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**DECENTRALIZATION OF
POPULATION AND
FAMILY PLANNING
PROGRAMS:
WORLDWIDE EXPERIENCE**

Draft for Mission Review
August 1994

**DECENTRALIZATION OF POPULATION
AND FAMILY PLANNING PROGRAMS:
WORLDWIDE EXPERIENCE**

**An OPTIONS Paper Prepared for USAID/Rabat
August 1994**

PREFACE

The USAID Mission in Morocco asked the OPTIONS Project to prepare a state-of-the-art paper on worldwide experiences with the decentralization of population and family planning programs. The Government of Morocco and the USAID Mission are very interested in learning more about the experience with decentralization in other parts of the world before changing or developing new approaches in the family planning program of Morocco.

This paper is the outcome of an extensive literature review in population and family planning, health and public administration. In addition, it draws on the experiences of the OPTIONS and RAPID Projects in providing technical assistance to facilitate and analyze the implications of decentralization policies in several countries (Philippines, Nigeria, Morocco, Kenya and Ghana). It builds on a background paper written for the OPTIONS Regional Workshop on Decentralization of Population and Family Planning Programs in Anglophone Africa held in 1993 in Uganda and incorporates information gained from that workshop. We have also talked or written to persons involved with each of the country programs reviewed in this paper. Surely, this is not an exhaustive review, but one that captures the current dynamism and range of experience in the ongoing process of decentralization of family planning programs.

Acknowledgements:

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LIST OF ACRONYMS

BKKBN	Indonesia National Family Planning Council
DHS	Demographic and Health Survey
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
MCH	Maternal and Child Health
MIS	Management Information System
MOH	Ministry of Health
NGO	Nongovernmental Organization
USAID	United States Agency for International Development
ZNFPC	Zimbabwe National Family Planning Council

Kenya

DDC	District Development Committee
DHMT	District Health Management Team
DMO	District Medical Officer
DPFPC	District Population and Family Planning Committee
DPO	District Population Officer
GOK	Government of Kenya
IDA	International Development Assistance
ILO	International Labor Organization
KDHS	Kenya Demographic and Health Survey
NCPD	National Council on Population and Development
NORAD	Norwegian Agency for Development
SIDA	Swedish International Development Agency
UNFPA	United Nations Population Fund

Nigeria

FHS	Family Health Services Project
FMOHSS	Federal Ministry of Health and Social Services
LGA	Local Government Authority
NDHS	Nigeria Demographic and Health Survey
PHC	Primary Health Care
PHCDA	Primary Health Care Development Agency
PPFN	Planned Parenthood Federation of Nigeria
RIS	Resource Intensification Strategy
SMOH	State Ministry of Health

Thailand

AMW	Auxiliary Midwife
AVSC	Association for Voluntary Surgical Sterilization
FHD	Family Health Division
MOPH	Ministry of Public Health
NFPP	National Family Planning Program
PCMO	Provincial Chief Medical Officer

Bangladesh

CARR	Committee on Reorganization and Reform
FHI	Family Planning Inspector
FPO	Family Planning Officer
FPMD	Family Planning Management Development Project
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
LIP	Local Initiatives Project (1993-1997)
MOH&FW	Ministry of Health and Family Welfare
NICARR	National Implementing Committee
TNO	Thana Nirbahi Officer
UIP	Upazila Initiatives Project (1987-1993)

Philippines

BHW	Barangay Health Worker
BSPO	Barangay Service Point Officer
CPO	City Population Office
DOH	Department of Health
DSWD	Department of Social Welfare and Development
FTOW	Full-time Outreach Worker
GOP	Government of the Philippines
LGC	Local Government Code
LGU	Local Government Unit
MOA	Memorandum of Agreement
MPO	Municipal Population Office
PFPP	Philippine Family Planning Program
POPCOM	Population Commission
PPO	Provincial Population Office

EXECUTIVE SUMMARY

Part I. Strategies and Issues

Rapid social and economic change, including rapid urbanization, is having an impact on governments' ability to manage those changes. Central governments face mounting difficulties in managing the process of growth and development, in addition to the maintenance of services and infrastructure. As a result, local governments and peripheral units—such as parastatal organizations—are increasingly becoming the focus of experiments with decentralization. Central governments are also giving renewed attention to private sector participation.

Decentralization is a massive undertaking that often involves rethinking the service delivery system and taking into consideration new jurisdictional, legal, personnel, and funding lines of authority. Decentralization is a fairly recent phenomenon, especially as applied to population and family planning programs. However, considerable experience is accumulating as a number of countries undertake organizational reforms leading to decentralization.

This paper examines worldwide experience with decentralization of population and family planning programs and synthesizes the experiences within a common framework. It proposes ways in which decentralization can contribute to the success of population and family planning programs; presents strategies that can be used to respond to the challenges and opportunities presented by decentralization; describes the successes and setbacks countries have experienced; and suggests ways in which donors can assist in the decentralization process.

Definition of Decentralization. Decentralization is the transfer of authority from the central government to other responsible entities. Four types of decentralization are defined that may be used in various combinations: *deconcentration* of limited administrative authority from the central level to subnational units within the same organization; *devolution* to local government authorities; *delegation* to parastatals; and *privatization* of some government functions to the private sector. These forms of decentralization vary in the extent of administrative transfer. The least extensive form is deconcentration, where authority remains within the organization but is conferred on peripheral units. In the more extensive forms, responsibility is taken by entities external to the government itself. Both deconcentration and devolution have territorial dimensions, while delegation and privatization have a functional basis.

Countries have different characteristics that affect the form and pattern of decentralization. It is important to bear in mind that several forms of decentralization may be implemented concurrently within a country. Experiences with decentralization range from governmentwide devolution of service provision in the Philippines to the use of field personnel to manage family planning activities at the state or provincial levels with varying degrees of central control in countries such as Thailand or Kenya. Decentralization in all these countries has both political and administrative dimensions that may or may not be closely intertwined.

Advantages of Decentralization. There are important advantages to decentralization. These include adapting services to local needs, making better use of service delivery partners, facilitating coordination of local organizations, and increasing local capabilities to plan and implement programs. One of the most attractive features of decentralization is its potential for increasing programmatic sustainability. To many, this justifies the significant administrative undertaking. If sustainability is defined as "the capacity of a national family planning program and the institutions within it to provide their current and potential clients with the information and services necessary to obtain the benefits of family planning—on a continuing basis and without external aid," the benefits come in developing managerial and technical expertise at the local level, using local data to tailor programs to the needs of the locality, mobilizing local resources, and making more effective use of private sector (NGO and commercial) service providers. This comprehensive diversification of the resource base—in human, financial and institutional terms—gives programs a much better prospect of success in offering preferred services to consumers for whom demand is institutionalized.

Strategies for Implementing Decentralization. A number of strategies can be pursued to help ensure success when implementing decentralization. The interests of the stakeholders in the process must be considered at every stage. At the planning stage, it is important to identify goals and objectives, the entity to which authority will be transferred, the functions to be retained and those to be transferred, and the means for transferring authority, resources and power. At the implementation stage, a plan is needed that provides appropriate financial and technical support to the decentralized units, mobilizes local resources, builds political support mechanisms at the national and local levels as well as local coordination systems, and provides for ongoing monitoring and evaluation of program progress. The role of central government officials will change. With devolution, in particular, it will be important to define new roles and responsibilities, focusing more on technical skills needed for determining and monitoring program direction and setting standards rather than on managerial skills used for program implementation. Local managers will also need new skills for planning, budgeting, and mobilizing local resources.

Problems Associated with Decentralization. Decentralization is a complex process, requiring considerable time to implement, and commitment, resources, coordination and communication among all levels of administration. Problems often arise as implementation occurs. These may be categorized as design problems, such as lack of correspondence between the objectives of decentralization and the administrative or regulatory framework to support those objectives, or implementation issues such as financial, human and infrastructure resource limitations. Problems also occur when decentralization does not produce the intended results, often due to lack of participation at the community level, vested interests of stakeholders who could not be budged, or political instability. The difficulties underscore the need to plan for decentralization, learn from experience through monitoring and evaluation, and adapt to changes in the social environment.

Donor Role in Support of Decentralization. Once a country makes the decision to decentralize (by political action), donor organizations can assist with the process. Careful thought needs to

be devoted to defining what is an optimal role for donors and how to promote future sustainability of the initiative. Donors can also play an important catalytic role in helping countries to assess the merits of potential organizational change and provide a vision for what decentralization would "look like," by bringing to bear national and international experience. They can also supply funds through a variety of mechanisms to facilitate decentralization. It will also be important to set up carefully planned evaluation studies to monitor the results from donor-funded projects to further our understanding of what works under what circumstances. Donors have a critical role to play in providing technical assistance and building capacity at all levels of the government and/or among supportive private sector organizations. In addition, donor support for policy analysis and information dissemination activities should not be overlooked.

Part II. Country Case Studies

Five case studies illustrate the diverse ways in which decentralization has been implemented in national population and/or family planning programs. Case studies include: the Philippines, Nigeria, Bangladesh, Thailand and Kenya. These countries represent a range of experiences, in terms of population size, levels of contraceptive prevalence, and stages of family planning program development. They also represent different administrative structures, types of government and forms of decentralization. In addition to the five detailed case studies, Part II also contains brief summaries of the experiences of other countries with decentralization of population and family planning programs. A series of tables compares the demographic characteristics, organization of population and family planning programs and forms of decentralization in selected African and Asian countries.

The case studies highlight recent experience with decentralization in population and family planning programs. Considerable central control is still evident in most of the case study countries due in part to the recency of decentralization efforts and, in part, to the forms of decentralization employed.

Philippines: The Philippines presents an example of nationwide devolution to local government units, beginning with the passage of the Local Government Code in 1991. In the Philippines, the Department of Health (DOH) is the lead government agency for family planning coordination and service delivery, while the Population Commission (POPCOM) plays an important role in advocacy, education and population-based planning.

Despite early difficulties with implementation, central ministries and local government units (LGUs) are well on their way to devising strategies to cope with their new responsibilities. LGUs are responsible for the delivery of all basic health services, including family planning. In addition, the national government will transfer specified amounts of funds to local governments. Within four years of implementation, they are to receive 40 percent of the Internal Revenue Allocation. In addition, they can now keep taxes they raise, and have the authority to introduce new taxes. Provinces and cities are responsible for planning, program management, and

coordination of population activities, and for those family planning services provided through provincial and city hospitals. Municipalities are responsible for delivery of services. The DOH remains responsible for monitoring and evaluation of local programs, standards, and technical support services such as logistics, training, and parts of information, education and communication (IEC) activities and the management information system. The POPCOM retains its role for advocacy and population-based planning and will provide technical support to local governments through its regional offices.

A USAID-funded pilot project has provided assistance to a few LGUs in an attempt to develop and test alternative models of technical assistance and policy/program implementation over the short term. Emphasis will be placed on clarifying the roles of the DOH and regional POPCOM offices, and providing technical assistance and training to other groups so that they can provide technical assistance to LGUs in the future. Developing skills and capabilities of local program managers to plan, budget and implement activities will be essential. Maintaining commitment of local leaders to population issues and family planning is also of paramount importance.

Nigeria. Decentralization in Nigeria, primarily devolution, was introduced in 1976 when 300 Local Government Authorities (LGAs) were established throughout the country. A local government system was considered essential to develop a national democratic system of governance and to improve the provision of services in local communities. At present, there are 589 local government authorities. In 1989, the responsibility for implementing primary health care, including family planning, and the power to secure and allocate resources were devolved to local government authorities by constitutional decree.

While devolution is the primary approach to decentralization employed in Nigeria, other approaches are concurrently being implemented. The Federal Ministry of Health has deconcentrated administrative functions by giving state ministries of health increased management and supervision responsibilities. In 1992, the government delegated select primary health care management and technical assistance to a parastatal organization, the Primary Health Care Development Agency. Privatization is also promoted by the government through its coordination of training and service delivery with the Nigerian Planned Parenthood Federation.

Numerous problems have emerged as LGAs adopt this new approach to service delivery. LGAs lack adequate staff and Health Committees who can solve problems, develop priorities, collect and use data for strategic planning, and develop realistic budgets. Mechanisms are not in place to supervise staff and monitor the use of resources. It will take several years to build the capabilities of LGAs to effectively operate, coordinate, maintain and expand health and family planning services. USAID's strategy for assistance has been to build capacities at the federal and state level to provide technical assistance that can be transferred to LGAs. The strategy is being applied to selected LGAs in 10 states.

Bangladesh. A USAID-funded project is working with the Ministry of Health and Family Welfare (MOH&FW) to operationalize the government devolution process (unsuccessful in other

sectors) for family planning program management by creating management committees that involve local political, family planning and community leaders. The management committee receives training in the development of action plans and the preparation of budgets to fund proposed activities. This approach has resulted in improvements in contraceptive prevalence in project areas, due to more effective utilization of community volunteers. The project also provides training to district-level family planning personnel to supervise and monitor implementation of action plans in subdistricts and unions.

In spite of a national policy endorsing devolution and a deconcentrated program structure and field management staff, most programmatic decision making in the Directorate of Family Planning in the MOH&FW remains highly centralized. Subnational areas have responsibility for administering local programs without any real authority to effect change on their own initiative. The Local Initiatives Project (LIP) motivates local-level family planning personnel to improve their program management capabilities, and in so doing, promotes bottom-up capacity building. Developing capacity at lower levels of administration can encourage and empower local program managers to bring about change.

The experience of LIP has been favorable. By 1997, project activities will have been implemented in about 25 percent of all subdistricts in Bangladesh. Contraceptive prevalence has increased faster in subdistricts participating in the project, primarily due to the higher visitation rates by community volunteers. Ideas and approaches from the project have diffused beyond the project boundaries. The World Bank is planning to adopt the LIP approach, extending this type of decentralization to more than 50 percent of the country. With relevant training and opportunities to put plans into action, local management of family planning programs can produce creative, innovative strategies that have a rapid impact on the program.

Thailand. The national family planning program in Thailand is the sole responsibility of the Family Health Directorate (FHD) of the Ministry of Public Health in Thailand. This provides a classical example of administrative deconcentration, in which the Ministry has administrative offices and staff in all provinces and districts for the management of health and family planning activities. During a USAID-funded pilot project, provincial managers in four provinces were given the authority and resources to develop locally appropriate information systems, plan activities, set targets, determine budgets and make adjustments as necessary to improve program performance in the absence of central control. The pilot project demonstrated that decentralized management resulted in improved responsiveness to local needs, more efficient management of resources and better coverage of the client population when compared to the control provinces.

While the existing deconcentrated program structure prior to the pilot project in no way impeded Thailand's dramatic success in achieving high levels of contraceptive prevalence and lowered fertility, the positive results from the pilot project illustrate the importance of having well-trained personnel at the local level, a complete and well-financed administrative structure in place, a good information system to guide local decision making, and high-level support for activities that will ultimately improve program performance. Despite favorable results from the pilot project

and the development of national guidelines for implementing decentralized management nationwide, funds were ultimately not available to extend the reforms to other provinces or continue them in pilot areas.

Kenya. The Kenya case study focuses on the deconcentration of its population coordination body, the National Council for Population and Development (NCPD), as manifested through the District Population Officer Program. This experience parallels the decentralization of rural development that began with the creation of District Development Committees in 1983. In keeping with the district focus, the government decided that districts should plan and implement population programs that follow national goals, yet are tailored to local needs and resources. Selected elements of the population program are decentralized, for example, the planning, management, coordination and monitoring aspects. Central government and ministries retain control over resources, policy, and personnel; continue to set national targets and goals; and establish budgets under which program activities are carried out.

The NCPD was created in 1982 to coordinate the increasingly multisectoral population program. In 1986, NCPD created the post of District Population Officer (DPO) to coordinate and manage district population and family planning activities in order to achieve national goals set by the NCPD. The DPO is secretary to the District Population and Family Committee, one of the sectoral subcommittees of the District Development Committee, which the DPO helps to establish. Currently, there are DPOs in 14 districts.

Kenya's decentralized population program is considered a partial success. Although DPOs were originally conceptualized to work more broadly on population issues, they have, in effect, concentrated primarily on family planning program efforts. DPOs have been well received in districts and their success in family planning education, coordination, and liaison with nongovernmental family planning organizations has resulted in a heavy demand for their services. Problems with supervision and training of DPOs by the NCPD have been aggravated by budgetary constraints set by the ministry within which the NCPD operates. Lack of qualified personnel and infrastructure has hampered the project's ability to place DPOs in other districts.

Conclusion:

How Can We Use What We Know to Improve Policies and Programs?

- **Countries have different characteristics that affect the form and pattern of decentralization.**

"Decentralization is more an art than a science" (Montgomery, 1983). There is no one best way to approach decentralization. The solution is to develop optimal relationships between the center and subnational units within the context of each country's cultural and political history and its bureaucratic organization. It is difficult to generalize from

experience and provide "how to" advice, especially across the various national settings involved.

- **Deconcentration is often the first step toward increased decentralization.**

Considerable central control is evident in many decentralized programs considered in this paper, due in part to the recency of experience but also as a result of the forms of decentralization employed. Even in situations where central control persists, there is still room for considerable autonomy and initiative on the part of local program managers, although the extent to which they are able to fully participate in planning varies tremendously from country to country.

- **Countries are gradually moving toward more extensive forms of decentralization, including devolution, either through evolutionary program development, experimental pilot efforts, or through implementation of formal legislation. However, the experience in the context of family planning programs is recent and incomplete.**

- **Decentralization may be inappropriate for some countries.**

Decentralization requires a demanding set of conditions which are not often present as past experience shows. When a country considers pursuing decentralization, it is important to carefully assess the advantages and disadvantages of decentralization and to reach an understanding of what decentralization can and cannot do. Other countries' experiences with decentralization may be instructive.

- **It is important to plan for change.**

While it is not possible to recommend how decentralization should be implemented in any given country, certain factors emerge as being especially important. These include: sustained political commitment at all levels; clearly written and widely disseminated guidelines; presence of administrative structures for planning, budgeting, staffing and monitoring; availability of appropriate infrastructure; and a good local-level information system.

- **Decentralization will fail without skilled professionals, adequate financial resources and appropriate infrastructure.**

Conditions do not have to be ideal for decentralization to occur, but decentralization will fail without skilled professionals, adequate financial resources and appropriate infrastructure.

- **Problems often arise as implementation occurs.**

Due to concern over such matters as implementation problems, lack of political commitment, impatience for change, or the short terms of office for locally elected officials, the process requires ongoing adaptation and flexibility to respond to problems as they occur. The difficulties underscore the need to plan for decentralization, learn from experience through monitoring and evaluation, and adapt to changes in the social environment.

- **Implementation of decentralization policies takes time.**

Decentralization is a lengthy process that may take 10-20 years to implement. It often involves a deep-seated change in attitudes and outlooks about ways of doing business. Personnel must learn to perform new duties, play different roles, and follow revised procedures. Mistakes will be made along the way, and a long period of organizational learning will ensue. Major organizational change of any type takes time.

- **Donors will continue to play important roles as facilitators, supporters and conduits for technical assistance.**

Once a country makes the decision to decentralize, there are many ways in which donors can assist with the process. First and foremost is to provide funds in support of various aspects of the decentralization process. Careful thought needs to be devoted to defining what is an optimal role for donors and how to promote future sustainability of the initiative. Given the enormity of the political, organizational, financial, and administrative change that is taking place, it will be important to leverage assistance to make the greatest impact given the number of subnational units involved. Strategies for assistance might include technical assistance to strengthen commitment to decentralization and family planning at the local level, implement programs of decentralization, and build capacities at all levels for planning, budgeting and monitoring decentralized programs. In addition, donor support for policy analysis and information dissemination activities should not be overlooked.

Decentralization is not a panacea for development or for the expansion of population and family planning programs. It is a strategy that may, under the right circumstances, with proper resources and conditions, lead to a number of desirable outcomes, including the attainment of such broad goals as managerial efficiency, democratization, strengthened popular support for government through the extension of participatory decision-making or programmatic sustainability. In the realm of population and family planning programs, decentralization offers great promise for expanding the coverage of family planning services by enabling program managers to make best use of service partners, resources and personnel.

**DECENTRALIZATION OF POPULATION AND FAMILY PLANNING
PROGRAMS: WORLDWIDE EXPERIENCE**

Part I. Strategies and Issues

by

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DECENTRALIZATION OF POPULATION AND FAMILY PLANNING PROGRAMS: WORLDWIDE EXPERIENCE

Part I. Strategies and Issues

1. INTRODUCTION

1.1 Overview

There has been growing interest in decentralization in recent years. Part of this interest is an outgrowth of the extensive literature concerning decentralization in the context of rural development programs over the past 20–30 years. Decentralization has also received increased emphasis in the context of new organizational approaches to implementing primary health care (Vaughn et al., 1984; Mills et al., 1991; Godinho, 1990; Kohlemainen-Aitken, 1992). There is growing interest in the subject, in Africa and Asia in particular. In a recent workshop in Anglophone Africa, 10 of the 12 African countries that participated have implemented or are moving toward decentralization in their population and family planning programs (OPTIONS Project, 1993). Recent workshops on decentralization in Francophone Africa, while not showing the same degree of country activism, have nonetheless demonstrated general interest in considering how decentralized planning and management could fit within their family planning programs (Vriesendorp et al., 1992; Vriesendorp, 1992; Kabore, 1992). A number of national family planning programs in Asia, based on the experience with field administration or deconcentration in health or other sectors, are now transferring increased authority for planning and program management to subnational units (McGirr and Smith, 1994).

Experience with decentralization is by no means complete. In fact, the subject has not been widely or systematically addressed in the context of population and family planning programs.¹ This paper contains detailed case studies for Philippines, Nigeria, Bangladesh, Thailand, and Kenya, and less detailed descriptions of the experience of a number of other countries. It is a work "in progress," in that the countries considered are only beginning to implement the process of decentralization. Although it is not always possible to precisely characterize approaches to decentralization, this paper provides an opportunity to synthesize the experiences of different countries within a common framework and to focus on specific aspects of their experiences. It also provides a better understanding of the decentralization process and all that it entails. There is no best way to approach decentralization. The solution is to develop optimal relationships between the center and subnational units within the context of each country's cultural and political history and its bureaucratic organization.

¹There is such limited experience in family planning that some examples used in this paper draw on experiences in rural development and health service organization (both in the U.S. and internationally) to clarify points.

1.2 Objectives of this Paper

The objectives of this paper are to:

- examine worldwide experience with decentralization of population and family planning programs and to synthesize the experiences within a common framework;
- present and propose ways in which decentralization can contribute to the success of population and family planning programs;
- develop recommendations on approaches and techniques program managers can use to respond to the challenges and opportunities presented by decentralization;
- describe the successes and setbacks countries have experienced in the process of decentralization; and
- suggest ways in which donors can assist in the decentralization process.

The paper is divided into two parts. Part I defines decentralization and discusses advantages, strategies, and problems associated with it. It also devotes attention to donor roles in support of decentralization. Part II presents country-specific experiences with decentralization of population and family planning programs.

2. DEFINITIONS OF DECENTRALIZATION

Broadly stated, decentralization involves the "transfer of planning, decision-making, or administrative authority from the central government to its field organizations, local administrative units, semi-autonomous or parastatal organizations, local governments, or nongovernmental organizations" (Cheema and Rondinelli, 1983, p. 18). More simply stated, it is the transfer of authority to plan, make decisions, and manage public functions from the national level to an organization or agency at the subnational level or external to the government itself (Rondinelli, 1981, p. 137). Decentralization should not be confused with the geographic dispersion of services within a country, for example, expanding health services and facilities to areas not previously served by government facilities.

There are various approaches to decentralization, including: (a) **deconcentration**, where select administrative functions are shifted from a central government ministry to its field staff in regional or district offices; (b) **devolution**, where the central government transfers to local governments decision-making authority, select public sector development activities, and the power to secure resources and/or make expenditure decisions; (c) **delegation to parastatal organizations**, where decision-making and management authority for specific functions are delegated to organizations that are not part of, or only indirectly related to, the central government; and (d) **privatization** for which government functions are transferred to the private sector.

As shown in Box 1, the four approaches to decentralization presented in this paper can be further distinguished according to territorial or functional criteria. Deconcentration and devolution represent the territorial basis for decentralization in which powers are transferred from national to subnational levels. Deconcentration represents an intra-organizational transfer of authority to field offices of the central organization, whereas devolution refers to "an inter-organizational transfer of power to geographic units of local government lying outside the command structure of central government" (Hyden, 1983, p. 85). The functional criterion for decentralization represents shifting authority for select government functions to parastatal organizations or interest groups. Most of the country experience included in this document pertains to the territorial forms of decentralization (e.g., deconcentration and devolution). In instances where delegation to a parastatal occurs, as in Nigeria or Zimbabwe, it is typically accompanied by some degree of geographic deconcentration.

Box 1. Approaches to Decentralization

MOTIVE FOR REFORM	BASIS FOR DECENTRALIZATION	
	Territorial	Functional
Managerial	Deconcentration	Delegation
Participatory	Devolution	Interest Group/ Privatization

Source: Adapted from Hyden, 1983, p. 86

In actual practice, the approaches to decentralization also vary according to the amount of responsibility transferred and the legal context for the transfer. Mills et al. (1990) have categorized variations in the amount of responsibility for various government functions associated with each form of decentralization, as shown in Box 2. This suggests that deconcentration is the least extensive form of decentralization in the amount of responsibility transferred to peripheral units, whereas delegation and privatization, which involve transfer of power to units essentially external to the government, entail substantially greater degrees of functional responsibility.

