakeholders understand the policy processes surrounding decentralization reforms. It is intended to help stakeholders engage more effectively in decentralization policy processes—guiding them in directions that will benefit FP programs and services and, ultimately, the clients they serve.

ANNEX 1: RESOURCES FOR ADVOCATES

Advance Family Planning. 2010. *Advocacy Resource Pack*. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health. Available at http://advancefamilyplanning.org/portfolio.

For CSOs looking to develop focused FP advocacy objectives and policy "asks," this resource pack provides a practical advocacy decision-making tool.

Advocacy Partnership. 2011. *TB/MDR-TB Advocacy Tool Kit*. Leamington Spa: Advocacy Partnership. Leamington Spa, UK: Advocacy Partnership. Available at http://stoptb.org/assets/documents/global/awards/cfcs/TB_MDR%20Advocacy%20Tool%20Kit.pdf.

While originally developed for tuberculosis (TB) advocates, this toolkit offers advocacy-oriented tools and guidance for CSOs that can be easily adapted to any issue area. The toolkit provides direction on how to effectively set goals and objectives; create an advocacy strategy and plan; work with the media and government; build coalitions and alliances; develop key messages; monitor advocacy; and mobilize resources and funding.

Arroniz Pérez, R. 2010. *Handbook for Political Analysis and Mapping*. New York: International Planned Parenthood Federation, Western Hemisphere Region. Available at http://www.ippfwhr.org/en/publications/handbook-for-political-analysis-and-mapping.

This handbook provides three modules to help organizations demand greater transparency and accountability from their governments. The modules are (1) identifying entry points to the political system, (2) understanding the political context, and (3) key actors.

CARE. 2001. Advocacy Tools and Guidelines: Promoting Policy Change. Atlanta, GA: CARE. Available at http://www.wsscc.org/sites/default/files/publications/care_advocacy_tools_and_guidlines_2001.pdf.

This series outlines essential advocacy skills, including how to form strategic relationships, monitor and evaluate advocacy initiatives, effectively use the media, develop an advocacy strategy and plan, and analyze policy. This series is primarily designed for CSOs looking to build their capacity to engage in advocacy.

The Health Communication Unit at the Centre for Health Promotion, University of Toronto. 2000. *Media Advocacy Workbook*. Toronto: The Banting Institute, University of Toronto. Available at http://www.thcu.ca/infoandresources/publications/ma%20workbook%20v104.pdf.

This workbook provides some useful tips on developing a media advocacy campaign, identifying the target audience, drafting key messages, and using the messages to effectively communicate with the audience. The workbook will prove most useful for CSOs with limited communication resources.

Johns Hopkins Bloomberg School of Public Health (JHSPH). 2013. *The Maternal and Child Health Leadership Skills Development Series*. Baltimore, MD: JHSPH. Available at http://www.jhsph.edu/research/centers-and-institutes/womens-and-childrens-health-policy-center/MCHLDS/.

Organized into six online modules, this series helps CSO and coalition leaders develop the skills they need to effectively manage teams.

Nash, R., A. Hudson, and C. Luttrell. 2006. *Mapping Political Context: A Toolkit for Civil Society Organisations*. London: Research and Policy in Development Programme, Overseas Development

Institute. Available at http://www.odi.org.uk/sites/odi.org.uk/files/odi-assets/publications-opinion-files/186.pdf.

This toolkit provides practical advice to CSOs looking to conduct a stakeholder analysis.

People's Voice Project and International Centre for Policy Studies. 2002. *Citizen Participation Handbook*. Kyiv: World Bank, Canadian Bureau for International Education, and Canadian International Development Agency. Available at http://siteresources.worldbank.org/INTBELARUS/Resources/eng.pdf.

Among other useful tips, this handbook provides a participatory social monitoring tool that CSOs can use to measure and monitor policy.

POLICY Project. 1999. *Networking for Policy Change: An Advocacy Training Manual by POLICY*. Washington, DC: Futures Group, POLICY Project. Available at http://www.policyproject.com/pubs/AdvocacyManual.cfm.

This training manual was prepared to help representatives of NGOs and other formal groups of civil society form and maintain advocacy networks and develop FP/RH advocacy skills. The manual's tools and approaches can be used to affect FP/RH policy decisions at the international, national, regional, and local levels.

Schnell, Anna, and Erika Coetzee. 2007. *Monitoring government policies: A toolkit for civil society organizations in Africa*. London: Catholic Agency for Overseas Development, Christian Aid, and Trócaire. Available at http://www.cafod.org.uk/layout/set/print/Media/Files/Resources/Policy/Monitoring-government-policy.

This toolkit—specifically designed for CSOs—provides in-depth, practical guidance and exercises on everything from how to build relationships and establish networks to how to analyze policy budgets and monitor government policies.

West Slevin, K., and C. Green. 2013. "Accountability and Transparency for Public Health Policy: Advancing Country Ownership." Washington, DC: Health Policy Project, Futures Group. Available at http://www.healthpolicyproject.com/index.cfm?ID=publications&get=pubID&pubID=194.

This brief provides leaders of CSOs working in FP, HIV care and treatment, and maternal health with guidance on ensuring good governance, social accountability, and transparency.

West Slevin, K., and C. Green. 2013. "Networking and Coalition Building for Health Advocacy: Advancing Country Ownership." Washington, DC: Health Policy Project, Futures Group. Available at http://www.healthpolicyproject.com/index.cfm?ID=publications&get=pubID&pubID=195.

By sharing resources and workload, networks and coalitions can take advantage of their members' capabilities and skills to plan and implement joint advocacy campaigns, present a unified front, and make collective demands to government. The Health Policy Project prepared this brief to provide leaders of CSOs with guidance on working within networks and coalitions to advocate for improved FP, HIV care and treatment, and maternal health policies and programs.

World Health Organization (WHO). 2008 (Draft). *Health Systems Governance: A Toolkit on Monitoring Health Systems Strengthening*. Geneva: WHO. Available at http://www.who.int/healthinfo/statistics/toolkit_hss/EN_PDF_Toolkit_HSS_Governance.pdf.

This toolkit provides insight into health financing, how to track financial commitments, and the relevant sources of information around health systems governance.

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