The boundaries between the forms of decentralization are not always distinct, and the term decentralization is often used instead of a more precise description of its form. Country examples are rarely found in their "pure" form. Governments may also use one or a combination of approaches in their efforts to decentralize government functions. In Nigeria, for example, three forms of decentralization exist in the delivery of health and family planning services. The government has gradually *deconcentrated* or reduced the federal Ministry of Health's administrative functions by giving state ministries of health increased management and

Box 2. Degree of Responsibility Associated with Forms of Decentralization

Functions	Deconcentration to ministry field office	Devolution to local government	Delegation	Privatization
Legislative	—	**	—	—
Revenue-raising	*	**	**	***
Policy-making	—	**	**	**
Regulation	—	**	*	—
Planning and resource allocation	**	**	***	***
Management: personnel	*	**	***	***
budgeting and expenditure	**	**	***	***
procurement of supplies	*	**	***	***
maintenance	*	**	***	***
Intersectoral collaboration	*	***	***	***
Interagency coordination	*	**	***	***
Training	*	*	***	***

Key:

*** Extensive responsibilities	* Limited responsibilities
** Some responsibilities	— No responsibilities

Source: Mills et al., 1990

supervision responsibilities. In 1992, the government also *delegated* primary health care management and technical assistance to a parastatal organization, the Primary Health Care Development Agency and its regional offices. The responsibility for implementing primary health care, including family planning, and the power to secure and allocate resources have been *devolved* to local governments outside the Ministry of Health by constitutional decree. Thus, several forms of decentralization may be present and functioning governmentwide, or even within the same sector (Silverman, 1992). The different forms of decentralization are discussed in greater detail in the following sections.

2.1 Deconcentration

Deconcentration is the least extensive form of decentralization and it may be the first step that a highly centralized government takes toward decentralization. A national organization, often the Ministry of Health, transfers selected administrative functions to regional or district offices of the ministry. Each office represents a clearly defined geographic area (provinces, districts), has one or more persons responsible for managing activities, has an identifiable staffing structure and budget for its activities, and has a means of communicating with the next level up in the hierarchy (Mills et al., 1990). Members of the staff of field offices remain employees of the central ministry or organization. There is some transfer of authority for decision making for planning, budgeting and adapting national directives to local conditions. For family planning programs, administrative functions of the field office might include planning for day-to-day management of the program, collecting and analyzing information relevant to that level, developing budgets to carry out activities, and recruiting and training staff for the field office. However, major administrative decisions are made by the central office. The objective of a deconcentration strategy is often to develop a complementary relationship between the ministries that have a sectoral approach to development, and the provinces, regions or districts that have an integrated approach to addressing local needs.

Often a distinction is made between forms of field administration (Mills et al., 1990; Hyden, 1983). In vertical forms, the local staff of each ministry reports directly to the central ministry. In integrated forms, there is a local head of administration or governor who is responsible for coordinating all government functions at that level. For example, the Provincial Chief Medical Officer in Thailand is responsible for the management of the family planning program in the province, but reports to the Provincial Governor, an employee of the Ministry of the Interior. However, the Ministry of Public Health is responsible for the officer's technical supervision. A similar administrative structure exists in Indonesia in which BKKBN personnel at each level are responsible to the local civil authority, but under technical control and supervision of the next higher BKKBN level.

2.2 Devolution

Devolution is a more extensive form of decentralization and involves a diversity of structures within the political system. Devolution is a political action involving national policy or law in which the government transfers authority to local governments for carrying out a range of operations encompassing more than one sector, and provides them with the authority to raise resources and make expenditure decisions. The local government units are largely independent of the central government. The local government units have, in most cases, a legal status, recognized geographic boundaries, specific functions to perform, and authority to raise revenues and make expenditures (Cheema and Rondinelli, 1983; Mills et al., 1990).

Devolution usually occurs as a result of a national decree and pertains to all government ministries, except for those few functions deemed national priorities such as national defense, customs, foreign affairs, immigration, etc. Devolution also can occur within a single sector. The

Gambia, for example, has devolved responsibilities for education to local communities. The governments of Senegal, Mali and Cape Verde have begun to devolve authority for some types of public service provision (Hobgood, 1992; Thomson, 1992). Senegal is also at the beginning stages of introducing a devolved public health and family planning program (USAID, 1992).

The Local Government Code in the Philippines is illustrative of full devolution (Republic of the Philippines, 1992). The national government there has devolved virtually all sectors to local government units (LGUs), with the exception of education and national security forces. The national government has transferred responsibilities for setting priorities and making decisions about how programs can be implemented to respond to the perceived problems of local governments. In addition, the national government will transfer specified amounts of funds to LGUs. Within four years of implementation, LGUs are to receive 40 percent of the Internal Revenue Allocation. LGUs can now keep taxes they raise and have the authority to introduce new taxes.

2.3 Delegation

Delegation entails assigning decision-making and management authority for specific government functions to an organization that is not part of or only indirectly controlled by the central government, such as a parastatal organization,² regional authority, or special service district (Rondinelli, 1989). Delegation involves increased autonomy of the parastatal organization from the central government, and sometimes frees the organization from civil service constraints and restrictions on revenue generation or resource allocation. Delegation does not occur governmentwide and is limited to a few government functions. The rationale for using parastatals may be to avoid the inefficiencies associated with direct government management, to achieve better cost control, or to put control in the hands of an organization that can be more responsive or flexible.

Internally, the parastatal can be organized on a very centralized basis (all planning and budgeting at headquarters) or geographically deconcentrated—with delegation of planning, budgeting, and even revenue generation transferred to regional or district affiliates. Therefore, delegation of responsibilities does not automatically imply that the services will be provided in a decentralized form. While the provision of services may be decentralized, and the central government may exercise less central control, authority may remain highly centralized within the organization, precluding local-level management.

Some governments have delegated responsibility for carrying out the national family planning program to a parastatal organization. For example, Rwanda, Zimbabwe and Tunisia all have nonministerial organizations responsible for the national family planning program. However, the

² A parastatal organization is defined as "any institution established by a statutory act of parliament, to conduct commercial or productive activities, perform public utility functions or provide social services" (Hyden, 1983, p. 85). Many parastatals are enterprises either wholly or partly owned by government, which are set up either for profit or nonprofit purposes.

directors of these organizations are appointed by the central government and their employees are members of the civil service. Organizations like these also vary in their degree of internal decentralization. In some instances, the national organization has retained complete authority for managing the family planning program. In other instances, such as in Zimbabwe, the parastatal has set up a system of field offices at lower administrative levels to manage the program, similar to ministerial deconcentration.

2.4 Privatization

Privatization entails the transfer of government functions to the private commercial sector or nongovernmental organizations (NGO). It is the most extensive form of "decentralization" because the private sector has extensive or even exclusive responsibilities for management and provision of services. There are many forms of privatization, from leaving the provision of services to market competition to forming partnerships between public and private agencies. Governments may encourage this approach in addition to other forms of decentralization for government-provided services. As part of the decentralization process, governments can provide an important enabling environment for private sector activities, which in turn, diversifies the resource base for family planning.

Governments may tacitly or explicitly set the conditions for private sector services. Family planning associations (often affiliated with IPPF) have often taken the early initiative of introducing family planning services in a country. In some countries, these associations have provided from one-fourth to three-fourths of all family planning services. Prior to government involvement (or with minimal involvement), the private sector had responsibility for providing whatever services were available. Also, when government services do not reach the lowest levels in the administrative hierarchy, such as in remote areas, the private sector, either commercial providers (including indigenous providers) or NGOs, may be "the only game in town." In Haiti, NGOs are filling an important gap in service delivery, and in India, the commercial sector actively provides services to consumers who do not have access to primary health care centers.

Privatization may also play a more explicit role in government policy. In this instance, it is usually assumed that the private sector can carry out a government function in a more cost-efficient manner. When government is involved in the provision of services, it may seek alternative ways of providing them in order to focus its resources on groups or areas where it can have the greatest impact. In a number of countries, governments are exploring ways to include various private commercial sector actors in the delivery of family planning services so that governments can focus their resources on couples who cannot afford to pay for family planning services and commodities. For example, government might contract with private organizations to provide health care coverage of the poor in urban areas or allow private sector providers to provide services in facilities previously used exclusively by the public sector.

However, no country has a completely privatized system of operation for family planning. Even in a country such as Egypt, where the private sector provides over half of family planning services, the government still plays a major role in the provision of family planning services

nationwide through the Ministry of Health and has a parastatal organization, the National Population Council, that is responsible for policy activities and coordination.

2.5 Alternative Classifications of Decentralization

Agreement as to the specific meaning and forms of decentralization is hard to come by. Conyers (1983; 1985) claims that decentralization in recent years has taken on different forms and questions the value of terms such as devolution and deconcentration. She classifies recent experiences with decentralization in terms of multiple dimensions, including variations in the types of powers transferred, the means of transfer, the level and the persons or organizations to whom powers are transferred. Silverman (1992) uses the term "hybrid" decentralization to reflect the possible co-existence of different forms of decentralization within a given country.

While decentralization is difficult to characterize precisely, conventional terminology serves as a common framework and contributes to understanding the implications of decentralization for population and family planning programs.

3. ADVANTAGES OF DECENTRALIZATION

Decentralization policies or strategies have been implemented for more than 20 years, primarily in local government administration of rural development programs in Africa (De Valk and Wekwete, 1990; Conyers, 1981; Mawhood, 1983; Rondinelli, 1983a; Rondinelli et al., 1984), Asia (Rondinelli, 1983b), and in health programs in Latin America and elsewhere (Mills et al., 1990). In recent years, decentralization is being considered in a new light, given the growing movement toward increased democratization and government restructuring. Decentralization is also being viewed as a means of increasing participation and strengthening local institutions. Decentralization potentially offers many advantages in the management and administration of population and family planning programs at the local level. Decentralization provides an opportunity to improve services by tailoring them to local needs and conditions, sets the stage for broader-based financing of family planning, and enables local administrators to respond more quickly to changes in the local environment and use human and financial resources more efficiently. Box 3 indicates potential ways that decentralization can help expand population and family planning programs.

3.1 Tailoring Programs to Local Conditions

The following example illustrates some of these advantages in a hypothetical setting in which decentralization has resulted in the evolution of very different service delivery structures in various areas of the same country. This is a broad conceptual overview; in reality, there would be an enormous number of practical steps required, in terms of planning and implementation, to reach the degree of differentiation between areas described in the example.

Box 3. Potential Advantages of Decentralization

- Adapt service delivery to suit local needs
- Reduce the amount of time required to respond to problems or changes in the environment
- Make more efficient use of staff time, transport, and resources
- Increase program sustainability
- Increase the capabilities of local organizations to plan, implement, and coordinate population and family planning activities
- Mobilize resources and political support within local communities to expand and improve family planning services
- Facilitate coordination of local organizations involved in service provision and reduce duplication

Country X has the goal of assuring that quality family planning services are widely available in all areas of the country and has recently devolved responsibility for the provision of health and family planning services to local authorities. Financial resources to pay for the programs have been transferred through grants to the local areas based on their special needs. Areas have also been given the authority to retain resources gained through various local levies and cost recovery measures, in order to meet demand and assure that desired services are available to the entire population. Before decentralization, all areas of Country X had similar programs, run by a centralized line ministry with little delegation of authority. The family planning program is relatively new, contraceptive prevalence is not very high, and the public sector is the predominant source of all services. Box 4 illustrates how programs might evolve in different areas of the country under decentralization.

Decentralized management also has great potential for increasing the efficiency of family planning service provision. Strategies to increase efficiency, such as establishing on-the-job training programs, using lower levels of health care personnel, changing the nature of supervisory visits, and combining clinic and community-based distribution channels (see Lande and Geller, 1991 for other strategies), may be especially effective in a decentralized setting. Community-based workers could be trained and supervised locally, which reduces the need to expend financial resources for off-site training and time-consuming supervisory visits. In addition, local managers could be given the authority to utilize lower-level health care personnel when appropriate (for pill distribution, IUD insertion, etc.), which conserves program resources and helps achieve sustainability goals.

Box 4. Tailoring Programs to Local Conditions

Area A is a large urban area, with some industrial base, educational infrastructure, formal sector employment, and availability of private physicians and pharmacies. The higher education levels and urban conditions result in lower desired family size and higher contraceptive prevalence. The budget for family planning in Area A has always been tight given the greater demand for services exerted by its population. Health officials in Area A analyze the needs of its population for family planning services paid for and provided by the public sector. A significant portion of the population in Area A already use the private sector for health care and medications, indicating some ability to pay and some preference for private services. If Area A can develop a system that allows this proportion of the population to purchase its own services, public funds can be targeted to those who cannot afford to pay (in Area A or in other areas). The availability of private service points suggests that it may not be necessary for the public sector to directly operate services. For those groups who cannot afford market-priced services, Area A can finance services obtained from private providers (e.g., through a voucher system, reimbursement of services, etc.), or provide some services directly. Given the commercial development of the area, it is not necessary for Area A to handle the logistics of supply to service delivery points either. Thus, decentralization in Area A relies heavily on privatization of service delivery and supply logistics. Program managers focus on providing services to the poorest segments of society, developing messages to reach their target population, monitoring usage of services through all channels, and assuring quality through the normal regulatory means.

Area B is a rural area with largely agricultural employment and less dense infrastructure. Compared to Area A, Area B has few private service outlets and few consumers who could afford to use them. Area B analyzes its population, the demand for services, and the availability of service providers in the area. The role for the Area B Health Department is very different from that in Area A. In Area B, the public sector has to underwrite services to almost everyone and directly operate the services. To assure that the services are planned and organized in close correspondence to local needs and with the most community participation, local program managers recruit and train volunteers to provide outreach services. Because static clinics are under-utilized, the program manager focuses on demand generation activities and reassigns some of the clinical staff to provide services through mobile clinics to improve access in remote areas. Service data is collected and retained in the area office, and managers have been trained in how to use the information to make informed decisions about the reallocation of resources within a budget cycle to focus on interventions that are having a higher degree of success and for planning future program activities.

3.2 Fostering Sustainability

Sustainability is defined as "the capacity of a national family planning program and the institutions within it to provide their current and potential clients with the information and services necessary to obtain the benefits of family planning—continually and without external aid. Achieving sustainability is a process through which the program moves away from dependence on external sources of financial and managerial assistance, and toward self-determination and financial autonomy" (Levine et al., 1994, p. 3). Strengthening local institutions is an initial step in gaining long-term commitment to programs at the national and community level. Building management and organizational capabilities is crucial for ensuring that service delivery systems continue to operate effectively after external support ends. When local level-program managers develop the ability to operate their own programs, the government must be prepared to scale back its involvement and to ultimately "let go," according to the decentralization plan. Sustainability is eroded if control by higher levels of government continues after it is no longer needed (Goldsmith et al., 1985).

Transferring authority and skills to local institutions would enhance sustainability in other ways, as well. Local managers trained in data collection and analysis techniques not only could provide central program officials with current, accurate information about community health systems, but also could use the information locally to allocate human and financial resources in the most efficient manner. Mobilizing public and private resources at the local level ensures long-term financial support for services. When local residents perceive they are benefitting from services supported by their payments, they have a greater sense of participation and involvement in the program. They will then be more likely to contribute time, labor and resources (Ostrom et al., 1992; Cernea, 1985; Uphoff, 1986). When community institutions have power and flexibility, citizens generally feel more of a stake in their program. Decentralization would also help achieve sustainability by encouraging local managers to identify alternative funding sources and mechanisms. They would likely seek to involve NGOs and private physicians, nurses and pharmacists. Linkages to traditional health regimes also may simultaneously address both cost and efficacy concerns (Steinmo, 1982). For example, a market-based project in Nigeria trained local providers in family planning and preventive health. These traders now sell anti-malarial drugs, aspirin, oral rehydration packets, bandages and family planning commodities, referring customers who need additional medical and family planning services to a medical institution (Lacey, 1988, p. 227). Under decentralization, local areas would have a great degree of latitude in determining the most appropriate mix of services to provide their population.

Thus, decentralization offers great promise for providing managers with opportunities to make best use of service partners, increase the efficiency of service provision, use collected data to make programmatic decisions relevant to their areas of jurisdiction, and make quick adjustments to program activities based on this information. These abilities will help local managers conserve financial resources, which will help achieve sustainability goals. The specific strategies to promote successful decentralization are described in the next section.

4. STRATEGIES TO PROMOTE SUCCESSFUL DECENTRALIZATION OF POPULATION AND FAMILY PLANNING PROGRAMS

To gain the benefits offered by decentralization, governments may undertake the substantial task of putting decentralized programs into place. This section describes several strategies that can be pursued to help ensure success. At the planning stage, it is important to identify goals and objectives, the entity to which authority will be transferred, the functions to be retained and those to be transferred, and the means for transferring authority, resources and power. The interests of the stakeholders in the process must be considered at every stage. Prior to implementation, a plan will be needed that specifies appropriate financial and technical support to the decentralized units, mobilizes local resources, builds in political support mechanisms at the national and coordination systems at the local level, and provides for ongoing monitoring and evaluation of program progress. This section also notes functions which the central government may wish to retain and highlights the management skills needed by local program managers to respond to supply and demand characteristics of program users. These strategies are summarized in Box 5 and are described in more detail below.

4.1 Specify Clear Goals and Objectives for Decentralization

Plans for decentralization are often shaped in terms of political, economic and administrative objectives (Silverman, 1992). Political objectives might be to increase popular participation in planning and development, redistribute the benefits of development, or enhance the role of the current incumbent political party. Economic objectives may be to facilitate social and economic development or to enhance the socioeconomic well-being of the population. Administrative goals include more efficient provision of services and the increased effectiveness of government operations, increased government accountability or better integration of government programs. The range of objectives within a single country can contribute to the difficulty of transforming the objectives into a practical and coherent program of decentralization. By way of example, Box 6 presents the objectives for devolution in Uganda.

The particular set of objectives selected, to a large extent, determines the degree, phasing and form that decentralization takes in a country setting. Thus, deconcentration and delegation may be implemented to promote managerial or administrative efficiency whereas devolution is more likely to fulfill the goal of increased participation and democratization. Priorities should be established as a means of determining the focus of the decentralization strategy to be implemented. The goals and objectives also provide the standards by which the process can be evaluated. However, implementation of decentralization is often inconsistent with its overarching goals and objectives (as noted in section 5.3).

4.2 Identify the Level to Which and Persons to Whom Authority will be Transferred

In territorial forms of decentralization, powers are transferred to regions, districts, states, or local governments. The size of the decentralized unit varies according to the particular administrative structures of the country, the needs of particular regions, and the capacity of the area to finance

Box 5. Strategies for Successful Decentralization

- Specify clear goals and objectives for decentralization
- Identify the level to which and persons to whom authority will be transferred
- Select strategies to transfer power, authority and resources
- Develop an implementation plan
- Develop effective strategies to coordinate activities among levels of government and between the public and private sector
- Define activities that would be retained at national level
- Build and sustain political support at local and national levels for population programs
- Identify training needs
- Estimate financial and technical support capacities of decentralized units and allocate appropriate resources
- Mobilize local resources for family planning
- Build monitoring and evaluation systems to meet national and local needs

and administer services (Rondinelli et al., 1984). For example, decentralization from federal to state levels in a country such as Nigeria or Mexico will be different from decentralization to the district level in a smaller country such as Kenya or Uganda. In Ghana, the number of districts increased from 65 to 110 as part of its decentralization program, which reduced the size of large districts yet still respected chiefdoms. Program managers need to be able to supervise the facilities and maintain relationships with constituent parts on a regular basis to facilitate service delivery at the local level. However, the smaller the administrative area, the less likely it is to have both the financial resource base and the skilled personnel required for implementation (Conyers, 1990).

A review of how the administrative structures at the national, intermediate and local levels will need to be reorganized to allow for real decentralization should be carried out at the earliest stages of planning. Decentralized functions can be transferred to elected leaders or councilors, political appointees, local government employees, nongovernment organizations or a combination of actors. The selection of an appropriate administrative level and actors should be based on

Box 6. Objectives for Decentralization in Uganda

"Decentralization in Uganda is designed to achieve the following objectives:

- to transfer real power to the districts and thus reduce the load of work on under-resourced central officials.
- to bring political and administrative control over services to the point where they are actually delivered, thereby improving accountability and effectiveness, and promoting people's feeling of ownership of programs and projects executed in their districts.
- to free local managers from central constraints and, as a long-term goal, to allow them to develop organizational structures tailored to local circumstances.
- to improve financial accountability and responsibility by establishing a clear link between the payment of taxes and the provision of services they finance.
- to improve the capacity of local authorities to plan, finance and manage the delivery of services to their constituents" (UNICEF, 1993, p. 1; see also Lubanga, 1993; Atiku, 1993).

analysis of which level of government and what type of organization is best suited to perform a particular function. The assignment of responsibilities between central government and subnational levels must be clearly articulated, just as the delegation of authority for specific government functions must be made clear to parastatal and nongovernmental organizations. Procedures should be designed for allocating specific functions among levels of administration, clarifying the relationships among different units, and modifying codes and regulations to bring them in line with the roles and responsibilities of the decentralized unit. The potential capabilities of individuals and organizations to plan and implement decentralized functions at the designated level, and the interests of stakeholders, must be considered at every stage.

4.3 Select Mechanism to Transfer Authority

There are various mechanisms available to national officials for the transfer of authority. Transfer can occur through legislative or nonlegislative means. Legislative mechanisms include constitutional and ordinary legislation, the former being common in federal systems. Devolution in Nigeria is the result of the Local Government Reform of 1976, but the transfer of responsibility for the provision of primary health care to local government authorities came as a result of a constitutional decree in 1989. The delegation of authority to ZNFPC, a parastatal organization responsible for the coordination and implementation of family planning activities in Zimbabwe, occurred as a result of an act of Parliament in 1985. Nonlegislative mechanisms include political directives and administrative devices, including financial and public service rules

and regulations, and ad hoc instructions from headquarters staff to their officers in the field (Conyers, 1990). In Thailand, administrative guidelines for implementing decentralized management in MOPH offices nationwide were drafted following the successful completion of a USAID-funded pilot project (MORE Project, 1992). Legislation is likely to be more effective and more permanent than political or administrative directives. However, legislation is less flexible because it is more difficult to change.

4.4 Develop an Implementation Plan

A key factor for success is the development of a national strategic plan for implementing decentralization that includes clear and realistic goals and measurable objectives. In addition, the plan should clearly define the method of transferring authority and financial resources to the decentralized unit. It should be disseminated continuously to a broad range of actors at both the local and national levels. Opposition may be reduced when agencies and individuals understand the purpose, benefits and potential achievements of decentralization from the beginning. Patience is required. It can take many years to develop a decentralized program that is well received at all levels of government and among nongovernmental organizations, traditional organizations and the general population.

Developing and implementing a plan for decentralization is easier to accomplish when an agency or unit within an agency is assigned the responsibility of designing, coordinating, implementing, evaluating and allocating human and financial resources to ensure that the needs of each decentralized unit are met. Often a unit within the Office of the President plays such a role and has the authority to issue administrative directions. The District Focus strategy in Kenya is administered from a unit within the Office of the President in close collaboration with the Ministry of Finance, the Ministry of Planning and National Development, and the Directorate of Personnel Management. In the Philippines, an oversight committee was created by the Department of the Interior and Local Government to oversee the implementation of the Local Government Code that devolved powers to local governments. The committee was comprised of senior officials from the executive and legislative branches of government, and leagues of provinces, cities, municipalities and barangays (Republic of the Philippines, 1992). In Uganda, a Decentralization Secretariat has been established within the Ministry of Local Government to coordinate relations between national and local agencies and to monitor the progress and impact of decentralization (UNICEF, 1993).

4.5 Develop Effective Coordination and Communication Strategies

Population programs require the interaction, coordination and communication of a large number of organizations at different levels of government, as well as nongovernmental organizations, providers and groups of intended beneficiaries. The various groups have their own goals, objectives and priorities. Collaboration at the subnational level is often a reflection of national-level coordination among the organizations and actors concerned (United Nations, 1978).

Governments need to develop effective strategies for coordination and communication among the various agencies and sectors at the national and lower levels. Mechanisms are needed to facilitate top-down and bottom-up forms of exchange. Horizontal linkages are needed to permit intersectoral coordination. National officials also need to work with local staff and leaders to develop flexible guidelines to better coordinate public and private family planning services within their communities.

4.6 Define Activities that would be Retained at the National Level

The role of the central government in implementing decentralized family planning programs must also be defined. One of the central government's responsibilities at the onset of decentralization is to help create administrative capacity at lower levels (Leonard, 1982). The responsibilities of the staff retained at the national level also changes. "Instead of trying to control every detail throughout the country, their job will be to prepare guidelines, to inspect work being done, and to answer requests for help from the regions and districts" (Nyerere, 1972, p. 8). As implementation proceeds, central government officials have to give up operational responsibilities and shift from being program implementers to program planners. The roles of national or federal government officials can include supervision, setting standards, allocation of resources and technical assistance. These responsibilities vary depending on the form of decentralization (see Box 7).

Box 7. Responsibilities of National Officials in Decentralized Programs

National officials in decentralized population and family planning programs could retain some or all of the following responsibilities:

- set national priorities and program goals;
- issue general directives and policy guidelines from time to time;
- develop and promote quality standards for family planning service delivery;
- provide financial, logistic and human resources;
- specify minimum qualifications for technical and professional officers to be employed at the local level;
- train local staff and, where advisable, elected officials;
- provide technical assistance and supervise local areas; and
- conduct research and organize monitoring and evaluation systems.

4.7 Develop Commitment to Decentralization and Population/Family Planning

Family planning is still a sensitive issue in many sub-Saharan African countries. Dialogue on the importance of family planning for maternal and child health and the overall well-being of the family is needed continuously to build and sustain political and financial support for family planning programs. National and local governments need to ensure that advocacy activities are undertaken so that financial, technical and human resources are mobilized and allocated to population and family planning programs.

Advocacy is important for maintaining commitment to the principles of decentralization at all levels of leadership. Once national consensus is achieved, advocacy will be instrumental in building consensus at lower levels of government administration. In Thailand, the director of the national family planning program actually participated in the design and implementation of the pilot project to test the feasibility of decentralized management. In Bangladesh, a key element in the success of the Local Initiatives Project is the participation of locally-elected leaders in the observational study tours to build support for decentralized program management. Frequently, governments support the concept of decentralization without transferring real authority for decision making and financial control (Crone-Coburn et al., 1992; Conyers, 1990).

Advocacy assumes varying importance at different levels of administration. At the national level, there must be support for population/family planning across ministries. In devolved systems, advocacy will help to ensure that adequate funds are allocated to manage the family planning program. Because local governments are responsible for provision of all services, family planning often competes for funds with other programs. In Nigeria, even within a single sector such as health, there is not a specific line item in the budget for family planning. The local authority allocates money to the component of primary health that includes family planning.

On the other hand, successful advocacy on the part of some local governments may also contribute to greater inequalities between subnational units. In Mexico, geographic disparity in health status increased after decentralization to the state level (Gonzalez-Block et al., 1989). In the Philippines, for example, areas with strong local leaders and population officers as advocates for family planning may be more successful in obtaining funds for the population program (Rimon et al., 1993).

4.8 Build the Capacities to Plan, Implement and Evaluate Projects and Programs

The decentralized unit, whether local governments, field offices, parastatal or nongovernmental organizations, must assess the supply and demand for services and develop and implement plans to meet needs within the community. Therefore, local program managers need skills to: identify problems and opportunities; identify or create possible solutions to these problems; make decisions and resolve conflicts; mobilize, allocate and monitor resources effectively; manage and coordinate agencies involved in local implementation activities; and gain political support among government and traditional leaders at the local level to promote and fund program

implementation. Specific skills needed to assess the supply and demand for family planning services are highlighted in Box 8.

Developing capacity to plan, manage and evaluate programs is an important issue, but it need not be an impediment to implementing decentralization. In Uganda, the approach is to introduce decentralized procedures and responsibilities now and help districts function in a way that will gradually build competence (Lubanga, 1993). In Kenya, however, it has been difficult to find and train suitable candidates to serve as district population officers. This may be true in other countries and sectors as well.

4.9 Estimate Financial and Technical Support Capacities and Allocate Appropriate Resources

The provision of resources to the local level is an absolutely key element for decentralization. This includes the extent to which local implementing agencies and organizations and elected political leaders receive sufficient financial, administrative, technical support and training from the central government or other higher administrative levels. The service delivery system needs to be fully functional with regard to personnel, equipment, logistical support and facilities, and have an adequate supply of family planning commodities. However, it is not necessary for the public sector to retain responsibility for all these functions. The commitment to decentralized family planning should be backed up by the transfer of sufficient resources or the authority to generate resources, and mechanisms must be in place to facilitate the transfer of resources. For example, the government of Uganda decided to phase in a change whereby money would go directly to districts through annually negotiated budget appropriations rather than being funneled through a line ministry or the Ministry of Local Government. Local finances would be controlled by an Executive Secretary, a local government Accounts Committee and an Auditor General (Lubanga, 1993). The Family Health Department of the Ministry of Public Health in Thailand used block grants to make funds available to provinces.

In devolved programs, governments may also need to reorient the way in which donor assistance is provided. External support may be channeled directly to the local level through a variety of mechanisms. There is then a need to develop standardized and agreed upon procedures to provide support to local organizations and develop systems of accountability that can be followed easily. Greater service provision roles may be envisioned for NGOs and the private commercial sector. Accountability standards are required for the central government, NGOs and donor organizations.

The transfer of funds from the central government, the retention of funds generated at the local level, and the potential influx of donor funds accentuate the need for sound financial management and budgeting skills at the local level. These skills are frequently lacking at subnational levels.

Box 8. Planning and Management Skills for Building Family Planning Programs

Supply Issues:

- **Developing targets and projections** for contraceptive use, disaggregated by contraceptive method
- **Building support** among influence groups
- **Meeting demand** by adding or expanding clinics; mobile vans; field workers, community workers; community supply depots; pharmacies and medical stores; the marketplace, and place of work
- **Sequencing** by adding services; and/or clinic/community approaches
- **Phasing** by geographic areas; and/or segments of the population
- **Mobilizing resources** including financial resources, buildings and labor from other public agencies, village councils, voluntary organizations, and the private sector
- **Coordinating** with government agencies and the private sector including private providers, the commercial outlets, and nongovernment organizations to provide and expand services
- **Planning, monitoring and evaluating** by designing information systems, collecting information, and using data to monitor performance and make strategic planning decisions about new program directions

Demand Issues:

- **Generating demand** through such activities as selecting media approaches, message strategies and levels of community involvement
- **Identifying clients** such as male vs. female; postponers, spacers, or limiters; low vs. high parity; newly married; youth
- **Identifying needs** for particular methods among temporary (such as pills and condoms), terminal (sterilization), long-term (IUDs and implants), and traditional methods

4.10 Develop Strategies to Mobilize Local Resources for Family Planning

In addition to government and donor support, resources must also be mobilized within local communities to support and sustain family planning programs. A difficult task is in providing guidelines to local governments or districts that assist local officials in developing strategies to tap into human, physical and financial resources in the community. This is especially important in multi-ethnic settings where different groups may not have equal access to local-level resources. Mechanisms must be in place through which local resources can be mobilized to build the capacity to sustain and/or expand the program. Since family planning services are often provided from multiple sources (which may differ between districts), interorganizational linkages can make more effective use of available resources (see Leonard, 1982; 1983).

There is a wide range of mechanisms available to generate funds at the local level and through the private sector (see Rondinelli, 1989; Rondinelli et al., 1989; and Johnson and Rahman, 1992). Self-financing and cost recovery schemes have accounted for large proportions of locally-based revenues (Rondinelli et al., 1989). Other strategies involve co-financing arrangements in which users participate in providing services or maintaining a facility; local revenues and levies; various types of intergovernmental transfers (including grants); authorization of municipal borrowing; and cost reduction. The private sector also serves as a local-level resource in its role of taking some of the burden for providing services off the local government.

For decentralization, an important characteristic of successful cost recovery systems is local-level revenue collection (Foreit and Levine, 1993). With a local system in place, it is important to ensure that the central government does not take money away from a clinic or locality when it is successful in generating its own funds. Maintaining a successful cost recovery/user fee system requires a decentralized financial system and increased accounting and management capabilities at the local level. However, these skills may be beyond the initial capabilities of most countries embarking on decentralization.

Another mechanism for generating funds is community-generated resources for maintaining the service facility and conducting outreach activities. The chances for local-level resource generation are increased if the community has been encouraged to participate in the process, if strong linkages with existing groups have been established, and if the community has some say about how resources are to be used. In some countries, communities pay for health services, including family planning. In the Gambia, for example, villagers contribute money or labor to pay the salary of a health worker. The government provides the health worker with supplies (including oral contraceptives); the worker sells the drugs; and the local development committee uses the money to buy additional drugs (Lande and Geller, 1991). Revolving drug funds and other community financing arrangements have also been used in local health financing projects in Zaire, Ghana and elsewhere. This mechanism has great appeal for government, however, it is important to have realistic expectations for the amount of resources that can be generated locally. Success with community involvement in construction of the service facility, for example, does not excuse higher levels of government from the responsibility for providing sufficient resources to ensure that the physical structure becomes a service center. Moreover, these service

centers often fail to achieve their goals because of a lack of resources for recurrent costs (Conyers, 1990).

Community participation is essential to successful decentralization. If community leaders and organizations participate in the decentralization process, local support for government functions may improve. If people feel they have a voice, they may more actively support government programs and be more willing to mobilize and generate resources (Cernea, 1985; Uphoff, 1986). Local groups constitute an important resource that can be mobilized for outreach, IEC, and resource generation in decentralized family planning programs. Linkages should be developed between existing groups that are involved in family planning (i.e., NGOs, women's groups, health practitioners, or local traders) and others that might become directly involved in broader aspects of population programs (i.e., social and athletic clubs, school organizations).

In Kenya, the government established a standing committee in each district to ensure the participation of women's groups in the decentralized program for rural development (Wanyande, 1987). Traditional healers in several states in Nigeria, and local traders in the city of Ibadan received training in primary health care and family planning methods (Tahzib, 1988; Lacey, 1988). These groups can be mobilized and others identified by program managers to extend the provision of family planning services in local government areas.

Many of these groups already exist and can be used to create an institutional base for decentralization. Local groups should be strengthened to build support for decentralization. Existing organizations, whatever their faults, persist because they meet the needs of the population and have credibility. It may take years for new structures to become effective and gain local credibility; and it is unlikely that a new organization could avoid the difficulties faced by existing organizations in the same environment (USAID, 1984).

4.11 Build Monitoring and Evaluation Systems

Monitoring and evaluation systems are essential to decentralized programs for tracking program performance and for identifying gaps in service delivery and underserved populations. Systems should allow for the collection and use of service statistics, census and survey data, as well as information from alternative data collection strategies.

While management information systems and evaluation strategies are needed at the national level to monitor program activities and the achievement of objectives and targets, systems are also needed at the local level to help communities assess program performance and alter program activities to meet changes in the demand for family planning. Local-level planners and managers must know what is going on in their area in order to manage resources effectively. They need access to timely, accurate information about the target audience they are supposed to serve. With decentralization, local-level sources of information are useful for planning activities, allocating and reallocating resources within a planning cycle, evaluating the effect of strategies, and tracking progress and achievement of objectives.

Information systems appropriate to local-level planning and decision making will look different from national-level management information systems (Reynolds, 1988; Korten, 1980). Information should be in easily recognizable formats, simple to collect, easy to interpret, and useful for making decisions and allocating resources. Information should be collected to track performance on locally-defined problems, priorities and activities. Successful programs focus on only a few key indicators (Satia, 1990). There is a tendency to base evaluations and formulate goals in terms that are more complicated than they need to be in local areas. At the village level, there is a need to interpret policies and indicators in ways that are understandable to local people. For example, presenting the health rationale for family planning is as valid as presenting the demographic rationale; however, the issues underlying national demographic targets often differ from the issues underlying targets or goals set by local communities. Box 9 suggests some minimum information needs for local areas.

Both general population data (which includes information on the size and characteristics of the local population) and family planning service statistics can be useful at the local level. Sources for such data include census data and administrative records, as well as surveys and service statistics maintained by government ministries of health, education, and agriculture. Local-level planners and program managers need training in how to gather and use such data.

Box 9. Minimum Information Needs for Local Areas

- Size and distribution of target population and subgroups
- Information on outcomes and impact of activities presented in understandable terms
- Information on social and economic determinants
- Complementary information from NGOs and the private sector

The Demographic and Health Surveys (DHS) and other population-based surveys are an important and rich source of information on family planning and health-related concerns. While conducted relatively infrequently, they provide information at both the national and subnational level. The sample sizes of recent surveys have been increased to produce reliable estimates at the province or regional level. In Indonesia, for example, provincial program managers are gaining the capability to prepare specific analyses of provincial level DHS data related to the priority policy issues in their province. There is some likelihood, however, that provincial estimates may mask considerable variation at lower levels of administration. Increasingly, program managers are interested in having estimates of demographic indicators at lower levels of administration in order to set targets, allocate resources, and monitor program performance. Sample size limitations do not allow the use of DHS data at lower levels of administration, unless the local area was included as one of the clusters in the sample. Even then, use of data at that level poses serious

problems of representativeness and of generalizability. Recently, however, promising new methods for calculating indirect estimates for demographic indicators for small areas from the DHS have been developed (Aliaga and Muhuri, 1994).

Considerable attention has recently been devoted to developing and adapting a number of alternative data collection strategies and analytical approaches applicable to local areas (see Bilborrow, 1993; Reynolds et al., 1988; Smith et al., 1988). The rationale is to collect more accurate information that is relevant to local policy priorities. Some data collection strategies recently developed include simple questionnaires, rapid assessment surveys, situation analysis, sentinel methods and focus group sessions. Training local data collectors and field supervisors to collect and use data facilitates local understanding of the value of the information collected. This leads to better information management and improved quality of the information.

5. PROBLEMS ASSOCIATED WITH DECENTRALIZATION

No matter how carefully planned the implementation strategy, problems will surely be encountered. Decentralization is a complex process, requiring considerable time to implement, commitment, resources, and coordination and communication among all levels of administration. This section examines some of the difficulties that may arise as decentralization is implemented and provides examples of some of the problems experienced in specific countries. Conyers (1985) divides the problems into three categories: design problems; implementation problems (associated with human and financial resources and infrastructure); and impact problems. The difficulties mentioned stress the need to plan for decentralization, learn from experiences through monitoring and evaluation, and constantly modify the approaches employed to suit changes in the social environment. Despite the variety of ways in which decentralization is implemented, many of the problems described below are common to all forms.

5.1 Design Problems

Problems with the overall design of the decentralization program occur in situations when local governments are created but given no powers or training for new responsibilities; when policies and legislation are enacted but not supported by corresponding changes in administrative procedures; or when decentralization is designed to bring power to the people but provides limited opportunity for participation. For example, in Bangladesh, the government devolution process was never really implemented according to the guidelines specified by the National Implementing Committee.

Most decentralization efforts are preceded by pilot testing in a few areas, or the process is phased-in in a few areas to allow problems to emerge and resolutions and adaptations to occur. The process takes time and trying to move ahead too quickly may derail efforts. In Kenya, the district population officer program was initially implemented in 14 pilot districts (out of 41) selected according to criteria related to population size and demand for family planning services. Five years after the initiation of the program, the program is being evaluated to determine its

effectiveness before a planned expansion to 17 additional districts is implemented. Problems also emerge when the design of pilot studies for decentralization does not take into account whether resources will be available to implement the reform on a national basis. In Thailand, the national program had insufficient resources to carry out the recommendations following the completion of a successful pilot project.

5.2 Implementation Problems

While the conceptual and operational aspects of decentralization are closely intertwined, most of the problems affecting decentralization arise during the process of implementation. Monitoring and evaluation throughout implementation are essential to determine the best ways of operating and to ensure that appropriate procedures are followed. A rapid appraisal was conducted at the early stages of devolution in the Philippines to identify areas of difficulty. As shown in Box 10, some of the problems identified pertained to issues of management, human resources and finance. Recommendations from this appraisal will be used to make adjustments to the decentralization process. Implementation problems generally concern people, money and organizational structures. Some of the issues associated with these areas are presented in the following sections.

5.2.1 Human Resources

The biggest human resource problem associated with decentralization is the shortage of sufficiently and appropriately trained personnel, which is especially severe at the local level (Konde-Lule, 1993; Smith, 1985; Rondinelli, 1981). Existing staff often lack the capacity to fully carry out their responsibilities subsequent to decentralization. New responsibilities associated with decentralization become a burden in areas that do not receive adequate staff and technical assistance. Personnel shortages make intersectoral coordination a necessity. Strengthening formal linkages with training institutions producing personnel is one way to address this issue (see Jitta, 1993).

Two additional issues are the transferring or seconding of national staff to local areas and the difficulty of filling technical positions in undesirable areas. National ministry staff may be threatened with transfer to lower positions in areas outside the capital or larger cities, where many amenities are absent and pay scales are lower. There are often extreme differentials in the distribution of trained personnel in many developing countries. In Uganda, for example, 76 percent of doctors, 80 percent of midwives, 72 percent of nurses and 64 percent of medical assistants employed by the government work in urban areas (Oryem-Ebanyat, 1993), although approximately 10 percent of the Ugandan population resides in urban areas. Health personnel are also sometimes unprepared to take instructions from nonhealth personnel or local officials. This is one of the conflicts that has occurred between medical officers in charge of clinics and family planning officers responsible for program management in Bangladesh (Sayeed, 1993, personal communication). A similar lack of coordination is evident in both the Philippines and the Kenya case studies presented in Part II of this document. Furthermore, the national ministry may be tempted to transfer the least qualified staff and keep the best staff for themselves. Conversely, staff may be promoted up the hierarchy from rural to central offices, continually draining decentralized levels of their best personnel.

Box 10. Illustrative Problems at the Early Stages of Devolution in the Philippines

Management and Organization Issues:

- Delayed preparation and dissemination of operational manuals to local governments
- Inadequate or incomplete guidelines from central offices of national agencies
- Poor quality of information from national agencies to local governments
- Reorganization of local governments based on devolved personnel rather than on perceived needs in local development
- Sectoral orientation of national agencies less relevant than areal orientation of local governments

Personnel and Human Resource Administration Issues:

- Confusion over guidelines concerning devolved staff
- Fears and apprehensions of personnel affected by the Local Government Code not being adequately addressed

Finance Issues:

- Perception that resource allocation would be reduced
- Inadequate or conflicting information about the amount of money
- Limited resource generation capacity at the local level

Policy Issues:

- Ambitious deadlines unrealistically rushing the decentralization process
- Uncoordinated timing of national agencies' submissions to local governments
- Absence of adequate overview on all dimensions of the Code because of emphasis on personnel devolution

Operational Issues:

- Lack of central coordination and orchestration of the process
- Unavailability of copies of the Code and the implementing rules and regulations
- Reiteration of the Code in information campaigns rather than clarification of confusing sections
- Need for guidelines on key aspects of the Code

Source: Associates in Rural Development, 1992

Replacing persons who are not well-suited to their posts may be difficult. If an ineffective person holds a newly created post in the decentralized program, the necessity of the post may be questioned rather than the appropriateness of the person executing the responsibilities of the position. In Kenya, the second group of district population officers (DPOs) were selected from the ranks of the parent organization (NCPD), rather than independently recruited due to a shortage of qualified personnel. Although technically competent in many domains, some lacked appropriate interpersonal skills to be effective in the role of DPO. Nonetheless, an early evaluation of the program called into question the position itself rather than the effectiveness of the staff in those positions (Larsen, 1991).

5.2.2 Financial Resources

Revenue generation is a key element of decentralization, but it is also one of the most difficult to implement. It is very hard for central governments to transfer authority for allocating resources to the local government. As a result, there is tight central control over resources, and local governments remain financially dependent. Often, money comes to local governments in the form of transfer payments, grants and subsidies. Local governments and organizations need the authority to plan and money to implement those plans in accordance with the needs of the local population. When funds are transferred to local areas, conflict is likely to arise over the amount of resources transferred: local governments will want more, national agencies will want to keep more.

In some cases, when central governments failed to provide the necessary financial resources to local governments, the quality of services actually deteriorated following decentralization. Local areas must be able to spend money allocated to them in a timely fashion. Sometimes when funds are channeled through a central ministry, it takes a long time before the local areas have access to them. Decentralization should streamline bureaucratic procedures and minimize the number of signatures required to obtain funds or supplies. Too many "coordinators" at intermediate levels is frequently the cause of bottlenecks in disbursement.

With devolution, however, local governments also have the capability to generate revenues by imposing taxes and levies, and implementing cost recovery procedures or user fees, etc. Safeguards must be built into the local financial management systems to ensure that the central government does not take away money when a locality has been successful in generating its own funds. Revenue generation is very difficult to implement in local government, in part because citizens in many countries are accustomed to thinking that government will or ought to provide the resources. It takes time to reorient such perceptions and then to generate a sufficient resource base to sever ties with the central government. Even then, transfer payments from the national to the local level may be required to maintain a degree of financial equity among local areas. Otherwise, poor districts may fail to provide adequate services or to recruit, pay and maintain competent workers.

Money is often the root cause for many of the difficulties associated with decentralization. Depending on the control procedures implemented, decentralization can facilitate corruption of

local officials or tighten standards of accountability. Accountability standards will be required both for the central government and for donor organizations.

5.2.3 Infrastructure

Setting up or extending a system of field administration or finding extra space for local government functions—such as the health committee, the district population office or the family planning manager's office—can pose great difficulties in countries where there is little existing infrastructure below the national level. The lack of facilities and support capabilities—including transportation, communications or office equipment—makes coordination among organizations and communication with the central level difficult. It also poses difficulties for local administration in mobilizing resources, supervising and delivering services and disseminating information to its target population. Supporting infrastructure development for decentralization also requires a source of funds. Another significant infrastructural problem lies in lack of planning for recurrent costs (maintenance and upkeep), which can in turn erode sustainability.

5.3 Impact Problems

Mounting evidence based on historical experience and evaluation procedures indicates that decentralization has not always achieved its stated objectives. A quick review of some of the objectives will show that the decentralization process may encounter problems resulting from failing to increase participation by empowering a local elite that inhibits community involvement; increasing inequalities as a result of differential resource generation capabilities (see Gonzalez-Block et al., 1989); or having insufficient time to work. Experience has shown that it is difficult to separate the effects of decentralization from those of other policies or events (Conyers, 1990).

In many countries, powers have been decentralized to the wrong people, either to the central government or political appointees or local elites (Wunsch and Olowu, 1990). Smith (1985) argues that the participatory quality of decentralized institutions is prone to erosion from above. There is a tendency to replace elected bodies with decision makers nominated from the center. This occurred in Bangladesh with the replacement of the popularly-elected Upazila chairman with a centrally-appointed Thana Nirbahi Officer. Local citizens have little chance to participate in or benefit from decentralization in such situations. Power, authority and often resources stay with the top leadership.

Often decentralization programs lack sufficient time to work. Due to concern over such matters as implementation problems, lack of political commitment, impatience for change, or the short terms of office for locally elected officials, the process requires ongoing adaptation and flexibility to respond to problems as they occur. This often involves a deep-seated change in attitudes and outlooks about ways of doing business. Major organizational change of any type takes time. Mistakes will be made along the way and a long period of organizational learning will ensue. Personnel must learn to perform new duties, play different roles and follow revised procedures.

The role of stability in political and organizational leadership cannot be understated, although it can have varying impacts. A change in political leadership can be the impetus for government restructuring in the form of decentralization, as in the Philippines or Uganda. In Uganda, the newly-elected National Resistance Movement Administration set into motion the process of decentralization in 1986 and created popularly-elected resistance councils and committees as the institutional structures for implementing a system of local governance (Lubanga, 1993; see also *Museveni Launches Decentralization*, 1992). New political leadership in Bangladesh changed the organization of local government and, as a result, the potential impact of its devolution policy. Yet, political commitment and long-term stability may not be sufficient conditions for decentralization. In Tanzania, even with strong commitment and leadership from Nyerere in defining the process, decentralization never really got off the ground in the early 1970s, despite efforts to redesign the process along the way. Perhaps the program was just too ambitious, or external events (such as deteriorating economic conditions or the war with Uganda) placed too great a burden on the system. With relatively new political leadership in Tanzania and the designation of a special unit responsible for coordinating family planning activities, the Ministry of Health is now reconsidering ways to decentralize its maternal/child health and family planning program. The extent and degree of decentralization that will be implemented remain to be seen.

6. DONOR ROLE IN SUPPORT OF DECENTRALIZATION

Decentralization is a massive undertaking that often involves rethinking the service delivery system and taking into consideration new jurisdictional, legal, personnel and funding lines of authority. The decision to decentralize is one that a country must make on its own. However, donors can play an important catalytic role in this decision. Through policy dialogue and analysis, donors can help assess the advantages and disadvantages of decentralization for a particular country, and provide a vision of what decentralization would "look like," bringing to bear collective national and international experience with the process. Donors also have an obligation to make judgements about the viability of the approach selected and help analyze the implications of the decision with host governments (Landell-Mills and Serageldin, 1991). Ultimately, however, the country itself must decide on its organizational and political structures. With less extensive forms of decentralization, such as deconcentration, donors may play a more active role in how the organization will be restructured and contribute to the design and planning of the decentralized system of management.

Once a country makes the decision to decentralize, there are many ways in which donors can assist with the process. First and foremost is to provide funds in support of various aspects of the decentralization process. Other strategies for assistance might include technical assistance to strengthen commitment to decentralization and family planning at the local level, to implement programs of decentralization, and to build capacities at all levels for planning, budgeting and monitoring decentralized programs. In addition, donor support for policy analysis and information dissemination activities should not be overlooked.

6.1 Donor Funding for Decentralization

The administrative structure of most donor organizations is designed to deal with government ministries rather than individual local governments. With deconcentration, this relationship would not change as the central ministry would receive funds and then make allocations to subnational units, using a variety of mechanisms (centrally-determined budgets, block grants, etc.). With devolution, instead of dealing with a single government, donors might have to deal with many autonomous local units. If there is no longer one ministry through which funds flow, how will funds be disbursed to a large number of local governments or subnational autonomous entities? It is necessary to establish a funding mechanism by which local areas can receive funds since the central government will no longer be responsible for providing services. Financial accountability is another issue. Donors may have to work both with the local government units where funds are being used and with the central government and keep track of who is responsible for what.

Various mechanisms are available for providing funds to local areas: through nonproject and project assistance and through NGOs and other private organizations. With nonproject assistance, it may be possible to give money directly to local governments in return for meeting certain criteria of the donor. For example, assistance might be linked to the contribution of matching funds for family planning, the appointment of a specific officer in charge of population activities, or making staff available for specific types of training. To be sustained, however, the actions required must be agreed upon willingly and backed up with strong commitment on the part of the government. Steps should be taken to institutionalize these systems of support to ensure that the programs or activities continue once external funds are expended. In Nicaragua, external funds were channeled directly to the local level, reducing the bureaucratic delays usually incurred at the central level. Direct access to donor support stimulated health directors to develop projects and work with donors to negotiate resources and develop creative strategies for resolving problems (Crone-Coburn et al., 1992).

Another mechanism for providing funds to local areas and ensuring that money is spent for family planning is to channel funds through NGOs or other private organizations because of their (often) more flexible funding arrangements. Following devolution in the Philippines, there was no mechanism for providing funds to the Department of Health that would ensure the money would be used to support training of local family planning service providers. Money had to be allocated to NGOs, which funded the clinical training of family planning personnel. Recently, however, the Department of Health has established a separate bank account administered by an external contractor. Now the department and the contractor review proposals from local government units and use account funds for approved activities.

Donors can also fund pilot or demonstration projects. At the initial stages of decentralization, for example, donors have funded pilot projects to demonstrate the feasibility of an approach or test alternative strategies for working with local government areas. In Thailand, a pilot study of decentralized management of the family planning program demonstrated the feasibility of the approach. In the Philippines, USAID is funding a pilot project to develop and test alternative models of technical assistance and program implementation over the short term, which can then

be applied nationwide over the long term. An essential component of pilot projects of this type is to provide on-the-job training and develop capacity so that the persons trained can provide technical assistance to other local units in the future, thereby contributing to long-term sustainability. After the completion of the pilot project using donor funds, the decision may be made to implement decentralization nationwide using country resources.

Decentralization may also be phased-in gradually, beginning with just a few areas, to allow greater concentrations of funding to be devoted to a few areas. This allows donors to limit funding, test and refine strategies, and set up systems of accountability. As problems arise and are resolved, the experience gained can be applied in other areas until decentralization is implemented nationwide. In this context, it is also important to fund comparative research about the results of approaches adopted by different areas or units within the country and to understand what works best under different sets of conditions.

6.1.1 Potential Problems and Issues

Despite its inherent advantages, using donor funds to get things started has several potential disadvantages, too. Project funding is often more generous and flexible than national program funds. Project momentum may be difficult to sustain when scaling up to the national level. Donor requirements for implementing a project, such as requiring a line item for family planning in the budget, may not transfer when the government takes over funding for the program. Even in well-funded programs, such as Thailand, countries may not have the resources to extend activities begun under a donor-funded pilot project. Staffing patterns also may be difficult to replicate. Often donors select the best people and raise their salaries for the life of a project. The government is unable to continue this practice and subsequently loses highly qualified and trained personnel to other projects. Finally, pilot success may be difficult to generalize, depending on the ingredients for success. Sometimes the areas selected for initial phase-in are those in which decentralization is most likely to succeed. They may have better existing infrastructure, more skilled personnel, a dynamic local leader, a tradition of community involvement, etc.

In disbursing funds to local areas, there are several additional issues to bear in mind. With the large number of local entities in need of funds, there is the potential for inequalities in the distribution of funds. Some areas may be easier to access physically or may be more attractive to the donor by reason of some special priority or ease of access for monitoring the allocation. Also, local politicians in some areas may be more adept in developing proposals for funding and receive disproportionate amounts of funds. Some areas may have access to greater local resources due to such factors as a larger tax base, more experienced personnel or other factors, and therefore, may be able to perform their functions more successfully than those with less revenue. Donors need to develop procedures and mechanisms that ensure equity in fund disbursement.

There is also a need to develop standard and agreed upon procedures for providing support to local governments and for developing schemes of accountability that can be easily followed.

Local governments also need to account for and report funding from all external sources so that mechanisms for reducing inequities may be implemented based on an accurate determination of all funds available to the local area. Local entities have fewer institutionalized mechanisms in place to handle complex and overly bureaucratic financial reporting requirements. On the other hand, channeling money through the central government is not always easy. A ministry often imposes strict rules on expenditure transactions, resulting in delays in getting money to subnational units.³ Local managers are unable to reallocate funds and project interventions are often delayed. It is important to streamline bureaucratic procedures and minimize the number of signatures required to ensure funds flow to the localities where they are needed in a timely fashion.

6.1.2 Donor Coordination

Given the increase in the number of geographic units receiving donor funds, the need for increased coordination among donor organizations should be emphasized. Donor coordination is necessary to reduce geographic disparities as a result of funding preferences or inequity. In very large countries, donors may question whether there is a need for some degree of geographic decentralization of donor offices, at least to the regional level, to better monitor program activities. In any event, the need for donor coordination is critical. However, donors often perceive "coordination" to mean "control" and may be reluctant to fully cooperate.

Since providing funds to local government units is a relatively new phenomenon for USAID, consideration should be given to holding a workshop for donors to exchange information and insights on mechanisms that have been developed to fund decentralized programs. What experience has been gained working with local governments and funding decentralization activities? Project funds have been used in the past to fund some aspects of experimental rural development projects (Rondinelli, 1983b), but little information exists on applications to population and family planning programs, except through a limited number of pilot projects. Donors are experimenting with approaches to providing funds directly to local governments in the Philippines, Uganda, and Nicaragua. Several donors will have relevant experience to report.

6.2 Donor Assistance Strategies

In addition to supplementary financial resources, donor assistance must be tailored to support the process of decentralization. Considering the enormity of the political, organizational, financial and administrative change that is taking place, it will be important to leverage assistance to make the greatest impact given the number of subnational units involved. For technical assistance, it will be important to continue working with national staff to help them define and adapt to new roles and responsibilities, develop implementation guidelines, conduct assessments and monitor

³ The difficulty of moving funds through a central ministry is often a rationale used for delegating authority to a parastatal or other nonministerial organization for the conduct of specified activities.

progress, including the development of national data bases that can be used by program planners at regional, district and subdistrict levels. It will also be important to identify local or national/regional consulting organizations to carry out technical assistance, monitoring and supervision functions. A resident advisor might be placed in headquarters to help broker the process. Donors could also fund pilot or demonstration projects to test alternative mechanisms for providing technical assistance.

For training, approaches that leverage investments include training of trainers; conducting national or regional workshops to train district personnel; and developing training materials that can be used across subunits. Policy analysis plays an important role in decentralized program implementation with its strategic focus on systems and niches of actors within them. It contributes to an understanding of decentralization initiatives by bringing to bear national and international experience with decentralization, and by assessing the legal and regulatory framework required, center versus peripheral roles, and the roles of stakeholders and donors. Given the recent and limited experience in the decentralization of family planning programs, information dissemination is an effective strategy for providing assistance to countries undergoing decentralization. Donor supported activities might include: communicating results of policy analysis, conducting observational study tours to other countries, convening information exchange workshops, or developing prototype manuals on issues applicable across subunits. Some of the ways in which donors can provide assistance are summarized in Box 11 and described in more detail below.⁴

6.2.1 Technical Assistance

Provide Assistance for Strategic Planning

Decentralization is best achieved with strategic planning. Implementation of decentralization must reflect strategic decisions that maximize resources and expand access to services in all geographic areas. Most governments do not have the resources or capacity to engage in appropriate strategic planning for decentralization. Strategic planning for decentralization involves funding studies to estimate the demand for family planning services; designating the providers, financial resources and types of services needed to meet the demand in the public, NGO and commercial sectors; and identifying potential sources for financing. It might also involve providing assistance to develop an implementation plan for decentralization which specifies objectives, timeframes, entities and resources needed to accomplish those objectives. Workshops can be conducted to assist local program managers to develop targets for methods and sources of services so that they can set realistic and achievable goals. At the national level, there must be a mechanism to reconcile local-level goals with national goals.

⁴ To a large extent, these assistance strategies are also relevant to the support of centralized family planning programs.

Box 11. Strategies for Donor Assistance

Technical Assistance:

- Provide assistance for strategic planning
- Support advocacy and consensus-building activities
- Assist with the development of subnational MIS
- Strengthen physical infrastructure of local organizations and service sites
- Devise mechanism for improved commodities logistics
- Support monitoring and evaluation activities

Training:

- Strengthen technical, management and planning capabilities
- Develop skills for data collection, analysis and use

Policy Analysis and Research:

- Conduct needs assessments
- Analyze and rationalize roles and responsibilities of each level
- Conduct legal and regulatory assessment
- Support research

Information Dissemination:

- Fund observational travel and workshops
- Develop case studies and manuals
- Assist with the development of locally-relevant IEC materials

Support Advocacy and Consensus-building Activities

There is a need to strengthen national political commitment for family planning and central government support for decentralization. At the local level, population/health offices need to work with local political leadership and community groups to gain support for programs and develop ways to work together to further the goals of the program. In a decentralized program, advocacy and consensus building are more difficult and expensive because more people at multiple levels are involved. At the local level, family planning competes with other activities for scarce resources and it may not be a priority concern.

Develop Subnational Management Information System

Local-level program managers need to have a simple yet effective system for storing and retrieving information relevant to the family planning program in their area. This capability will facilitate informed decisions about program direction and resource allocation. Assistance is often required in determining the informational content; entering and retrieving information in appropriate formats for decision makers; and using the information to determine program direction, monitor progress and allocate or reallocate resources based on performance. Donors may need to provide computers, software and training in setting up a management information system relevant to local needs.

Strengthen Physical Infrastructure of Local Organizations and Service Delivery Sites

As programs expand and the need for decentralized program management increases, there is a need for physical facilities such as office space and buildings from which the activities can be carried out. In addition, the cost of equipment, supplies, computers and vehicles may be out of initial reach to local offices. Donors may be able to provide some funds for institution building in a few areas as the program is phased in. Local program managers may be aware of a few small items that can make a big difference in improving service delivery. Having small amounts of discretionary funds in the hands of local program managers can often make a big difference. This also circumvents the need for central procurement and approval.

Devise Mechanism for Improved Commodities Logistics

The allocation of family planning commodities to local service providers is a potentially weak link in a decentralized program. Local facilities need a steady supply source, which requires careful planning and monitoring. Logistics databases may need to be revised to ensure that local program managers are receiving and distributing supplies in a timely fashion. Decentralized warehousing of commodities may be another option to bring supplies closer to delivery points. Streamlining procurement procedures is essential for ensuring that supplies are where they are needed. Over the long run in devolved programs, local governments might negotiate directly with suppliers to procure their own contraceptive commodities. On the other hand, central governments may decide to retain the responsibility for commodities logistics to ensure supply and to gain the advantages of bulk buying.

Support Monitoring and Evaluation Activities

Monitoring and evaluation are vital skills in a decentralized program setting. It will be important to collect and use information at the local level for planning, improving resource allocation and measuring progress. In countries where district or locally-elected government officials approve and provide budgets for development sectors, local health and family planning staff will also need to use monitoring and evaluation findings to account for past expenditures and advocate for new budgets. Finally, indicators for measuring progress and assessing impact will need to be developed for measuring the success and cost-effectiveness of decentralized program planning.

6.2.2 Training

Capacity building is an important component in all program expansion efforts. Empowering local communities to decide on matters that affect them and to take on responsibilities for service provision is important, but this effort will fail to ensure better programs if the persons running those programs are incompetent (Landell-Mills and Serageldin, 1991). The need for training is always an important component of population programs as personnel change, as new procedures and contraceptives are introduced, and as administrative and organizational changes occur. In Africa, training and capacity building are especially important because there is a deficit of highly trained persons.

As local areas assume more responsibility for staffing local offices, they will be increasingly responsible for recruiting, hiring and firing their own personnel. If there is a problem in filling posts in some rural areas, persons who live in the area should get priority status in selection and training. Incentive systems of some type may be needed to attract qualified personnel to less desirable areas. There is a need to develop a personnel management information system to keep track of positions in subnational offices, the characteristics of the current occupants of those positions, and the number of positions that need to be filled. This information can be used to ensure that employees are matched to suitable jobs and to identify training needs.

Strengthen Technical, Management and Planning Capabilities

Training is needed at all levels of government, not only for program planners and managers, but also for local officials, service providers and population officers. Mechanisms for training include on-the-job training, local and regional workshops, international training and training of trainers. At the central level, training is one tactic for providing information about decentralization and the new roles and responsibilities for officials. Staff also need new skills in planning, budgeting, supervision and monitoring. At the local level, training materials and courses are needed to develop skills in data collection and analysis, target setting, advocacy, strategic planning, budgeting, management, setting up local-level MIS systems, monitoring and evaluation, coordinating and monitoring activities of NGOs and private commercial sector providers. Local officials, too, will need information about decentralization and accountability standards and guidelines for working with donors.

Develop Skills for Data Collection, Analysis and Use

Local program managers need data to assess the current situation in their area, plan program activities, monitor interventions and reallocate resources as needed to ensure desired outcomes. In many instances, the skills needed to collect information, assess the quality and utility of the information collected, and analyze, present and use it in ways that inform decision making are absent. Considerable attention should be focused on improving the skills needed to obtain and use appropriate information for local-level planning.

Some topics for potential training workshops are: sources of data, general demographic concepts and techniques; simple methods of data analysis and presentation; collection and analysis of information relevant to the local level (using local-level census data and maps for planning, using DHS data, developing a simple system of recording births at the lowest administrative level, rapid appraisal methodology, eligible couple mapping, target setting, etc.); and integration of population, health and family planning information with other sectoral information.

6.2.3 Policy Analysis and Research

Conduct Needs Assessments

One of the reasons decentralization is so promising is that it provides the opportunity to shape local programs to local needs. Each local program will vary depending on the pattern of consumer characteristics and needs and the provider network. Program managers need assistance in analyzing demand (fertility preferences, knowledge and use of contraception); assembling supply data (perhaps by mapping public and private sector service points); and making strategic decisions based on what is optimal for the area. The needs assessment will determine the status of family planning in each subnational unit based on data pertaining to supply and demand. It can also specify the technical assistance needs, training needs, equipment, etc., and serve as a basis for developing a work plan to carry out activities. This information is often included as part of a strategic planning exercise.

Analyze and Rationalize Roles and Responsibilities of Each Level

Donors could provide assistance in the design and organization of decentralized programs and procedures. It is necessary to analyze the current situation in country and understand the current approach and problems the program faces. As mentioned earlier, the interests of the stakeholders in the process should be considered at every stage. Donors could work with local counterparts to design procedures for allocating specific functions among the levels of government, make clear the relationships among different units, and design planning and monitoring procedures suited to the existing administrative skills of local officials. In Senegal, USAID is funding a health planner to work with the newly formed Decentralization Committee. This person is reviewing and defining membership and appropriate responsibilities for the committee, focusing on the integration of MCH/FP activities into the overall health plans of regions.

In the Philippines, Kenya and Uganda, for example, assistance has been provided to define or clarify the roles of population/health offices and officers. In the Philippines, the roles of the population officer and the health officer in each of the local government units needs to be clearly spelled out and agreed upon by all parties. The role varies from area to area depending on how the service program is implemented. Donors can serve as the neutral third party to bring persons together to collaboratively specify logical and appropriate roles for each officer. To date, confounding factors of status, funding from the Department of Health versus the Population Commission and historical animosity between organizations have prevented this from taking place.

Conduct a Legal and Regulatory Assessment

Donors can sponsor reviews of the laws, codes, regulations and directives that specify the types of services and methods that can be provided in different locations and by different providers. With devolution, local government units take responsibility for provision of health and family planning services. National laws and standards, however well-intentioned, may have adverse consequences when autonomous local government units have authority for providing family planning services. Laws governing who can provide which services in what settings need to be reviewed to ensure that regulations would not inhibit service expansion in areas where facilities and providers are not readily available. A review may also include financing mechanisms that are available locally. It is necessary to provide national guidelines, while allowing units some degree of flexibility to determine the right set of rules for their situations. For example, state laws in Nigeria prohibit nurses and midwives from establishing maternity and family planning homes without physician supervision. In areas where there are no doctors, this regulation might be relaxed to ensure access to services that otherwise would be unavailable (Lacey and Torrey, 1993). Donors can also assist local counterparts to develop strategies to change regulations that impede service delivery in local areas affected by decentralization.

Support Research

Research is needed to support the decentralization process. Research programs receiving support should focus on capacity building for population-based, action-oriented research; rank topics in order of priority to meet the national agenda and fill gaps in data; and incorporate qualitative, quantitative and participatory research with communities. It will also be important to fund comparative research about the results of approaches adopted by different areas or units within the country to understand what works best under different sets of conditions.

6.2.4 Information Dissemination

Fund Observational Travel and Information Exchange Workshops

It may be worthwhile for donors to fund observational travel so that central and subnational decision makers can visit countries where decentralization is already underway. Providing support to convene national or cross-national workshops creates a forum for presenting basic issues associated with decentralization and allows participants to exchange information on implementation strategies and lessons learned.

Develop Case Studies and Manuals

Donors can provide funding for the development of case studies representing international experience with different forms of decentralization for presentation to host country counterparts. Developing procedural manuals and guidelines that are relevant and can be disseminated across subunits is another useful strategy for assistance.

Assist with the Development of Locally-relevant IEC Materials

Assistance also could be provided for the development of local-level advocacy and IEC materials that could be used to build consensus among officials and local leaders and to inform the population about the benefits of family planning and the types of services that are available. Assistance might be needed in using available data, targeting materials to particular language or ethnic groups and funding workshops to disseminate the materials to relevant audiences. Paying for printing costs often ensures that materials actually get produced.

7. CONCLUSION

Decentralization is a recent phenomenon, especially as applied to population and family planning programs. However, considerable experience is building, and a number of countries are undertaking organizational reforms leading to decentralization. Countries have different characteristics that affect the form and pattern of decentralization. Four approaches to decentralization were identified: deconcentration, devolution, delegation, and privatization. Both deconcentration and devolution have territorial dimensions, while delegation and privatization have a functional basis. It is important to bear in mind that several forms of decentralization may be implemented concurrently within a country.

"Decentralization is more an art than a science" (Montgomery, 1983). There is no one best way to approach decentralization. The solution is to develop optimal relationships between the center and subnational units within the context of each country's cultural and political history and its bureaucratic organization. It is difficult to generalize from experience and provide "how to" advice, especially across the various national settings involved.

Decentralization may be inappropriate for some countries. Decentralization requires a demanding set of conditions which are not often present as past experience shows. When a country considers pursuing decentralization, it is important to carefully assess the advantages and disadvantages of decentralization and to reach an understanding of what decentralization can and cannot do. Other countries' experiences with decentralization can be instructive in this regard.

While it is not possible to recommend how decentralization should be implemented in any given country, certain factors emerge as being especially important. These include: sustained political commitment at all levels; clearly written and widely disseminated guidelines; presence of administrative structures for planning, budgeting, staffing and monitoring; availability of appropriate infrastructure; and a good local-level information system. Conditions do not have to be ideal for decentralization to occur, but decentralization will fail without skilled professionals, adequate financial resources and appropriate infrastructure.

Problems often arise as implementation occurs. Due to concern over such matters as implementation problems, lack of political commitment, impatience for change, or the short terms of office for locally elected officials, the process requires ongoing adaptation and flexibility to respond to problems as they occur. The difficulties underscore the need to plan for

decentralization, learn from experience through monitoring and evaluation, and adapt to changes in the social environment.

Decentralization is a lengthy process that may take 10-20 years to implement. It often involves a deep-seated change in attitudes and outlooks about ways of doing business. Personnel must learn to perform new duties, play different roles and follow revised procedures. Mistakes will be made along the way and a long period of organizational learning will ensue. Major organizational change of any type takes time.

Once a country makes the decision to decentralize, there are many ways in which donors can assist with the process. First and foremost is to provide funds in support of various aspects of the decentralization process. Careful thought needs to be devoted to defining what is an optimal role for donors and how to promote future sustainability of the initiative. Given the enormity of the political, organizational, financial and administrative change that is taking place, it will be important leverage assistance to make the greatest impact given the number of subnational units involved. Clearly, donors will continue to play important roles as facilitators, supporters and conduits for technical assistance. Strategies for assistance might include technical assistance to strengthen commitment to decentralization and family planning at the local level, to implement programs of decentralization, and to build capacities at all levels for planning, budgeting and monitoring decentralized programs. In addition, donor support for policy analysis and information dissemination activities should not be overlooked.

Decentralization is not a panacea for development or for the expansion of population and family planning programs. It is a strategy that may, under the right circumstances, with proper resources and conditions, lead to a number of desirable outcomes, including the attainment of such broad goals as managerial efficiency, democratization, strengthened popular support for government through the extension of participatory decision-making or programmatic sustainability. In the realm of population and family planning programs, decentralization offers great promise for expanding the coverage of family planning services by enabling program managers to make best use of service partners, resources and personnel.

Part II of this report examines more closely the status of decentralization of population and family planning programs in a number of countries. The case studies highlight recent experience with decentralization and illustrate how far there is to go before realizing the benefits of complete program decentralization.

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**DECENTRALIZATION OF POPULATION AND FAMILY PLANNING
PROGRAMS: WORLDWIDE EXPERIENCE**

Part II. Country Case Studies

by

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DECENTRALIZATION OF POPULATION AND FAMILY PLANNING PROGRAMS: WORLDWIDE EXPERIENCE

Part II. Country Case Studies

1. OVERVIEW

The review of advantages, strategies for implementation, and problems associated with decentralization in Part I illustrates the complex nature of the process. Part II of this report examines many of the issues discussed in a country-specific context. The bulk of Part II focuses on the recent experience of five countries in the decentralization of their population and/or family planning programs. Case studies are included for the Philippines, Nigeria, Bangladesh, Thailand and Kenya. A synopsis of other countries' experience follows. A series of tables compare the demographic characteristics, organization of population and family planning programs, and forms of decentralization for a number of countries in Anglophone Africa and Asia.

The countries selected for detailed case studies represent a range of experiences, in terms of population size, levels of contraceptive prevalence, and stages of family planning program development. For example, Nigeria is a very large country, with low levels of contraceptive prevalence, and half of services provided by the private commercial sector. Thailand has very high prevalence with the vast majority of services provided by the government, and with little external assistance from donors at the current time. The case studies also represent different administrative structures, types of government and forms of decentralization. Experiences range from governmentwide devolution of service provision in the Philippines to the installation of field personnel to coordinate population and family planning activities in districts in Kenya (deconcentration).

The case studies highlight the recent experience with decentralization in population and family planning programs. They also highlight the importance of using donor resources to get programs off the ground. Most of the case studies describe donor-funded pilot projects used to test implementation strategies in a limited number of areas. One problem with this approach is that the selected pilot or phased-in areas are often ones in which the conditions are most favorable for success or were chosen for other special reasons, which makes it difficult to generalize from their experience. Secondly, project funds are generally more generous and flexible for covering all sorts of contingencies. It will be hard to generalize results once donor resources are gone and countries continue to extend decentralization to other areas. It will nonetheless be important to set up carefully planned evaluation studies to monitor the results from pilot studies in order to further our understanding of what works under what circumstances.

Decentralization takes time. Considerable central control is evident in most of the case study countries due in part to the recency of experience and also as a result of the forms of decentralization employed. It will take time for organizational change to occur, and for behaviors

of persons in organizations to change. The full ramifications of what decentralization has to offer when carried out to its logical conclusion have not yet become clear. It will be important to reexamine the situation in many of the countries considered in this paper at a later date.

The case studies also show that decentralization has been proceeding in an ad hoc fashion, with little evidence of the transfer of experience between countries. This may be due to the recency of experience, but is also the result of a lack of dissemination of relevant information across countries. Many of the documents upon which this report is based are project documents, evaluation reports or ministerial publications that are not widely circulated outside the country. It is hoped that this paper will help to address the lack of information on the decentralization of population and family planning programs by making apparent the different issues associated with decentralization, its inherent problems and potential benefits, and by describing the recent experience of a number of countries.

2. CASE STUDY COUNTRY SUMMARIES

Most of the country experience included in this document pertains to territorial forms of decentralization—deconcentration and devolution—in which the central government transfers authority from national to subnational units. In instances where delegation to a parastatal organization occurs, as in Nigeria or Zimbabwe, it is typically accompanied by some degree of geographic deconcentration.

- The Philippines presents an example of nationwide devolution to local government units, beginning with the passage of the Local Government Code in 1991. In the Philippines, the Department of Health is the lead government agency for family planning coordination and service delivery, while the Population Commission plays an important role in advocacy, education and population-based planning. The case study focuses on program implementation in the early stages of devolution and presents some of the difficulties encountered along the way.
- In Nigeria, power was devolved to local government areas (LGAs) through the 1976 Local Government Reform. However, it was not until 1989 that LGAs were given mandatory responsibilities for the provision of primary health care, under which family planning falls as a component of maternal and child health. The government family planning program is nascent with overall prevalence at 6 percent and the government providing less than 40 percent of services.
- The Bangladesh case study focuses on the ongoing efforts of a USAID-funded project to operationalize the government's devolution policy in the context of the family planning program by building management capacity at lower levels of administration. Despite a deconcentrated program structure and field management staff, most programmatic decision making remains highly centralized.

- The national family planning program in Thailand is the sole responsibility of the Family Health Directorate (FHD) of the Ministry of Public Health in Thailand. FHD provides a classical example of administrative deconcentration, including its recent attempts to provide provincial program managers with increased autonomy and a greater role in planning and budgeting.
- Finally, the Kenya case study focuses on the deconcentration of its population and family planning coordination body, the National Council for Population and Development through the District Population Officer Program begun in 1986. This experience parallels the decentralization of rural development which began with the creation of District Development Committees in 1983.

3. PHILIPPINES: DEVOLUTION OF THE NATIONAL FAMILY PLANNING PROGRAM

3.1 Background

The Philippines has an estimated population of approximately 68.7 million people with an annual growth rate of about 2.5 percent per year between 1980 and 1990. The 1993 Demographic and Health Survey showed a contraceptive prevalence rate of 40 percent, including 25 percent for modern methods. The total fertility rate is estimated at 4.1 compared to 5.0 in 1983 and 5.9 in 1973.

The Philippine population program has had mixed success. As early as the late 1960s, the Government of the Philippines made strong policy statements and began implementing a national family planning program. In 1969, a Population Commission (POPCOM) was formed by President Marcos and given the authority to plan and coordinate population activities. As the program started up and expanded, it enjoyed high status as one of Mrs. Marcos's favored projects.

Even with the strong political support of the government, problems were apparent early. In the mid-1970s, studies showed that the primarily clinic-based program was not reaching the rural population. In response, POPCOM initiated an outreach project that was designed to reach persons who were not receiving services through the clinics. The project used volunteers, known as Barangay Service Point Officers (BSPOs) to perform outreach activities including condom supply, resupply of pills, and clinic referrals. By 1980, more than 52,000 BSPOs were recruited and active throughout the country. The BSPOs were supervised by full-time outreach workers (FTOWs), who in turn reported to provincial, city, or municipal population offices that had also been established throughout the country. When the outreach project was first developed, POPCOM envisioned that it would initially fund the local population offices, and that eventually local governments would begin to pick up the costs. During the late 1970s, the Philippines had a strong population program and the potential for success seemed tremendous.

There were many problems with the outreach project, however, which were primarily administrative and political in nature. For one thing, the BSPOs were perceived as competing

with the local health workers who were also providing family planning outreach services. More importantly, the BSPOs lacked adequate technical training, which resulted in misinformation being passed on to users (or potential users). In the mid-1980s, the Marcos government began to lose interest in sustaining its population program, which began a long downhill slide.

The decline of the population program continued with the election of President Cory Aquino. President Aquino was elected with the support of the Catholic Church and thus was initially unable to support the population program. Moreover, POPCOM was first attached to the Department of Social Welfare and Development (DSWD), whose Secretary's opposition to the population program made it almost impossible for POPCOM to remain active. Finally, in 1988, the POPCOM board designated the Department of Health (DOH) as the lead government agency for family planning coordination and service delivery while POPCOM became the lead agency for population and development activities among government and nongovernmental organizations. Over the past five years, DOH has been rebuilding the program.

The history of the program is relevant to the issue of devolution, because nearly all of the local government units (LGUs), in spite of little support from the central government, have indeed picked up the costs of the population offices from POPCOM. In 1992, 89 percent of the original provincial population offices (PPOs) and 70 percent of the city population offices (CPOs) were still in existence, funded by the local government units. It is through these structures that most observers believe that devolution of the family planning program can succeed.

3.2 Rationale

The rationale behind the decentralization of government services in the Philippines is, as President Cory Aquino has stated, the institutionalization of democracy at the local level. The Local Government Code (LGC) allows each local government unit to grow in the direction it has determined for itself and in accordance with its own capabilities. Local government officials themselves believe that local problems are best solved by local people, and the LGC empowers local governments to develop their own priorities and address their own problems as they see fit. The LGC transfers responsibility, authority, decision-making powers and funds to local government units—provinces, cities, municipalities and barangays.

3.3 Timing of Decentralization Effort

The Local Government Code of the Philippines was several years in the making. It was signed into law in October 1991, followed by a transition period of six months during which the specific details of the implementation strategy were to be worked out and disseminated to LGUs. Some line departments, notably the Department of Health, initially tried to delay implementation of the code. As time went on, each of the departments began to realize that devolution was a reality they would have to face. Planning began, and the DOH began actively preparing for devolution. It soon became apparent that six months was not nearly enough time to plan transfers of funds and to decide upon the number of people (as well as which specific people) the national government would devolve. The transition was extended first to October 1992, then to December

1992, and in the case of the DOH to April 1993. However, by the end of October 1992, memoranda of agreement were signed by DOH and each LGU. These memoranda included the number, names, and responsibilities of staff members who would be devolved to local government health offices. The transfer of funds took longer, and in the interim period, DOH continued to pay salaries for some devolved staff.

Although the process was slowed down from its extremely ambitious attempt to have full devolution of all government services (except education) within six months of the signing of the law, it has only taken about 1.5 years to almost completely devolve government services. This is not to say problems were not encountered along the way (see Associates for Rural Development, 1992). Implementation problems generally revolved around human resources, financial and organizational issues. (See Box 9 in Part I of this report for a more detailed listing of some of the problems encountered in the early stages of devolution in the Philippines.)

3.4 Administrative and Political Structure of the Philippines

The Philippines is divided into 14 regions. These regions have no political standing, rather they are administrative divisions in which many national line agencies have regional offices. For example, while a region has no governor, legislature, or elected officials, there are regional offices of the DOH; POPCOM; Department of Agriculture; Department of Education, Culture and Sports, etc. The country is also divided into 75 provinces and 60 cities. Provinces and cities are equivalent in their political status. Both have elected officials: provincial governors or city mayors and "sanggunians" (provincial or city councils). Provinces and cities are further subdivided into municipalities, which also have their own elected officials. There are over 1,500 municipalities in the Philippines, which in turn are subdivided into the smallest political unit, barangays. There are over 52,000 barangays, each with an elected Barangay Captain.

The administrative divisions of the country have taken on renewed importance with the advent of devolution. Regions have become less important than the provinces and cities. Most of the regional staff of line agencies, including the DOH, have been devolved to local levels (defined as any unit below that of the region). The DOH has retained only two or three people in each region responsible for coordinating family planning activities and services. The DOH has maintained a significant number of staff at the local level, but most of these are hospital employees. One notable exception to the weakening of regional authority is POPCOM, which has retained all of its regional staff, about 30 persons in each regional office.

3.5 Functions Devolved

The LGC is very specific about which functions will be devolved and which will be retained at the national level. The LGC states that LGUs will be responsible and accountable for the delivery of all basic services including family planning. Provinces and cities are responsible for planning and overall coordination of population and development activities, and for those family planning services provided through provincial and city hospitals. Municipalities are responsible

for delivery of services. In terms of family planning program activities, LGUs are responsible for:

- developing population/family planning plans, including setting targets and developing budgets;
- monitoring and coordinating activities at the local level;
- delivering services; and
- IEC.

According to the DOH Rules and Regulations Implementing the Local Government Code (Republic of the Philippines, 1991), the DOH will retain responsibility for monitoring and evaluation of local programs, projects, facilities, setting of standards, protocols and guidelines, and for technical support services. Technical support services are defined by the DOH to include logistics, training, parts of IEC and parts of the management information system (other parts of the latter two activities will also be carried out by LGUs).

3.6 Human Resources

As described above, there are two components to the Philippine Family Planning Program: the population management and coordination function and the service delivery function. After DOH became the lead agency for family planning, the Family Planning Service Division became responsible for coordination and monitoring, as well as for service delivery primarily through its network of hospitals and rural health clinics. POPCOM retains its role in population advocacy, education and population-based planning in the field of population and development.

Under devolution, LGUs are responsible for delivery of services. The outreach structures (provincial and city population offices) founded in the mid-1970s remain, to a large degree, intact. Nearly all provincial and city governments have population offices, although only about 11 percent of the municipalities have population offices. The delivery of family planning services is undertaken through health clinics and workers who provide direct service delivery. They are assisted by voluntary health workers, and BSPOs attached to population offices who provide primarily information, motivation and referrals, and occasionally supply condoms and resupply pills. The structure of human resources under devolution is described below.

National: Approximately 42,000 of 72,000 DOH staff have been devolved to the local level. The staff remaining as DOH employees will be responsible for national planning and coordination plus regional planning and coordination. DOH will also retain responsibility for operating and staffing regional and district hospitals. Hospital services include delivery of the following family planning services: sterilization, IUD insertion, and injections plus the supply methods.

Regions: In each region, there are two or three DOH staff remaining who are responsible for monitoring and coordinating family planning. To a certain extent, the Regional Health Director will be involved in the population program, but family planning is only one of up to 28 health services he/she is responsible for. There are also 28–32 staff at each POPCOM regional office.

POPCOM will play a major role in providing technical assistance for advocacy, planning and IEC to LGUs under the devolved system.

Provinces and Cities: Most provinces and cities have both population offices and health offices. According to the LGC, provinces and cities that currently have population offices must retain them for five years. After that they become optional. For those provinces and cities that do not have population offices, the establishment of them is optional. President Ramos has urged all LGUs to have population offices and has urged Congress to enact legislation to make population offices mandatory. Population offices are staffed by a director and a varying number of technical and administrative staff. The population offices are responsible for planning and coordinating activities at the local level. Many of the PPOs and CPOs still have active BSPOs visiting households, providing family planning information, and making referrals to clinics for long-term methods. In addition, some provide condoms and resupply pills, subject to the availability of supplies (and their being authorized to perform these services).

There are also provincial and city health offices. The health offices are responsible for planning and coordinating all health services within the LGU, including family planning. Rural Health Units (there is one in each province) provide pills, insert IUDs, and if providers have been trained, give injections and perform sterilizations. Health offices also have a network of Barangay Health Workers (BHWs). The BHWs visit households, as do the BSPOs, however they provide the full range of health services, including nonclinical family planning. Given the number of their health-related responsibilities, it is not clear whether the BHW can devote as much attention to family planning services and outreach as may be needed.

This set-up can obviously lead to confusion, particularly in instances when coordination between the population and health offices is lacking. The situation is sometimes aggravated by the longstanding rivalry for control of the family planning program between POPCOM and DOH staff. Under devolution, it will be important to work with the local government executives to ensure that either the population or the health office will lead population and family planning activities. Following this designation, it will be necessary to work with this office to assess its capabilities to carry out its responsibilities and to recommend changes in its structure or functions to carry out the new mandate and avoid future confusion and the lack of coordination that has hampered program efforts in the past.

Municipalities: Although the LGC requires that municipalities provide family planning services, it is expected that the actual delivery of services at the municipal (and barangay) level will occur not only at municipal health centers known as RHUs, but will also be provided by BSPOs and BHWs, supervised by and reporting to provincial or city health offices.

3.7 Financial Resources

The LGC allows for the transfer of a tremendous amount of funds from the central government to local governments. Nevertheless, many local governments feel they are not being given sufficient funding to take on all of the responsibilities that are being devolved. A period of

negotiation will most likely take place over the next several years. The government has created an oversight committee to resolve differences between LGU officials and national departments when estimates differ as to how much money will actually be required for an LGU to absorb devolved staff and operations.

The LGC provides two mechanisms for local funding: direct transfer payments from the national government and local revenue generation through taxation. Prior to the implementation of the LGC, LGUs received 10-15 percent of the Internal Revenue Allotment (IRA), the total revenue collected by the national government. Under the LGC, the government will transfer 30 percent of the IRA to LGUs in 1993, 35 percent in 1994 and 40 percent in 1995, after which the allotment will remain at 40 percent. The LGC also gives each LGU the power to create and levy its own taxes in a wide variety of areas including amusement, business, capital investment, agricultural products and, most importantly, real estate property taxes. Since they can now keep the tax revenues generated, LGUs have a greater incentive to collect taxes. A study carried out in 1992 showed that tax collection had already increased from 20 percent to over 80 percent in certain provinces (Rimon et al., 1992).

3.8 Program Implementation

Because of government regulations and requirements for counterpart funding, getting money to LGUs under the current system can take a long time. For this reason, the Secretary of Health has recently stated that he wants most activities that are the responsibility of DOH (regarding family planning) to be contracted out. The quickest way to get things done at this point is to have other local Philippine and international organizations do them. Over the years, DOH's capabilities will be strengthened until DOH can run the entire program. In that light, program implementation details are described below.

Policy making, advocacy, and coordination will be done at both the national and LGU level. General population policies are developed at the national level. While LGUs have to follow national policies, advocacy will take on an even more important role. Since it is now LGU officials who will decide how much emphasis to give and how much money to spend on family planning, a strong local level advocacy program must be implemented. USAID, through various cooperating agencies, is providing assistance to POPCOM and DOH to strengthen their advocacy skills.

Training will remain the responsibility of the DOH. DOH considers it a national responsibility to ensure that local staff are trained to national standards. An NGO in the Philippines is currently coordinating clinical training for all DOH and LGU health personnel, also for nonclinical personnel including PPO and CPO staff.

IEC will be done both nationally and locally. DOH will provide IEC materials relevant for the entire country. Local population offices will augment this with materials, radio and TV spots, etc., relevant to specific LGUs.

Logistics will remain the responsibility of the national DOH, which has contracted procurement and delivery of contraceptives to provinces and cities to CARE/Philippines. Once commodities are transferred to the LGUs, the LGU will be responsible for distributing commodities to the various service delivery outlets.

NGOs are an important component of the national program. Nationally, they play a critical role in managing and coordinating various types of services, such as training, for which the DOH does not currently have the mechanisms to carry out on its own. These efforts will be coordinated both locally and nationally. They are also locally involved in service delivery. The LGU population or health office will be responsible for coordinating the efforts of NGOs to ensure the broadest possible coverage for services and to facilitate information transfer to the local and national MIS.

Supervision will be the responsibility of each level. Each LGU will designate personnel to supervise the work carried out in their own jurisdiction. Supervision of the entire national program will be retained at the national level.

Standardization of guidelines and protocols for service delivery will be the responsibility of the DOH. These will be passed down to LGUs through the regional offices, which are now known as DOH field offices under devolution.

Monitoring and evaluation will take place at both the national and local level. The MIS serving the national program has been less than adequate. DOH, LGUs and NGOs have different reporting systems and oftentimes incompatible hardware, which makes standardization difficult (DOH, 1992). Since DOH took over responsibility for the family planning program, its Field Services health information system (FSHIS) gathers information on all health services including family planning, but it does not go into enough depth on family planning information and gathers information only from DOH health centers (excluding information from NGOs, private practitioners and acceptors of BSPO services).

Under devolution, the system is being changed to incorporate all family planning service providers, and the forms will be standardized across LGUs. The details are now being worked out in a pilot study. It will be important for the future success of the MIS for local managers to recognize the need for timely, accurate and relevant information pertaining to family planning for planning and decision making, and that they know how to use data for such purposes. This is an area of weakness among LGUs that is currently being addressed through another pilot project.

3.9 Leadership at National and Local Levels

The Secretary of Health, after initial hesitancy regarding devolution, has become a strong supporter of the process. Understandably, government officials at the national level were initially reluctant to accept devolution. The enactment of devolution took authority and responsibility from the DOH and transferred it to LGUs. In terms of regional offices, the DOH has had many

of its staff and functions devolved. It will take time to get used to the new structure. With the Secretary's support, devolution is proceeding fairly smoothly.

At the local level, commitment to family planning varies among LGUs. Obviously, LGUs that have officials committed to the program and willing to put resources into it are most likely to succeed. It will be important, however, to establish population and family planning programs with broad-based support in LGUs, so as not to be dependent on a particular governor or mayor whose term lasts for only three years. It will also be extremely important to build a program run by trained capable staff and to build a constituency among local civil servants. In this manner, the program can be sustained regardless of what happens when elected officials change.

3.10 Future Directions

At this point in time, it is difficult to generalize from the Philippine example. It is among the most extreme attempts at decentralization in a developing country. But the process of implementing the LGC has just begun. It will be important to monitor progress overall, but also in the context of whether the family planning program gets back on its track toward increasing levels of contraceptive prevalence. A USAID/Manila-funded pilot project, begun in spring 1992, has provided assistance to 5-6 LGUs in an attempt to develop and test alternative models of technical assistance and policy/program implementation over the short term. Emphasis will be placed on identifying and clarifying the roles of the DOH and regional POPCOM offices and providing technical assistance and training to both groups so that they can provide technical assistance to LGUs in the future. Some of the key issues emerging from this pilot study are described below.

Past decisions and policies affecting the Philippine family planning program have perpetuated rivalries between POPCOM and DOH which are visible at the local level and cause confusion. It is hoped that past differences can be resolved and that overall responsibility for managing and coordinating family planning program efforts at the local level will be decided by the authorities in each LGU.

An extensive network of human resources exists in LGUs and should be tapped in a meaningful way. To maximize the extent of outreach and referrals, BSPOs should be retrained and reactivated for community outreach in family planning, and their efforts should be closely coordinated with public health field personnel.

There are very limited planning skills among local managers in LGUs. Training will be needed to plan, coordinate and implement the program in LGUs. Skills are needed in budgeting, financial accounting, target setting, and using data for decision making. It will be important to assess demographic conditions in LGUs, determine what services are available, and to monitor progress toward program goals. Disparities in the technical capabilities of managers will place LGUs at a disadvantage when submitting proposals to DOH to receive funds for local activities. Those LGU managers most adept at preparing good proposals and lobbying on behalf of their jurisdiction may be more successful in procuring national funds. It will be important not only

to build skills at the local level, but to ensure equity concerns are somehow built into the funding processes. A related issue will be to develop systems of accountability, once DOH parcels out the funds, to minimize opportunities for corruption.

These are just a few of the issues that need to be addressed in the short run. In 1994, a larger pilot project will begin providing assistance to 20 LGUs. It will be important to have a good system of feedback to learn from the pilot projects. Each year more LGUs will be brought into the pilot program. There are many challenges and risks associated with devolution, but the opportunities are far greater than the risks.

4. NIGERIA: A CASE STUDY OF A DEVOLVED PRIMARY HEALTH CARE AND FAMILY PLANNING PROGRAM

4.1 Background

Nigeria has a population of 98 million, as estimated in 1994, making it the most populous country in sub-Saharan Africa. Like most sub-Saharan African countries, contraceptive prevalence rates are low. The 1990 Nigerian Demographic and Health Survey (NDHS) shows that use of contraceptives is about 6 percent among currently married women of reproductive age, with 3.5 percent using modern and 2.5 percent using traditional methods. Among all women of reproductive ages, 7.5 percent are using some form of contraception and 3.8 percent are using modern methods. Oral contraceptives are the most popular modern method (1.2 percent), followed by the IUD and injectable.

Family planning services and commodities are provided by a variety of sources. The 1990 Nigeria Demographic and Health Survey (IRD/Macro International, 1992) shows that government hospitals and health centers provide about 37 percent of family planning services. With decentralization, it is expected that Local Government Authorities (LGA) will meet at least 11 percent of the demand. The Planned Parenthood Federation of Nigeria provides about 4 percent and the private commercial sector (including pharmacies, medical stores, private physicians, and private hospitals and health centers) provides close to 50 percent of services. The source of services and supplies varies by method. Of those women using oral contraceptives, 62 percent obtain them from the private commercial sector, primarily from pharmacies and medical stores. The majority of IUDs are inserted in government facilities (about 61 percent). Injectable users receive their injections from both public facilities (45 percent) and private doctors or clinics (48 percent).

Organized family planning began in Nigeria in 1958 when a Lagos Medical Officer began offering contraceptives to postpartum women as part of his regular maternal welfare clinic. By November of 1964, he organized the Family Planning Council of Nigeria (Wright, 1968; Ojo, 1973). As a voluntary organization, the Council operated on private foundation funds and patient fees without receiving direct government assistance. By 1973, the Council operated 18 branch clinics in six of Nigeria's 12 states (Ojo, 1973).

In later years, the Council became a local affiliate of International Planned Parenthood Federation and was renamed the Planned Parenthood Federation of Nigeria (PPFN). Currently, PPFN operates 15 model Planned Parenthood clinics and more than 55 clinics in government health facilities, institutions, and other rented or donated accommodations (PPFN, 1990). PPFN provides services in 23 states and plans to expand into all 30 states of the federation.

Government involvement in family planning services began with Nigeria's Fourth National Development Plan, 1981-1985. The plan called for the provision of family planning services within government health facilities to assist couples to regulate the size of their families. At present, government-provided family planning services are integrated into decentralized primary health services. The Federal Ministry of Health and Social Services (FMOHSS) provides policy guidance and strategic support to the states and the Federal Capital Territory, while state ministries of health (SMOH) plan and coordinate the state health care systems, provide training, and assist Local Government Authorities (LGAs) with the management and operation of select primary health care facilities. Close to 600 LGAs have primary responsibility for providing family planning services as part of their primary health care responsibilities.

4.2 Rationale for Decentralization in Nigeria

In Nigeria, three forms of decentralization exist in the delivery of health and family planning services. The Federal Ministry of Health and Social Services has gradually *deconcentrated* or reduced federal administrative functions by giving state ministries of health increased management and supervision responsibilities. The government *delegated* primary health care management and technical assistance to a parastatal organization, the Primary Health Care Development Agency (PHCDA). *Devolution* of decision making, the power to secure and allocate resources, and responsibility to implement primary health care, including family planning, have shifted from federal and state ministries of health to local government authorities.

Decentralization in Nigeria, primarily, the devolution of power and decision making, is an outcome of a major national reform of local governments that was introduced by the military government in 1976. The 1976 Local Government Reform was a reaction to the centralized powers of the Gowon administration. After Gowon was overthrown, the new military government institutionalized a system of power sharing among the three levels of government: federal, state and local. A representative local government system was considered essential for developing a national democratic system of governance (Gboyega, 1987). In terms of service delivery, it was felt that a local system of administration would be more responsive to local needs and conditions; local administrators with increased authority could respond more quickly to changes in the local environment; and local government would be able to mobilize local human and financial resources to expand services.

In 1976, 301 local governments were created. The 1976 reorganization outlined the powers, program responsibilities, financing and political structure of local governments. A major outcome of the reform is that all local governments have a common structure, powers and financing system. There are currently about 589 local governments ranging in population size from

150,000 to 500,000. It is possible that more will be formed prior to new national elections. Communities continue to pressure the government to become a LGA. By becoming an LGA, they are eligible to receive federal allocation of resources for community development programs.

4.3 Decentralized Family Planning as Part of Primary Health Care

The LGAs have mandatory responsibilities for the provision of primary health care. The Constitution of the Federal Republic of Nigeria Decree 1989 states that the functions of local government include: the provision and maintenance of primary, adult and vocational education; the development of agriculture and natural resources; and the provision and maintenance of health services (Federal Republic of Nigeria, 1989).

Primary health care consists of 10 components including maternal and child health. Family planning is part of the maternal and child health component. Family planning services are offered to prevent unwanted pregnancies, secure the desired number of pregnancies, space pregnancies, and to assist couples in limiting the size of their family (FMOHSS, 1988). Of the 7,725 public sector service delivery points, family planning services are provided at 1,492 or 19 percent of public sector sites (USAID, 1992). In rural areas of Nigeria, where private medical stores, pharmacies and clinics are not available, public sector health facilities are the only source for family planning services and the supply of modern contraceptives.

The LGA primary health care system is organized at three basic levels: village, district and the local government level. Each level has its own health committee that makes decisions about primary health care including family planning (USAID, 1992). Locally-elected councils in consultation with the SMOH, are responsible for establishing the health committee. The committee includes representatives of the council, the State Hospital Management Board, NGOs, professional health staff, and leaders of the local community. The functions of the health committee include: the formulation of project proposals; delivery of services; intersectoral coordination; collection of basic data; and mobilization of resources (FMOHSS, 1988). State ministries are slowly transferring responsibilities to the health committee. Health staff in the LGA clinics report to the health committee chairperson rather than to the SMOH, as before.

The health staff of the LGA can consist of a chief medical officer, doctors, community health supervisors, public health nurses, midwives, nurses, a community health superintendent, laboratory technicians, dispensary/pharmacy technicians, record officers, community health assistants and a family planning manager who is usually a nurse. The LGA family planning manager is responsible for commodity flows, coordinating service delivery, identifying training needs and developing or obtaining IEC materials. The family planning manager plays a key leadership role in ensuring that family planning issues are included in the primary health care annual plan and budget. The LGA family planning managers receive most of their technical support, training and commodities from the state family planning coordinator.

In summary, primary health care is a fairly new responsibility for the LGAs. As expected, numerous problems have emerged as LGAs adopt this approach to service delivery. Olowu and

Wunsch (1992) observed that LGAs lack adequate staff and health committees that can solve problems, develop priorities, collect and use data for strategic planning, and develop realistic budgets. They also observed that mechanisms were not in place to supervise staff and monitor the use of resources. It will take several years to build the capabilities of LGAs to effectively operate, coordinate, maintain and expand primary health care services, including family planning.

4.4 Responsibilities at Different Levels of Government

Local governments, with assistance from the FMOHSS, SMOH and the PHCDA, are slowly developing the capacity to provide primary health care services, including family planning. The Primary Health Care Services Department of FMOHSS provides policy guidance and strategic support to the states and the Federal Capital Territory. The Department of Population Activities of the FMOHSS is responsible for coordinating activities to implement Nigeria's population policy. At present much of the coordination has taken place between the federal level and the donor community (UNFPA, 1991). Efforts are underway to pilot different approaches to assist the LGAs with coordination and advocacy activities. In the future, it is expected that this department will play a role in consensus-building activities among the LGAs.

Supervision of primary health care for states and LGAs is the responsibility of four regional primary health care zonal offices. In the past, the zonal offices were the responsibility of the Primary Health Care Services Department of the FMOHSS. At present, the zonal offices are the responsibility of the Primary Health Care Development Agency, a new parastatal organization that consists of former FMOHSS staff. SMOH plan and coordinate the state health care system and provide training and a range of other support services to LGAs.

The LGAs are responsible for: the operation of health facilities within its area; provision of primary health care services; mobilization of community support; and the provision and maintenance of health infrastructure (USAID, 1992). The LGA primary health system includes village health posts (serving about 500), dispensaries (serving 10,000), health clinics (serving 20,000 to 50,000) and primary health care centers (serving 20,000 to 80,000 people). It is through this network of facilities that LGAs provide family planning services. The federal and state ministries of health will continue to provide family planning and other health services through the network of government hospitals. A detailed overview of responsibilities among the tiers of government and the PHCDA is provided in Table 1.

While the Planned Parenthood Federation is not presented in the table, it plays an active role in promoting decentralized family planning services. PPFN targets LGAs with high density populations that have few or no family planning clinics. It provides contraceptives through its clinics and community-based distribution programs; training of state and LGA nurses in clinical service delivery; and IEC materials to state and LGA clinics. It also works with women's organizations and cooperatives to promote their involvement in family planning services.

Table 1. Responsibilities of Tiers of Government and Primary Health Care Development Agency, Nigeria 1993

TASK	ORGANIZATION			
	Federal MOH	State MOH	LGA	PHCDA
Advocacy	Gain support of other federal ministries and the private sector	Gain support and involvement of other state ministries and private sector	Elicit support among formal and informal leaders in the community	Promote primary health care at all levels
Legislation	Formulate legislation and regulations as needed	Advise on legislation and inform the general population		
Planning	Develop national plan and provide technical support to the states and LGAs in developing plans	Develop family planning state plan and assist LGA with FP program plans	Develop annual plans that prioritize needs of the community	Offices in Lagos and the four zones. No state offices. Will assist LGAs in developing plans and budgets
Coordination	Coordinate all health and family planning activities	Coordinate family planning efforts at the state level, and among LGA FP managers within PHC	Coordinate efforts among groups within the community Mobilize community support	Coordinate effort with FMOHSS, SMOH, and the donor community
Monitoring & Evaluation	Develop impact evaluation strategy Develop HIS and collect and analyze data from the state and LGAs facilities Monitor change and report findings	Collect additional FP data from LGAs and state health facilities, send to federal government and donors Analyze data for planning purposes	Collect facility data on service delivery and submit it to the state and federal MOH	Monitor PHC and FP. Focus on the quality of the HIS service statistics Assist states in collecting HIS data Disseminate findings
Training	Support teaching hospitals and university programs	Provide training in FP for LGA staff		Through coordination with SMOH, will identify gaps in training in LGAs and provide training when necessary
IEC	Develop national IEC strategy to be adopted by the SMOH	Develop mass media materials for LGAs		
Logistics		Provide FP commodities to LGA FP manager	Maintain facilities for service delivery	
Supervision		Supervise efforts in LGA Hold quarterly FP manager meetings		Assist states with supervision

Sources: Federal Ministry of Health, 1538; Discussions with key government officials, PHCDA and FHS staff.

4.5 Financial Support

The LGAs can receive financial support for primary health care from five sources: the Federation Account that funds competing development activities, the Primary Health Care Development Agency through the model LGA special grant program, the state budget, local taxes, and in some cases, from external donor organizations. However, the majority of funding received by LGAs comes from federal transfer payments, that is, the Federation Account.

The Federation Account is the basis for sharing national revenues among the three tiers of government. About 75 percent of the Federation Account is made up of oil receipts. LGA budgets are influenced by conditions in the international oil market. In 1989, the states received about 32 percent of the Federation Account, LGAs received about 10 percent. In absolute *Naira*, the amount of money allocated to states and LGAs increased in some years by 25–28 percent. In 1990, the intergovernment transfer system was restructured. LGAs now receive 20 percent of the Federation Account (Olowu and Wunsch, 1992). The increase in funds for LGAs came from the federal government's share. It is estimated that close to 90 percent of the LGAs budget comes from the federal account.

The amount of the Federation Account that is allocated to LGAs is based on the same formula that is used to allocate resources among the states. The 1990 revenue sharing formula for states is based on a number of factors including equality among states (40 percent), population (30 percent), revenue efforts (10 percent), land mass/terrain (10 percent) and a social development factor (10 percent), which includes the geographic distribution of the population, primary school enrolment, the number of health institutions and hospital beds, water supply and rainfall.

Each tier of government is able to generate revenues through taxation. LGAs can generate revenue from: property taxes, market and trading fees and licenses, motor park dues, canoe park dues, entertainment taxes, motor vehicle taxes, driver license fees, land registration fees, and license fees on television and radio stations. However, about 90–95 percent of the LGAs funding comes from transfer payments. The more money LGAs generate locally, the less they receive from transfer payments (Olowu and Wunsch, 1992). This system provides little incentive for LGAs to generate revenues locally.

Within the LGA, the elected council makes all financial decisions regarding the allocation of federal resources for development programs. The health committee of the LGA presents its budget to the council for approval. The council collects and reviews all development budgets. In an urban LGA (such as Mainland Lagos), the council reviews five major budgets: works and housing, education, agriculture and rural development, community development and welfare, and health. Most of the budget for health is for staff salaries. There is little money budgeted for drugs and medicine. In the Lagos Mainland LGA budget, family planning commodities are not included in the budget since contraceptives are received from the state family planning coordinator.

The Chief Medical Officer and the health committee must lobby the elected council to approve the health budget. Like most politicians, the elected council members support those budgets that generate the most political support. Because the health budget must compete with other development programs, it can vary from year to year. Policy analyses are needed to assess funding priorities of the elected councils in LGAs that must select among a number of development projects. Little is known about the level of financial support councils devote to primary health care in general, and in particular to family planning services. It is also unclear how the SMOH will provide funding to the LGAs in the future. At present, the states provide financial support for state health personnel who have been transferred to LGA health facilities.

4.6 Special Concerns for Decentralized Family Planning

Decentralization can play a major role in strengthening family planning services in Nigeria. In a country that has numerous ethnic groups and languages, it can help adapt service delivery to suit local culture and needs of the population. It can also reduce the amount of time and resources required to respond to problems or changes in the environment since local staff and health committees can address problems and constraints as they emerge. Since LGAs can generate and retain financial resources, this new approach may encourage staff to mobilize resources within local communities to expand population programs and family planning services. Decentralized services can also increase the capabilities of regional and local organizations to plan, implement, and coordinate projects and programs.

However, there are also a number of potential constraints that can influence the provision of family planning services. Some key areas of concern are presented below with possible intervention strategies.

Obtaining budgets for family planning: In Nigeria, locally elected officials make financial decisions regarding the allocation of resources among development sectors. Family planning as part of primary health care must compete for its budgets on an annual basis. Elected officials and pressure groups will determine which sectors receive priority in a given year. To ensure that the objectives and targets of the national population policy are met, family planning services may require a special grant for population programs. Studies are needed to determine the most effective strategies for increasing funding for family planning at the LGA level while ensuring that local staff and health committees have control over planning, implementing and allocating resources.

Achieving national targets: Nigeria's population policy specifies a number of targets concerning IEC, contraceptive use and fertility reduction. A major problem that most countries face with decentralized services is that it is difficult to achieve national targets when local governments can pursue local priorities and interests. In the northern regions of Nigeria, for example, where contraceptive use is low, family planning may be pushed aside for other primary health care interests and/or development programs. Consensus building activities and policy dialogue are needed at the LGA level to raise awareness about the benefits of family planning for the

community and households. The Department of Population Activities of the FMOHSS could initiate dialogue of this nature to develop consensus-building capabilities at the LGA level.

Promoting the method mix: Oral contraceptives are the most popular method of modern contraception in Nigeria. While pills are an effective contraceptive method, long-term family planning methods, such as the IUD, injectable, implants and sterilizations, are needed to reduce Nigeria's total fertility rate to its target of four children per woman. National and state ministries of health will need to explore ways to strengthen service delivery in LGAs while allowing local staff the freedom to plan, implement and budget for service delivery within their communities.

Health staff in LGAs including the family planning managers will need training and technical assistance in selecting an appropriate method mix, generating demand for different methods through IEC activities, providing a choice of long-term methods that meets the needs of individuals and couples in the community, and lobbying locally elected officials to fund and expand family planning services.

4.7 USAID Response to Decentralized Family Planning Services

The Family Health Services (FHS) Project (1988–94) of the USAID Aid Affairs Office (AAO) in Lagos was designed to increase the acceptability and availability of integrated family planning services throughout Nigeria in the private and public sectors. The long-term goals of FHS were to reduce infant and maternal mortality rates, the number of high risk pregnancies and the total fertility rate in Nigeria.

The FHS Project has played a major role in strengthening the FMOHSS and the SMOH capacity to expand family planning services in Nigeria. Resources and technical assistance have been used to develop the capacity of state family planning coordinators to expand services within the state. As mentioned above, the coordinators are playing a critical role in providing technical assistance and commodities to LGA family planning managers. FHS has also devoted considerable resources to train staff within the public, NGO and private commercial sector. In addition, IEC strategies have been implemented at the federal, state and local government level to raise awareness and use of family planning. The project has also played a major role in designing the health information system (HIS) that is currently being used to monitor primary health care and family planning activities in the LGAs. The FHS Project has greatly contributed to improving the quality of family planning services, especially for long-term methods.

The FHS Project has also strengthened private sector activities by promoting Nigeria's robust and enterprising private health and commercial sector. Private sector activities of FHS are carried out through more than 30 private sector subprojects. The activities fall into five general groups: 1) training nurses in clinical family planning methods from private clinics and hospitals; 2) training retired nurses as family planning vendors; 3) training and supporting community-based distribution activities; 4) training market traders to supply family planning commodities; and 5) promoting employer-based family planning services. The types of organizations that are supported for private sector subproject activities include: nurses and midwife associations,

women's organizations, private clinics and hospitals, nursing homes and maternity clinics, and employer-based industries such as the Nigerian Railway Corporation.

During the remaining months of FHS, staff have redirected project resources to respond to the new responsibilities of LGAs while continuing to promote the private commercial sector. The new approach is called the Resource Intensification Strategy (RIS). FHS is coordinating its efforts with the PHCDA, FMOHSS, SMOH and NGOs, such as the Planned Parenthood Federation of Nigeria and the private commercial sector as mentioned above.

The RIS has targeted 10 states and select LGAs within these states (at least four per state) that are the most likely to expand family planning services. The selected LGAs: a) have existing NGO and private commercial sector family planning efforts; b) offer or have the potential to offer broad-based services; c) serve a large population; d) show demand for family planning services; and e) have local leadership that is willing to support family planning activities. The selection of the target LGAs is determined jointly by the SMOH, LGA and FHS. RIS efforts are underway in five states: Abia (8 LGAs), Anambra (6), Plateau (15), Niger (7) and Osun (7). Additional states will include Oyo, Enugu, Bauchi, Kaduna and another state yet to be identified. Training, through workshops and one-on-one collaborations, is a key component of project activities. The focus is on strengthening skills at the national and state levels to build their capabilities to provide technical assistance to the LGAs. Skill development areas include strategic planning; quality of care measures; data collection and analysis; monitoring and evaluation; IEC activities; and advocacy and constituency building. The zonal offices of FHS will play a major role in providing technical support to the states.

It is too early to evaluate these efforts. The RIS represents a strategy to use scarce resources to support both states and LGAs in family planning service delivery while collaborating with different divisions of the FMOHSS and PHCDA and promoting the private commercial sector. FHS is designing an evaluation strategy so that AAO/Lagos can learn from this approach and use the information to design the follow-on project, The Nigerian Family Health Services Project, 1994–2000.

4.8 Future Directions

Nigeria has just begun to devolve primary health care including family planning. This new organizational approach to service delivery creates numerous challenges at the national, regional and local level. Within the LGAs, health staff, community health committees and elected officials are challenged to make a range of decisions on all aspects of family planning service delivery such as developing targets, identifying clients, selecting the method mix, generating demand, mobilizing resources, coordinating the public and private sectors and lobbying local elected officials to fund and expand primary health care including family planning services. The federal and state ministries of health working in collaboration with the FHS Project and the PHCDA are exploring ways to strengthen service delivery in LGAs while allowing local staff the freedom to plan, implement and budget for service delivery within their communities.

Decentralization also changes USAID's approach to technical assistance. Decisions had to be made concerning the organization to work with in strengthening the family planning program. Choices included the Planned Parenthood Federation of Nigeria, which is a decentralized nongovernmental organization; different departments within the FMOHSS and other federal institutions including the Federal Office of Statistics; 31 states, close to 600 LGAs; and the private commercial sector. The FHS Project and AAO/Lagos decided to maximize their resources by focusing on states and LGAs that have the highest potential to succeed. Assistance is provided to the public sector and private NGO and commercial sectors within the RIS states.

The FHS Project, through its Resource Intensification Strategy, will assist the federal and state governments in determining ways to strengthen the capabilities of LGA staff and health committees to improve and expand family planning services. The FHS will also play a major role in increasing the number of skilled staff at the state and LGA level through its training programs. It is also assisting the government to develop an appropriate logistics system to meet the needs of a decentralized system and Nigerian institutions to develop strategies for monitoring activities in the public and private sector and to evaluate the impact of program activities on fertility decline.

While decentralization shows some promise to expand and improve family planning programs in Nigeria, it is too early to determine if decentralized programs will increase the use of modern family planning methods, and consequently, lead to fertility decline. Policy analyses are needed to address a number of program design and implementation issues. Information is needed to identify the characteristics of LGAs that have the greatest potential to expand family planning services. The knowledge is needed to promote a phased approach to strengthen family planning services. The results of the analysis would be useful to governments and donors who do not have the resources to provide technical and financial assistance to all LGAs. Determining the types of support services and technical assistance, including training, that is required to promote decentralized family planning services is another area for policy analysis. At present, governments and the donor community are experimenting with a combination of support services. Evaluation strategies need to be designed to maximize learning about the different packages that are being put in place to support the LGAs.

There are a number of program impact issues that need to be assessed. A key area is related to the basic assumptions of decentralization. That is, do family planning programs tailored to local needs result in increased use of services and supplies? Are decentralized family planning programs more cost-effective than centralized government programs? Answers to these questions will help the government and the donor community to develop appropriate strategies to meet the needs of its diverse communities.

5. BANGLADESH: ADMINISTRATIVE DECONCENTRATION OF THE MINISTRY OF HEALTH AND FAMILY WELFARE

5.1 Background

Bangladesh has an estimated population of 117 million persons with a growth rate of approximately 2.4 percent according to the 1991 Census. The Bangladesh Contraceptive Prevalence Survey (CPS) in 1991 showed a prevalence rate of 40 percent, including 31 percent for modern methods. This represents a substantial increase since the last survey in 1989, when overall prevalence was 31 percent. The total fertility rate is estimated to be 4.9.

The government family planning program began in 1965, when the Government of East Pakistan created the Family Planning Board. Since independence in 1971, the Bangladesh government has strongly supported family planning. It views the reduction of the population growth rate as its highest development priority and is committed to supporting public and private sector family planning. In the late 1970s, maternal and child health activities were combined with family planning and located in what is now the Ministry of Health and Family Welfare (MOH&FW). There is also a National Population Council (chaired by the Prime Minister), which is responsible for formulating population policy and coordinating population and development activities across ministries.

Within the MOH&FW, there are separate divisions for family planning and health: the Directorate of Family Planning and the Directorate of Health. Each is vertically structured with little coordination of activities (Larson and Mitra, 1992; Shutt et al., 1992). The integration of family planning and maternal and child health is an important component of family planning policy, and most family planning services are provided in conjunction with maternal and child health services, in clinics as well as in home service delivery. There are a few components of maternal and child health, however, delivered through vertical programs in the Directorate of Health (e.g., immunization and oral rehydration therapy), and while they share some of the same facilities, they have separate staff in addition to those used for family planning (Nag, 1992).

Contraceptives are distributed through three delivery systems: hospitals and clinics (including satellite clinics), field workers, and retail outlets. Although exact proportions are not available from the 1991 CPS, the government is responsible for providing approximately 70 percent of family planning services through its network of hospitals and clinics and by field workers. NGOs are the source for an estimated 24 percent of users. Another 5 percent obtained contraceptives from private/commercial outlets or social marketing programs (Larson and Mitra, 1992).

5.2 History, Rationale and Timing of Decentralization

Coinciding with the beginning of the Ershad government in 1982, the Committee on Reorganization and Reform (CARR) was constituted to review the structure of the Bangladesh Government and to develop a policy agenda to achieve administrative decentralization as a way of increasing local participation in government. A National Implementation Committee

(NICARR) was formed soon thereafter and charged with implementing CARR's proposed reforms. The resulting Local Government Ordinance of 1982 provided the government with the legal framework to implement government decentralization policies. The original ordinance created the local governing bodies at the upazila or subdistrict level, called Upazila Parishad or councils. The Resolution on Reorganization of Thana Administration delineated areas of responsibility between the national and upazila government. Subsequent amendments to the ordinance provided these councils with authorized forms of revenue raising including certain forms of taxation. However, they also specified explicit guidelines on how the money collected could be spent, including ceilings for various types of projects. The original CARR guidelines provided broad and independent decision-making and resource allocation authority to the Upazila Parishads, theoretically decentralizing many government functions. However, as actually implemented through NICARR, the central government retained controlling power and authority over most activities and disregarded most of the recommendations and reforms suggested by CARR (Khan, 1987).

The difficulties of achieving administrative decentralization have been attributed to weak political commitment at the highest levels, the unrepresentative character of the Upazila Parishad, retention of centralized bureaucratic control, and the weak financial basis for the upazila. Upazilas became a centrally-directed, financed, and controlled adjunct of national government, totally dependent for administrative, financial, and logistic support (Khan, 1985, p. 258). Although praised as a potentially beneficial institution and format for local governance, in 1991 the newly formed parliamentary government dissolved the Upazila Parishad and its chairman position. Local governance now rests in the hands of the Thana Nirbahi Officer (TNO), a centrally-appointed officer at the subdistrict (upazila) level, which has been renamed as a thana.

This case study focuses on how the MOH&FW and the Directorate of Family Planning have operationalized the government devolution policy, which has been unsuccessful in other sectors. The MOH&FW makes use of a deconcentrated system of field offices for program management and service delivery at subdistrict and lower levels of government. The central ministry retains control over resources, policy and personnel and many aspects of the overall management of the family planning program, but transfers authority for day-to-day management and implementation to program managers at the local government level. Since the mid-1980s, the Directorate of Family Planning has encouraged decentralization. The MOH&FW has increased the number of service delivery points in subdistricts and unions, encouraged the use of satellite clinics to bring services closer to clients, and recruited and trained large numbers of family welfare assistants (FWA) to provide family planning services to potential users in their homes. It has also requested NGOs to expand their programs into rural areas in support of the government's decentralization policy (Shutt et al., 1991). As a result, a need for strengthening subnational management structure has emerged.

Following the second five-year plan, five hundred new management positions were added at the newly expanded local level. The government also ordered the formation of local family planning committees comprised of political, civil, educational and other leaders. The Population and Family Planning Sector under the third and fourth five-year plans (1985-95) of the government

calls for increased local participation through decentralized administration at lower levels of government (Huq, 1992). The government goal of decentralized management of family planning programs was operationalized initially through the Upazila Initiatives Project (UIP) and presently through the Local Initiatives Project (LIP) administered by the Family Planning Management and Development (FPMD) Project as part of the bilateral Family Planning and Health Services Delivery Project of the USAID Mission in Bangladesh. The UIP ran from 1987-93 and has been succeeded by the LIP, which will run from 1993-97. See FPMD (1991) and Helfenbein and Sayeed (1992) for project descriptions. Information on Bangladesh's approach to decentralization of family planning program management is based on the experience of these projects.

5.3 Deconcentration of MOH&FW and Directorate of Family Planning

Bangladesh is divided administratively as follows: there are 4 divisions or regions, 64 districts, 460 thana (subdistricts), and 4500 rural unions. Each union contains 3 wards, which is the lowest formal institutional level of government. Each ward is comprised of several villages and administratively organized into units of four to five thousand persons each (Huq, 1992). Table 2 shows the deconcentrated administrative structure of family planning service delivery and management in Bangladesh.

Table 2. Program Administration by Geographic Area: Bangladesh

Geographic Area	FP Management and Personnel	Clinic Management and Personnel	Service Facilities
Districts	Deputy Director for Family Planning	District Medical Officer Physicians Family Welfare Volunteer (FWV)	Hospitals Maternal Child Welfare Centers (MCWC)
Thana (subdistricts)	Family Planning Officer (FPO) Assistant FPO	Medical Officer FWV	Thana Health Center MCWC
Unions	FP Inspector/ FP Assistant	Senior FWV Medical Asst. Health Asst.	Health and Family Welfare Center Rural Dispensaries MCWC
Wards	Family Welfare Assistant		
Units, Villages	Volunteers		Home Visits Satellite Clinics

The government provides family planning services through the following delivery channels: central MOH&FW is responsible for overall administration, resource management, and policy making for the national family planning program. The Directorate of Family Planning is responsible for FP/MCH services, IEC, commodities, personnel and evaluation. There are four Division Directors for FP/MCH who supervise and coordinate district staff. The Directorate of Family Planning has administrative structures with full-time staff, down to the union level.

At the district level, the Deputy Directors for Family Planning are responsible for overall program implementation, including the coordination of public and private organizations. The District Medical Officers supervise all clinical services in both family planning and MCH. Family planning services are provided in hospitals and Maternal Child Welfare Centers, which are staffed by female doctors and/or a Family Welfare Visitor (FWV) who has received 18 months of training in the provision of family planning services.

At the subdistrict (thana) level, the Family Planning Officer (FPO) manages the program and has the same responsibilities as the Deputy Director in districts. The FPO is aided by an assistant family planning officer and support staff. Most subdistricts have a Thana Health Complex where sterilizations, IUD insertions, and other outpatient services are provided. A medical officer is responsible for FP/MCH clinical activities at this level and for supervising clinical activities at lower levels. Given the complicated administrative structure and the joint provision of FP/MCH services, the chain of command within the program at different levels is not always clear.

The (male) Family Planning Inspector (FPI) manages the program in unions and monitors the performance of (female) Family Welfare Assistants (FWA) in wards. A FWV manages the Health and Family Welfare Centers that exist in about 60 percent of unions. These centers provide nonsurgical contraception (orals, IUDs and injectables), primary care for side effects, and basic MCH services. A FWV also conducts satellite clinics in remote villages where clients can typically receive pills, IUDs, injectables, advice and follow-up care. Static clinics are under-utilized because of shortages of supplies and the difficulty for women to travel alone.

Satellite clinics are also run in villages by the union-level FWV. Nationwide, there are approximately 29,000 female outreach workers (FWAs) who motivate couples to use family planning, make referrals to clinics, supply oral contraceptives and condoms, and provide counseling to couples in their homes. Under the LIP, the role of the FWA has shifted more toward supervision of a cadre of volunteers, who provide outreach services in their communities using regular and intensive home visits. FWAs ensure volunteers are supplied with contraceptives, answer their questions about methods, follow-up volunteer's requests, and keep records of program activity for input to the MIS. The development of a management cadre at the service delivery level under LIP has been an important element in operationalizing decentralization.

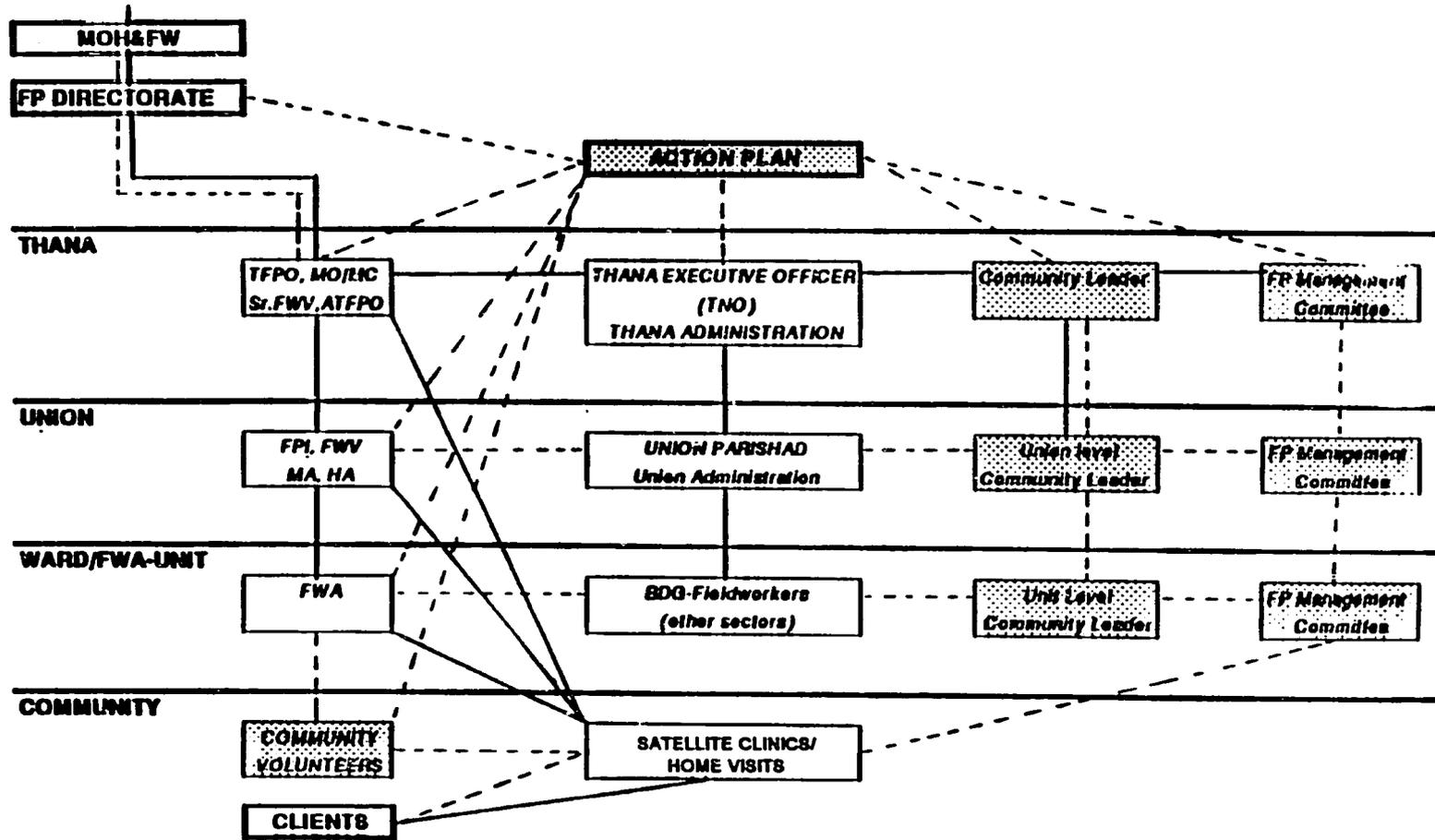
5.4 Leadership at Central and Local Level

There is strong government support for family planning and the improvement of maternal and child health in Bangladesh. The LIP approach builds political commitment for population at the subdistrict level and below through the creation of management committees that oversee family planning activities. Management committees involve local political and religious leaders, elected officials, service providers and managers, and local elites in the planning process and the development of action plans to improve family planning performance. Figure 1 shows how the decentralized management component, as implemented through the LIP, interfaces with the family planning program structure and the local political units. The active participation of elected officials through the Parishad system and community members, such as through the involvement of female volunteers, creates broad-based support for family planning. Many of the action plans also specify procedures for involving local leaders in the promotion of family planning.

The LIP is highly regarded and has the support of the highest levels of the MOH&FW and the Directorate for Family Planning. Because it operates within the framework of the existing government program, it is seen as being supportive of government efforts to extend and improve the quality of family planning. To maintain their interest and support, senior officials in family planning at the national and district level, and even members of Parliament, have been involved in study tours and workshops so that they are aware of and support ongoing activities.

At the local level, LIP is responsible for creating or reactivating subdistrict management committees that are responsible for planning, implementing, and monitoring program activities. They develop action plans that specify the collection of baseline information, targets and areas of program emphasis, procedures for recruitment and training of village volunteers, types of IEC activities, and the creation of additional management committees in unions and wards. The action plan also specifies the supporting roles for the existing family planning field staff, local government administration, and their family planning management committees. A budget for proposed activities is included as part of the action plan. All action plans are reviewed and approved by the Directorate of Family Planning before receiving project funds for implementation. As a result of the active involvement of senior officials in project activities, action plans are approved by the Directorate of Family Planning in a matter of days, rather than months.

Figure 1. LIP Intervention in Health and Family Welfare System



Key:
 - - - - - = Where LIP activities strengthen the MOH&FW System
 ——— = Existing BDG-MOH&FW structure

□ = Critical components added to MOH&FP by LIP
 Other Sectors = Agriculture, Social Welfare; BRDB; Youth; Women; Health; NGOs

5.5 Financial Resources

Most of the money for the population sector (90 percent) is provided by the international donor community (Kantner and Noor, 1992). The government, in its fourth five-year plan, has allocated 4.2 percent of its sectoral budget for family planning (and 2.6 percent for health). At the local level, the majority of funds for family planning come from the MOH&FW. The Directorate of Family Planning pays for its offices and staff, and provides a budget to districts, and from there, to subdistricts, for family planning administration and service delivery.

A small additional amount of funds for family planning may also be available from the TNO who controls the development budget for the subdistrict. Subnationally, however, program priorities do not always match political and budgetary priorities. While population control may be considered of great national importance, at the local level, spending for family planning may receive much lower priority.

In addition to the program funds available to subdistricts, the LIP also makes grants to subdistricts to fund approved action plans in unions. Most of this money goes toward training volunteers and conducting motivational meetings. Subdistrict administration must contribute approximately 10 percent of the total action plan budget. Based on Phase I experience, the local contribution averaged 35 percent of the UIP grant. The financial contribution is intended to provide a sense of ownership in the plan and commitment to seeing the plan effectively carried out. The use of local financial resources is encouraged to help build the financial sustainability of community family planning activities. It was initially thought that the dissolution of the Upazila Parishad and chairman and replacement by the centrally-appointed TNO would weaken local input into the allocation of resources because he is generally not a resident of the subdistrict and is rotated on a two-year term between subdistricts. Thus, he would not be dependent on local support to remain in office and would have less of a personal stake in the progress of the community. However, TNOs have been successfully integrated into the program. Although local contributions to action plan budgets have declined as an overall percentage of the total budget, thanas and unions continue to provide the required 10 percent contribution.

5.6 Human Resources

Training is the responsibility of the central government through a separate organization established in 1979, the National Institute for Population Research and Training (NIPORT). Although the government provides some training through headquarters, regional training centers and FWV Training Institutes, a recent evaluation suggested that the government bestows low priority to the training of family planning staff (POPTECH, 1992). There is a shortage of mid-level family planning management and the family planning program competes with other programs for scarce talent. NGOs have had some involvement in training through the development of materials and programs that have subsequently been adopted by the government.

The LIP makes use of existing government service providers, program managers, and local officials, many of whom have been recruited in recent years. The LIP provides short-term and

on-the-job, project-related training of management personnel through study tours, workshops, manual development, and supervisory visits of project staff. Members of the management committee selected for participation receive training in the development of action plans, preparation and management of budgets, collection of quality data, supervision of service providers, and monitoring of activities. This promotes bottom-up capacity building in the development of relevant skills for program managers. As part of action plan implementation, the management teams are responsible for recruiting and training the cadre of female volunteers who conduct the house-to-house visits and collect information for input to the MIS.

5.7 Other Program Implementation Details

IEC: The Directorate of Family Planning is responsible for the development and dissemination of IEC materials, although the action plans also typically contain information on how IEC will be used in the subdistrict and union activities.

Logistics: Commodities are paid for from the central program budget and are distributed to districts based on information from the family planning MIS. There are many problems with shortages of supplies and inefficient management of logistics. Efforts are being made to increase the number of warehouses and storerooms for supplies to minimize delays in shipments to clinics and to FWA. Building warehouses in subdistricts will facilitate the local distribution of commodities to community outlets and will put supplies closer to the management level responsible for distribution.

Standards: The MOH&FW is responsible for the development of national standards. Family planning training materials for NGOs and cooperating agencies are being updated to standardize norms for the delivery of family planning services.

NGOs: NGOs play an important role in service delivery. The government views NGOs as complementary to its efforts and has assigned them prime responsibility for service delivery in some areas. Since 1987, the government has requested NGOs to provide services in rural areas, mostly in areas where the government program has not been involved. For the most part, subdistricts selected for inclusion in the LIP do not have active NGO service components, although a few representatives from NGOs have been included in LIP study tours. The subdistrict FPO and management committee are responsible for coordinating with NGOs to expand the resources available to support family planning services and community-based management. With the current emphasis on the development of action plans for the entire subdistrict, coordination functions will be enhanced since activities in all unions will be monitored by the FPO.

The LIP planned to promote a larger role for NGOs to take over and support LIP-generated activities, contributing to longer-term sustainability. However, the transfer of responsibility for decentralized management has not occurred due to the inability of NGOs to directly support the government's public sector program.

MIS: The collection and utilization of information is an important element in improving local program management. FWAs are trained to work with volunteers to collect baseline information in villages pertaining to the number and location of eligible couples and their status regarding family planning use. Information is mapped and statistics aggregated to higher levels to allow the calculation of monthly contraceptive acceptance rates for wards and unions. This information feeds into the national MIS, but is also used locally to monitor and evaluate activities.

Supervision, Monitoring and Evaluation: An important contribution of the LIP is the supervision and technical assistance it provides on a regular basis to subdistrict and union program managers. Regular site visits by supervisory staff keep activities going where program staff might otherwise let them flounder. These visits also furnish a mechanism for providing on-the-job training to remedy problems. Sometimes a union or subdistrict will have a very active council chairman or a first rate FPO who will do this, but in most cases, site visits by supervisors deserve a lot of credit for keeping things on track.

The LIP has also emphasized the integration of district and subdistrict supervisory systems by involving district officials in supervision and monitoring. Responsibility for monitoring family planning personnel and program performance will lie with the district and subdistrict family planning officials. Supervisory staff regularly visit project areas to monitor progress and complete performance reports that rate each area's success in implementing its action plan.

5.8 Observations

The experience of LIP has been very favorable. By 1997, management teams from more than 25 percent of thanas will have received training in family planning program management and implemented action plans in their respective areas. According to a series of micro-surveys in LIP areas, contraceptive prevalence has increased faster in subdistricts participating in the project largely because of highly successful visitation rates by volunteers. A detailed survey of participating and nonparticipating subdistricts is planned to verify this preliminary finding. Ideas and approaches have diffused beyond project boundaries. District officers are increasingly taking the initiative to adapt the strategy to other areas not covered by LIP. The World Bank is also considering adopting the LIP approach, extending this type of decentralization to more than 50 percent of the country. With relevant training and opportunities to put plans into action, local management of family planning programs can produce creative, innovative strategies that have a rapid impact on the program.

In spite of a national policy endorsing devolution and deconcentrated program structure and field management staff, most programmatic decision making in the Directorate of Family Planning remains highly centralized. Subnational areas have responsibility for administering local programs without any real authority to effect change on their own initiative. The LIP motivates family planning personnel to improve their program management capabilities, and in so doing, promotes bottom-up capacity building. It has been said that top bureaucrats do not believe they have sufficiently trained persons at the middle level. This lack of confidence is often coupled with a fear of losing power, no longer being in control, and resistance to change. Local areas

must sometimes demonstrate the capacity to take on increased responsibilities. Capacity building in LIP has not been an attempt to wrestle power from the central government, but to focus attention on areas where central management has been inadequate, such as in the case of satellite clinics and contraceptive supply. In so doing, LIP has focused on operationalizing government policy, not substituting for it.

The entire Bangladesh family planning program is heavily subsidized by external donor assistance. Decentralization activities have occurred as a result of USAID assistance and have been phased-in over the life of the UIP/LIP Projects. This has allowed for progressive experimentation, considerable flexibility in approach, and opportunities to adapt to rapidly changing circumstances. The LIP approach was first implemented in thanas, then it changed its focus to unions after the Upazila Parishad was dissolved. Because of the success at the union level and the high participation of unions, LIP is once again focusing efforts on the thana. The goal is to improve management of family planning at the thana level, taking into consideration the total pool of resources, including those from LIP and NGOs. LIP is now in its third stage of evolution, focusing on the district as a critical locality to ensure overall sustainability of the LIP approach. The emphasis is also shifting the supervisory capabilities of the district FPOs to include planning and general management systems. The concepts of leadership, capacity building and management systems have gradually changed from a project-specific orientation to a program orientation. Implementing a decentralized system of program management takes time, and developing capacity at all levels of administration can encourage and empower program managers to bring about change. Setting up and staffing an administrative infrastructure is a first step toward future autonomy in decision making and program management at the local level.

6. THAILAND: ADMINISTRATIVE DECONCENTRATION OF THE NATIONAL FAMILY PLANNING PROGRAM

6.1 Background

Thailand is a high contraceptive prevalence country with a strong, mature, active national family planning program. According to the 1987 Demographic Health Survey, the contraceptive prevalence rate was 67.5 percent, including 64 percent for modern methods. There is considerable variation, however, in prevalence by region and among provinces. The goal of the family planning program is to increase contraceptive use in low prevalence areas and to raise the national rate to 77 by 1996. Thailand also has achieved dramatic declines in fertility. Since the program began in 1970, the total fertility rate has declined from around 6 to 2.4 currently. The annual rate of population growth has declined from 3 percent to 1.4 percent for the same period of time.

The National Family Planning Program (NFPP) in Thailand is implemented by the Family Health Division (FHD) of the Ministry of Public Health (MOPH). It is predominantly a public sector program complemented by private sector services. The government is the source for 84 percent of contraceptive users, with the private commercial sector providing about 15 percent of services,

and nongovernmental organizations (NGOs) and other institutions providing less than 2 percent. The Thai government has always encouraged and allowed the private sector and NGOs to do their share, even if their activities diverged slightly from MOPH policies and procedures (POPTECH, 1991b).

FHD retains budgetary and management authority for the NFPP while using the extensive existing network of MOPH hospitals and health centers to deliver services. The Ministry of the Interior also administers public health facilities in which family planning services are provided in Bangkok and other municipalities. Currently, there are over 8000 government health centers, mostly in rural areas, and over 700 government hospitals. The program is largely clinic-based (both public and private sector), although there is some use of community-based distribution. Thailand also has made extensive use of paramedics for the provision of supply methods and for the insertion of IUDs.

The family planning program in Thailand is now funded primarily by the Thai government. When USAID began phasing out support for contraceptive commodities in 1982, the FHD budget increased fourfold to accommodate the purchase of commodities by the Government of Thailand (Bennett et al., 1990). USAID bilateral assistance to Thailand ended in 1989. Although the family planning program is sustained by government support, the FHD seeks to increase the cost-effectiveness of its interventions and to promote the use of long-term methods.

6.2 Deconcentration of MOPH/Family Health Division

Thailand has four regions (Bangkok is part of the Central region), and is divided into 76 provinces, including the Bangkok metropolis. Provinces are comprised of districts (approximately 700 nationwide). Tambons are the next smaller unit within the districts. Several villages comprise a tambon. The administrative structure with its corresponding levels of health facilities is shown in Table 3.

Since the promulgation of its population policy in 1970, and the creation of the NFPP, the Thai government has systematically extended its service delivery facilities throughout the country, using the MOPH network of physicians, nurses, auxiliary midwives, and health workers to administer and provide family planning information and services. To manage the extensive network of providers, FHD uses the provincial and district health offices and their personnel to monitor and implement family planning activities in provinces, districts, tambons, and villages.

Table 3. Program Administration by Geographic Area: Thailand

Geographic Area	MOPH Service Facility	Family Planning Management & Personnel	Political Leadership
Province	Provincial Health Office Provincial Hospital	PCMO	Provincial Governor
District	District Health Office District Hospital	District Health Officer Hospital Director	District Governor
Tambon	Tambon Health Center	Tambon Health Workers Auxiliary Midwives Mobile Motivation and Service Teams	Tambon Chief
Village	Mobile clinics	Village Health Volunteers	Village Head Man

Thailand's use of provincial field offices to manage its health and family planning program follows the model of administrative deconcentration. Provincial officers have clearly defined administrative responsibilities for managing the family planning program and limited authority for independent decision making and planning. Each province also has a governor, who is the highest ranking civil service official at that level. Governors are employees of the Ministry of the Interior and have overall responsibility for development activities in the provinces and districts. Provincial development budgets are controlled by the provincial governors. The government has recently made block grants to provinces for all development projects within the province. However, provinces have to follow guidelines specified by the central government. Most of the development funds are spent on nonhealth-related activities.

There are MOPH administrative offices in all provinces and districts for the management of health and family planning services. The provincial chief medical officer (PCMO) oversees all health and medical services in the province, including family planning. The PCMO reports to the MOPH/FHD for all technical matters regarding the family planning program, but is responsible to the provincial governor. The PCMO and district health officer are responsible for managing program activities in the district hospitals and the tambon health centers, and the work carried out at mobile clinics. They also select, train and receive reports from the network of village volunteers, who collect information on eligible couples for input to the national management information system (MIS). The most peripheral employees of MOPH work in tambon health centers and provide health and medical services, including family planning. The auxiliary midwife (AMW) is the most peripheral staff position for family planning, and historically AMWs have played an important role in providing services in the transition from high to low fertility in Thailand. Generally, an AMW has a high school education and two years training in family planning and maternal and child health.

This case study first describes the existing form of deconcentration characterizing the MOPH and the national family planning program as administered by FHD. It then describes a pilot project that tested the feasibility of transferring additional planning and management authority to provincial offices. The final section presents our understanding of the current status of decentralization in the FHD, including some observations pertaining to successful implementation of decentralized management.

6.3 Functions of the Family Health Division

Central FHD is responsible for national program planning, setting national priorities, and maintaining national statistics. FHD has separate departments for logistics, procurement, training, IEC and research. In addition, FHD is responsible for budgeting activities, dispensing funds to provinces and districts and providing requisite technical support. Unlike many other countries, Thailand does not have a separate organization responsible for policy, awareness-raising and coordination of population and family planning activities.

Despite the availability of program management personnel in provinces and districts, FHD has been responsible for planning, setting targets and budgeting for activities at the province and district level. As contraceptive prevalence has increased, program priorities have shifted from a nationwide program to one focusing on underserved population groups and increasing contraceptive prevalence in low prevalence districts. Since 1980, FHD has used census data pertaining to contraceptive use, disaggregated to provincial and district levels, to calculate the size of target populations and to allocate resources and plan interventions for specific areas. FHD sets targets to raise contraceptive prevalence in provinces and dictates the specific types of interventions used to attain those goals. Provinces and districts implement these interventions within the fixed budget specified by FHD.

Financial Resources: All government and donor resources for the NFPP are channelled through FHD to maintain control over finances. Recurrent costs for the NFPP are covered by the central MOPH budget. (FHD is not involved in any of the recurrent operational costs of the province, except for the provision of contraceptive supplies.) Provinces and districts have a centrally-determined budget with fixed line items for interventions and specific activities. Money from FHD is used for planning, implementing and monitoring program interventions, and paying for related expenses such as travel, per diem and materials. Provinces have no mechanism for reallocating funds between activities. At present, small amounts of additional funds are available from other sources, including: MOPH mobile service delivery funds, external donors (UNFPA and JICA), and from the provincial development budgets controlled by the governors.

MIS: FHD receives monthly reports of service statistics from each district containing information on new acceptors and methods of contraception supplied. This information is combined with projected data from the decennial census to estimate the contraceptive prevalence rate by method and month for provinces and districts. FHD sends an active users report to the PCMO approximately four months later.

Training: The central FHD staff is responsible for training regional and provincial program managers. There are regional MCH centers to train nurses and midwives in family planning and maternal and child health. There are also regional training centers for training other medical personnel. The Thai government has always emphasized ongoing training for all levels of service providers (POPTech, 1991a). It has a highly qualified, well-trained provincial and district staff. Staff recruitment is actually done in the provinces and districts. As a by-product of Thailand's social and economic development, provinces have been able to attract and keep qualified personnel.

Logistics and Procurement: Central FHD is responsible for procuring contraceptive commodities and distributing them to provinces for distribution to local service delivery sites.

IEC: FHD has overall responsibility for IEC. Provinces may also be involved in planning local IEC campaigns and developing family planning messages, if their proposed activities are approved by FHD. For example, provinces have produced radio and television spots, and messages recorded on cassettes have been used by mobile teams for case recruitment and to announce sterilization campaigns.

Supervision: Provincial staff members travel to districts to supervise case recruitment and service provision. District staff members supervise activities at the tambon and village level. Provincial budgets include a line item for per diem and travel to make these supervisory visits.

Private Commercial Sector and NGOs: MOPH and the NFPP have a close relationship with the private commercial sector and NGOs. Operational districts for NGOs and the community-based projects are selected in consultation with the NFPP to maximize the availability of services and prevent duplication. Provincial and district personnel are consulted and informed before any activities are undertaken in their areas. Government facilities provide clinical backup support and serve as referral points for clinical methods (Nirapathpongorn and Viravaidya, 1983).

Community Participation: There has not been much community participation in determining how the NFPP should be run in local areas such as villages. Although there are village health volunteers in every village, they function more for facilitating activities that are planned and funded by the province or district. The AMW is a village-level worker, who may well be the voice through which the village raises its concerns to higher authorities.

Summary: Although central FHD has overall responsibility for most aspects of the NFPP, provincial offices do have considerable responsibility for planning, day-to-day management and supervision of provincial and district activities, adapting national plans to the local level, and recruiting and training staff to perform administrative functions of the field office. The provincial staff are well-qualified and highly trained. They have been eager to take on additional authority to plan, budget and manage the program in their respective areas.

6.4 Rationale for Increased Decentralization

There is considerable interest in raising the efficiency and cost-effectiveness of the family planning program to improve performance and making services more responsive at the local level. Improved management has also been a concern of FHD since the early 1980s (Marshall and Adamchak, 1989). Another element in the emergence of decentralization may have been the changing pattern of foreign support. When it had lots of foreign aid, FHD may have been more important as a central organization. When aid declined, the government became more interested in promoting increased effectiveness and efficiency, reverting to a system of expanded local authority.

The initial idea for decentralization of program management came from a 1986 needs assessment for primary health care, which concluded that centralized authority was a constraint to improved management (Kamnuansilpa et al., 1992). Within a broader project focusing on high priority districts, FHD and USAID subsequently sponsored a pilot study to determine whether decentralized management would improve family planning program management. The rationale was that provincial and district officials would be better able to determine local needs, develop appropriate strategies to deal with them, monitor and supervise interventions, revise strategies accordingly, and do this for less cost. Efforts to decentralize program management have also come about as a result of a demand for more autonomy by energetic and well-trained provincial managers who feel competent and capable to plan, program and monitor activities in family planning (Donaldson and Bennett faxes).

6.5 Pilot Project for Decentralized Management

The pilot project took place from 1987-89 in six provinces in northeast Thailand. Four provinces were selected to implement decentralized management and two additional provinces were selected to serve as controls. In these provinces, FHD would continue to operate as usual. Complete details of the study are contained in the final project report (Kamnuansilpa et al., 1992).

The four experimental provinces in the pilot project were given the authority to:

- "conduct local assessments of service needs;
- set local family planning priorities and targets;
- select the districts which would receive additional resources and technical assistance;
- select the mix of interventions that would be undertaken in these districts to raise contraceptive prevalence;
- determine the budget that would be allocated to each district to carry out these activities, monitor implementation of the interventions and the expenditure of budgeted funds; and
- make adjustments to priorities, targets, strategies and interventions and budget as appropriate to improve performance" (Kamnuansilpa et al., 1992, pp. 14-15).

The project began by providing technical assistance to conduct a needs assessment and management training in the experimental provinces. Because of the existing administrative infrastructure, no new staff were required to implement decentralized management. Planning functions were quickly transferred to the provinces; FHD was slower to give up control for resource allocation and budgeting, but the experimental provinces had this responsibility by the end of the pilot project.

With increased authority for managing the family planning program in provinces, the PCMO worked with districts to develop plans and budgets for submission to FHD and the Budget Bureau. District program managers had authority for planning and monitoring family planning activities within the limits specified by the province. The pilot project staff provided technical assistance to provinces to set up their MIS and trained the staff of the PCMO office in its use. They also worked with the provincial staff to develop skills in setting priorities, developing work plans and budgets, and assessing and monitoring service delivery and interventions.

Pilot Project Financial Resources: As part of the pilot project, FHD changed its mechanism for disbursing funds in the experimental provinces. Instead of receiving funds from the centrally determined budget with fixed line items, FHD made block grants to the provinces which allowed funds to be reallocated during the fiscal year to meet unexpected local needs. At first, the budgets submitted from the provinces contained items that they were sure FHD would agree to fund. With block grants, provincial program plans became more innovative and responsive to local conditions and priorities. There was considerable variation in how provinces allocated funds to districts and to activities. For example, provinces provided funds to all districts, not just the high priority districts, and used different criteria for disbursing funds among districts. Provinces made allocations to districts on the basis of approved work plans. Provinces and districts gained access to a limited amount of additional funds from private drug companies and pharmacies, district hospital service charges, NGOs other than AVSC, injectable service fees, and some staff contributions of per diem (senior staff wanted to demonstrate they could effectively manage project funds) to supplement the block grants and routine budgets.

With increased decentralization, provinces showed considerable variation in how they programmed resources and selected interventions. Provinces demonstrated they were able to tailor interventions to local conditions and raise overall levels of the CPR in doing so. For example, provinces participating in the study showed variation in the extent of involvement of district managers in resource allocation decisions, the way in which they used the MIS to guide resource allocation decisions, the use of local leadership to assist with recruitment campaigns, and the implementation of multiple intervention strategies (rather than relying on a single strategy as was the tendency for central FHD.)

Pilot Project Provincial MIS: The purpose of the MIS in experimental provinces was to monitor overall family planning performance, measure the impact of project interventions on the contraceptive prevalence rate and the use of long-term methods, and to facilitate the selection of interventions. With decentralization, it is important for service data to be processed locally and without long delay to better identify problems and allocate funds to address them.

In the pilot project, the provincial MIS was set up to include results from the annual census of married women of reproductive ages and of couples using contraceptives conducted by the village health volunteers, integrating the results of the service statistics and the census to provide an ongoing monthly measure of CPR. Cost information was also included to measure overall program efficiency and cost per acceptor. Data from all districts could be entered in a day and a report generated for immediate use. Monthly reports were used by provincial managers to allocate project funds; the reports generated by the system were distributed at monthly meetings for discussion with district program managers. Program managers could choose or reprogram case recruitment activities according to the success or failure of recent activities as monitored by the MIS.

Pilot Project Results: Data from baseline and follow-up surveys, from the new provincial MIS, and interviews with family planning managers and providers at the local level were used to determine the impact of decentralized management on family planning use.

Although there were problems with the experimental nature of the project design¹, the pilot project in northeast Thailand clearly demonstrated that decentralized management of family planning programs resulted in greater responsiveness to local needs, more efficient management of resources, and better coverage of the client population. Although the contraceptive prevalence rate increased in both experimental and control provinces, the increase was greater in the experimental provinces. Results showed a positive relationship between the extent of decentralization (increased autonomy in planning, budgeting, resource allocation and monitoring) and acceptance of long-term methods (IUDs and sterilization). Increased decentralization also resulted in improved efficiency; despite reduced budgets, the number of IUD acceptors and sterilizations increased far more than in control provinces (Kamnuansilpa et al., 1992).

6.6 Follow-up to the Pilot Project

Pleased with the results of the pilot project, FHD's attitude toward decentralization became more favorable. FHD asked for assistance in developing guidelines for implementing increased decentralization of management authority for each level of government: central, regional, provincial and district. These guidelines are summarized in "Policy and Procedural Guidelines for Decentralization, Family Health Division, Ministry of Public Health, Thailand" (MORE Project, 1992).

¹FHD promoted some elements of increased decentralization in the control provinces toward the end of the pilot project, although not to the same extent as in the experimental provinces.

This document outlines policy changes that would be needed to achieve the objective of increased decentralization of planning and resource allocation. FHD would have to:

- redefine the role and responsibilities of the central and regional offices of FHD;
- devise a mechanism for providing funds to provinces;
- transfer authority to provinces to determine interventions and activities;
- provide assistance to provinces for the development of a revised and streamlined MIS; and
- provide technical assistance to provincial managers on needs assessment, planning and monitoring.

The document included procedures for determining the amount of money that would be provided to provinces and for governing how funds could be allocated or reallocated to specific activities. It also specified the supervisory and monitoring responsibilities required at different administrative levels, and presented components of a yearly planning and resource allocation cycle that would be needed to implement decentralization. The changes would be phased-in over a period of 4-5 years, starting with those provinces where regional MOPH offices are located to capitalize on available expertise for providing technical assistance. Progress toward decentralized management would be reviewed at the end of each fiscal year by central and regional MOPH, adjusting the levels of technical assistance provided to the provinces on the basis of their need for achieving the objectives of increased decentralization.

FHD would provide the funds (in the form of grants), set national priorities and provide the required technical and supervisory support. They would retain authority for training, IEC, logistics, procurement, etc. Regional MOPH offices would provide technical assistance to help the central office monitor the provinces' experience with decentralization. Provinces and districts would interpret national priorities within the context of local needs and resources. Provinces would have full discretion for family planning funds, although some budget items would have rates fixed by national guidelines (per diem, for example). There would be latitude for shifting of funds within line items (e.g., between programs) with central approval, but changes between budget items would require Budget Bureau approval. Districts would have the authority to plan and allocate the resources provided by the province based on an approved work plan, but provinces would retain authority over districts. The degree of decentralization to districts would vary according to their capacity and the delegation of authority to them by the provinces.

6.7 Current Status of Decentralization

Implementation of decentralization has not yet been supported as described in the "Policy and Procedural Guidelines for Decentralization" (MORE Project, 1992). FHD has not provided technical training for decentralized management to regional or provincial health officers. Although a supportive policy climate exists, it may take some time for the ideas and new leadership at FHD to take hold of the process. Although FHD has allowed more freedom to provinces to set targets, specify interventions appropriate for the provinces and to allocate funds, provinces have been slow to seize the opportunity. One component of the pilot project is being

carried out: with the assistance of UNFPA, FHD is expanding the provincial MIS to selected provinces in the northeast region by 1996. The objective is to implement a reporting system that will support effective decision making and strengthen management practices at the provincial and lower levels.

The delayed replication of the pilot program was due to the limited budget of the NFPP. (The pilot project had been implemented using funds from USAID/Bangkok and University Research Corporation through NIDA.) The NFPP has allocated block grants for IEC activities in selected districts to replicate the pilot project. Replication of the MIS is not possible due to its high cost.

The concept of decentralization has become a national issue, with other ministries considering changes in administrative strategies. MOPH alone cannot move very fast because the superstructure is very strong, and all changes in resource allocation procedures have to be approved by the Budget Bureau and the National Auditing Office. During 1991-92, the government made block grants to each province for all development projects within the province. However, provinces must follow guidelines and categories of funding specified by the central government. Little of the money from the block grants was spent on health-related activities.

Regional Health Promotion Offices will monitor and evaluate the progress and impact, if any, of decentralized management in the provinces. Evaluation plans and indicators will be developed when FHD fully implements decentralized management. Progress is being made, albeit slowly.

6.8 Observations

The existing program structure (strong central office with provincial and district field offices) has in no way impeded Thailand's dramatic success in achieving high levels of contraceptive prevalence and lowering fertility. The program's success has been attributed to a number of factors that are clearly outlined in Bennett et al. (1990). However, Thailand's experience with deconcentration and the results from the recent pilot study pertaining to increased decentralization of program management highlight several factors that would contribute to successful implementation of decentralization.

First, implementing decentralization policies and procedures requires political commitment. The family planning program has benefitted from strong leadership and commitment within MOPH, but also at other levels of government. Provincial governors have recognized the importance of lower growth rates for increased social and economic development and initiated family planning activities in some provinces independently of FHD. In response to this interest, FHD provided training in 1987-89 to provincial and district governors in appropriate service delivery strategies for family planning. Provincial and district program managers have also elicited support from governors for building or renovating facilities when needed and for providing assistance in special family planning campaigns.

Second, FHD leadership strongly supported the efforts to decentralize management to the provincial level. Involved from the beginning in planning and monitoring of the pilot project,

the director of FHD greatly facilitated the budget flow and autonomy in planning. He was very enthusiastic about the results and began implementing elements of decentralization in the control provinces before the project ended. He also recommended continuation of the process and commissioned a group to develop guidelines to implement decentralized management nationwide.

Third, having a complete administrative infrastructure in place through deconcentration provided a firm foundation for providing increased autonomy. This has been cited in other countries as an important preliminary step to increased autonomy in program management (Manganu, 1990). No additional managerial staff were needed or had to be transferred from the central offices to the provinces. The high calibre of existing staff at all levels, and the availability of the necessary skills and capabilities to take on the additional responsibilities associated with decentralization facilitated the transfer of authority. Local governments must sometimes demonstrate the capacity to plan and manage in order for central authorities to grant more responsibility.

Fourth, the availability and utility of the provincial MIS had a major impact on increasing the capability of provincial managers to effectively plan and allocate (or reallocate) resources in ways that could affect the levels of contraceptive prevalence. Having an up-to-date, current, and accurate source of information made it possible to reallocate resources to activities and to areas that were most successful, resulting in a greater impact on contraceptive prevalence. (However, the NFPP has no policy or plan to replicate the system due to budgetary limitations.)

The NFPP leaders have always been flexible in their approach and have put the goal of service provision above any territorial concerns about who will deliver services or how they will be provided (Bennett et al., 1990). Program leadership has been responsive to new and innovative strategies for improving the national program. As the program now turns its attention to improved management and increased cost-effectiveness, it makes great practical sense to consider decentralization of program management to achieve these goals.

7. KENYA: A CASE STUDY OF THE DISTRICT POPULATION PROGRAM

7.1 Background

Throughout the 1970s and 1980s, Kenya had the distinction of having both the oldest national family planning program in sub-Saharan Africa and one of the highest fertility rates in the world. Kenya has recently gained further distinction as a country now experiencing a rapid decline in fertility, as the 1993 Kenya Demographic and Health Survey (KDHS) reports a total fertility rate of 5.4, down from 7.7 in 1984. The decrease in fertility observed in Kenya occurred across all population groups, including age, economic, rural/urban, and birth order groups (Brass and Jolly, 1993).

As yet, there is no consensus as to the primary cause of this drop, but contributing factors certainly include reductions in infant and child mortality, increased participation in education (and the increasing costs to parents for educating their children), shifts in economic trends that favor

smaller families, the continued expansion and government support of family planning, and the broad range of innovative and effective NGO family planning activities. The importance of increased acceptance of family planning is supported by the contraceptive prevalence rate for modern methods, which has increased from 18 to 28 percent between 1989 and 1993 (NCPD, 1993).

In Kenya, a closer examination of the population program reveals a myriad of services and providers. These include the government at varying levels of administration, the private commercial sector, nongovernmental organizations, and grass-roots organizations, any combination of which may be connected through such program elements as IEC, training, contraceptive supply, etc. The 1993 KDHS shows that the government supplies approximately 68 percent of modern contraceptive methods through its network of hospitals, health centers and dispensaries. The private sector, including the Family Planning Association of Kenya and other NGOs, is the source of supply for about 25 percent of modern method users, and community-based distribution is the source for approximately 3 percent of users.

The focus of this case study is the decentralization of the National Council on Population and Development (NCPD) and its District Population Program. Family planning services, provided through a hierarchy of MOH and NGO health service delivery institutions, are coordinated via the DPO program.

7.2 Kenya's Decentralization Program

The principal form of decentralization currently in progress in Kenya is deconcentration. Essentially, representatives of central government organizations, such as the Ministry of Health or the NCPD, exist alongside those of local government. Selected elements of the population policy program—such as planning, management, coordination and monitoring—are deconcentrated. However, central government and ministries retain control over resources, policy and personnel, set national targets and goals, and establish budget levels within which the various decentralized committees (described below) must operate.

Although the district-level government bureaucracy has existed since independence in 1963, emphasis on decentralization intensified in 1983, when the government initiated its District Focus for Rural Development policy. This national policy for rural development shifted responsibility for planning, implementation and management of development programs in all sectors from the central ministries to the districts. The official guidelines for the district focus state:

"Responsibility for the operational aspects of district-specific rural development projects has been delegated to the districts. Responsibility for general policy and the planning of multi-district and national programs remains with the ministries...The objective of this strategy of shifting increased responsibility to the districts is to broaden the base of rural development and encourage local initiative in order to improve problem identification, resource mobilization, and project design and implementation" (GOK, 1987, p. 1).

The guidelines redefined the role of the District Development Committee, which existed in all 41 districts, to include responsibility for "rural development planning and co-ordination, project implementation, management of financial and other resources, overseeing local procurement of goods and services, management of personnel, and provision of public information" (GOK, 1987, p. 1).

7.3 Rationale for Decentralization of Population Policy Program

Kenya's population and family planning program was included in these early decentralization plans (Johnston, 1984). In Kenya there is general consensus that rapid population growth can have negative consequences for development, and that therefore population/family planning warrants strong support. Government efforts in family planning began at independence in 1963, and Kenya was the first sub-Saharan African country to institute a national family planning program in 1967. During the 1960s and 1970s, the establishment of data resources and infrastructure developments were the primary program efforts.

In spite of the early establishment of a national family planning program, President Kenyatta did little to encourage family planning efforts, and the early family planning work was done mostly under the auspices of NGOs. This lack of strong political commitment probably contributed to the slow start of the program. It was not until the early 1980s that appreciable efforts were extended and some of the desired effects of the program were observed in the form of increases in contraceptive prevalence and reductions in fertility. By this time, a large number of outlets were providing family planning services in the country.

The NCPD was formed in 1982 to coordinate the increasingly multisectoral population activities. NCPD was located within the Ministry of Home Affairs and National Heritage until 1993, when it was shifted to the Ministry of Planning and National Development. It is charged with improving family planning program effectiveness by developing, implementing, evaluating, and coordinating population programs in government agencies and the private sector.

In keeping with the district focus, the Government of Kenya determined that districts should plan and implement population programs that follow national goals, yet are tailored to local needs and resources. Since its inception in 1983, the District Focus has been revised and strengthened. Two National Leaders Conferences, in 1984 and 1989, brought together leaders from all levels of government, community leaders and representatives from Kenya's many population-oriented NGOs. At the 1989 conference, President Moi called for community participation in planning and implementing population programs so as to ensure cultural sensitivity and local-level priorities. Government officials attending the conference voiced their support for the efforts of the NCPD and the District Development Committees.

The formation of the NCPD was followed in 1985 by the formation of District Population and Family Planning Committees (DPFPC) to facilitate the implementation of the district focus with regard to population activities. These committees are charged with formulating district population goals co-terminus with efforts at reaching a specified set of demographic, educational and service

delivery goals set by the NCPD (GOK, 1986). In 1986, the post of District Population Officer (DPO) was created. The DFFPC is composed of the District Commissioner (who is chair), District Population Officer (who is secretary), a representative of the District Development Committee, representatives of all relevant Ministries at the district level and representatives of relevant NGOs. The DPO makes sure the DFFPC meets regularly. The DPO then assists in carrying out the recommendations of the committee, in liaison with government ministries and NGOs.

DPOs, as the district representatives of the NCPD, liaise between the NCPD and organizations/agencies working in districts, to plan for and assess district needs for population programs. DPOs are supervised by NCPD, but report to the District Commissioner and the District Development Committee. DPOs are responsible for coordinating population activities and UNFPA-sponsored projects, raising awareness of population issues, collecting and analyzing data and monitoring progress toward goals. They meet regularly with district authorities, both sectoral department heads and political officers.

Although DPOs are mandated in all 41 districts, the position is being phased in. Six DPOs were posted in 1988. The initial districts were selected to obtain a reasonable representation of the national population and to focus on priority areas for implementing family planning policy (e.g., high density, urbanization, availability of data, etc.) The number of districts having DPOs increased to 14 in 1990, and an additional 17 posts are proposed. Eventually DPOs will be posted in all districts. Until such time, the District Commissioner assigns a District Officer to perform the duties of the DPO. However, only a limited number of districts without a DPO formed a DFFPC, and in some cases, DPOs have been assigned to cover two districts.

Initially, the DPO was to coordinate all family planning activities at the district level, and since 70 percent of users get their services from the public sector, this coordination and support function was presumed to include the public sector MOH family planning services. Specifically, the DPO was also supposed to be an active member of the District Health Management Team (DHMT), where the DPO would lend technical support for monitoring, evaluating and coordinating family planning activities. In practice, coordination among the DPO, the District Medical Officer (DMO) and the DHMT has not always worked smoothly. DPOs have only occasionally been active on the DHMTs. It has depended on the personalities of the DPO and the DMO. Where one or the other was "defensive" about their territory, there was often little interaction. The DPOs often found a much more receptive audience for their services among the NGOs. Occasionally, where the DMO and DPO got along well and saw coordination as mutually beneficial, there was some useful interaction on planning and monitoring of family planning activities.

Naturally, the strength of the DPO's technical and interpersonal skills often determines his or her success in initiating and coordinating program activities. Some of the early difficulties with the program stemmed from the difficulty of recruiting qualified personnel, locating office space and obtaining the necessary equipment with which to carry out their duties. Due to a shortage of trained personnel in districts, DPOs have often had to take on the added responsibilities of the

district statistician and economics officers, although they tend to lack appropriate technological support, such as computers, to adequately fulfill these duties. Given the broad nature of their responsibilities, DPOs in a few districts do not seem to be very well-suited for their posts.

7.4 Fiscal Resources and Budget Issues

The DPO program received financial support from a number of foreign aid sources (SIDA, NORAD, USAID) as well as agencies of the UN (ILC, UNFPA). This support has covered training, personnel, computers, vehicles and contingency budgets as well as construction and furnishing of DPO offices. Training and technical assistance has been assumed by IDA/World Bank. The government of Kenya has assumed costs of recruiting DPOs, secretarial services, training facilities, drivers and vehicle maintenance. NCPD has paid for its own personnel to provide training to DPOs and monitor activities in the field.

At present there are no direct fiscal contributions to the DPO program from districts. However, elected members of parliament sit on the District Development Committees, and representatives of the NGOs active in each district are invited to attend meetings of the DPFPC, as are district representatives of the various government ministries. The District Development Committees receive a budget from each ministry within the national government, and have the power to allocate this budget in line with national goals for development. The DPO can help to advocate for increased financial allocations to family planning activities.

This is not to say that the central government controls all population resources. For example, at the level of municipalities, city councils have the authority to generate funds from licenses, fees, etc., which can be used according to municipal priorities. Currently, these funds are divided primarily between education and health services for the communities.

7.5 Program Implementation Details

Training: The initial six DPOs were recruited at large and trained for their posts. The next eight were taken from within the NCPD. The DPO program called for a two-month intensive training period, to be conducted by a special team of Kenyan consultants and one consultant from the United Nations. Training of the first cadre of DPOs was thought to be quite good. The second cadre did not receive the same extensive training, which was conducted this time by NCPD personnel.

The DPOs serve as trainers as well. They are responsible for training DPFPC members on managing population programs. DPOs present seminars and programs on the analysis of population and family planning data to relevant groups in their districts, including the District Health Management Team.

IEC: Since 1986, NCPD has had primary responsibility for IEC, which it coordinates with the National Family Planning Program in the Ministry of Health. NCPD also coordinates IEC activities with the Ministries of Agriculture, Technical Training and Applied Technology, and

Culture and Social Services. The District Population and Family Planning Committee is to liaise with the Ministry of Information and Broadcasting for IEC. The DPOs are to work with the DPFPC in all aspects of IEC. A 1990 project review noted that "Currently the heaviest demands on DPOs are for directly serving IEC-type functions and dealing with other IEC-related project activities" (Freymann, 1990, p. 46).

Management Information System (MIS) and Logistics: Over the past decade, several MIS systems have been tried in developing a national family planning information system. MOH has recently decided to consolidate the collection of family planning statistics in the Logistics Management Database in the Division of Family Health. This is the most elaborate family planning information system, but it currently contains mostly information from government clinics with an overall reporting rate of about 66 percent during the last two years. NCPD has established a database to consolidate NGO statistics, but this, too, is a sporadic effort with incomplete coverage. It is the responsibility of the DPO to make sure that MOH, NGO, and private commercial sector providers in districts have the necessary forms and participate in providing information to the different databases.

NGOs: NGOs provided about 13 percent of Kenya's family planning services in 1993. Foreign donors support NGOs by channelling funds through NCPD, which then allocates resources to NGOs within the constraints of ministry regulations. In districts, the DPOs coordinate the efforts of NGOs, and they have thus far been successful in liaising with them. The DPO has become an important ear of the government and NCPD for NGOs. NGOs have appreciated the lobbying efforts of DPOs and are happy to work with them. As a result, there has been improved coordination between the government and NGOs in the provision of family planning services (Larsen, 1991).

Standardization: The Ministry of Health is responsible for setting standards for family planning service delivery. There has been some concern that NGOs have different standards for service delivery. The DPOs are to work with the NGOs to arrive at a standard that all NGOs will meet.

Evaluation: The District Health Management Teams, with assistance from the DPO, are to develop an evaluation program for family planning activities. The DPO is also slated to develop an evaluation program for community-based delivery activities. However, an external evaluation of the DPO program recommended that DPOs not evaluate projects, as "it would completely change their present well-balanced role as coordinators and facilitators" (Larsen, 1991, p. 7).

7.6 Observations

Kenya's decentralized population program is considered a partial success (Larsen, 1991; Freymann, 1990). With the plethora of family planning services provided in Kenya, DPOs have shifted from their original mandate of working on broader population and development issues to focus more on family planning efforts. DPOs have been well received in districts and their success in family planning education, coordination and liaison with nongovernmental family planning organizations has resulted in heavy demand for their services.

Kenya has, however, encountered problems with its decentralized DPO program. These problems have provided opportunities for lessons learned and actions have been taken to make adjustments to the program. In particular, NCPD has become an inefficient bureaucracy, chronically short-staffed and very slow in moving funds to the NGOs. Some of the inefficiency can be attributed to the weak position of the organization within the Ministry of Home Affairs and National Heritage. For example, NCPD was required to stay within the budgetary ceiling set by the Ministry, even when incoming support to NGOs exceeded the ceiling amount. This occurred because the Ministry was unwilling to increase the government's recurrent costs by increasing these ceilings. Careful consideration of these and other difficulties led the government to shift NCPD to the Ministry of Planning and National Development in 1993. NCPD may now have more flexibility to fully reflect all donor resources in its annual budget. Flexibility is an important issue, as conditions and roles change as decentralization is implemented.

Another lesson has been learned from the recruitment and training of DPOs. In the initial stage of the DPO program, there were also difficulties in filling the DPO posts. Those posted have not received sustained support, supervision and communications from NCPD headquarters. Lack of qualified personnel and infrastructure hampered the project's ability to place DPOs in districts. Problems with supervision and training of DPOs by the NCPD were also aggravated by budgetary constraints set by the Ministry of Home Affairs. NCPD's move to the Ministry of Planning and National Development should improve this situation. Kenya's experience demonstrates that training and the need for well-qualified personnel at the local level to guide program efforts are essential elements for a decentralized program.

To fully understand the Kenya family planning program, a similar analysis would be needed of family planning service delivery by the MOH, NGOs and the private commercial sector. The government is currently setting definitions and categories of its health facilities, as well as creating District Health Management Boards, which include representatives of both government and nongovernment agencies (MOH, 1991). The boards are supposed to play a key role in allocating resources generated from cost-sharing fees among the various primary health care needs in the district. This is a major effort at decentralizing some of the planning and resource allocation functions previously handled mainly at the center. Health Management Boards are in the early stages of implementation, so there is little to report, but the role of the District Population and Family Planning Committees will need to be reviewed in relation to the functions of the newly established health boards to ensure appropriate coordination and adequate support of family planning activities. Again, the importance of careful planning and coordination for successful decentralization is clearly demonstrated in Kenya's case.

8. ADDITIONAL COUNTRY SUMMARIES

8.1 Anglophone African Countries

In recent years, a number of African countries have decentralized population programs and primary health care services including integrated family planning and maternal and child health programs. Tables 4-6 illustrate the characteristics of family planning programs and the approaches to decentralization taken by nine countries in Anglophone Africa, including Nigeria and Kenya. The information for Anglophone African countries was gathered largely from the OPTIONS II Regional Workshop on Strategic Planning for the Decentralization of Population and Family Planning Programs in Anglophone Africa, held in Uganda in June 1993.

Most of the Anglophone countries represented in the tables are moving toward the devolution approach to decentralization. This may be a result of changes in political leadership and the growing movement toward increased democratization and government restructuring. For some countries, like Nigeria, decentralization is the result of a constitutional decree that affects several development sectors. For other countries, select ministries, such as the Ministry of Health, are making administrative decisions to decentralize program management as a way to tailor programs to suit local needs. Decentralization is clearly a recent phenomenon in most countries and only limited experience has accrued. Even countries that made the decision to decentralize at earlier points in time, such as Botswana and Nigeria, have changed approaches over time. Despite apparent similarity in the overall approach to decentralization, the information presented in the tables masks considerable differences in implementation on a country-by-country basis. Some of this experience is captured in the country summaries that follow.

Botswana

In Botswana, family planning services are integrated into maternal and child health services. Over the past twenty years, the primary health care program, including maternal and child health and family planning, has changed its approach to decentralization, shifting from deconcentration of Ministry of Health services to devolution. As early as 1973, the government made District Councils responsible for clinics, health posts and mobile clinic locations, while keeping select administrative duties with the central Ministry of Health. Conflicts emerged among the field staff of the Ministry of Health and the District Councils, which in some cases affected the quality of services. By 1988 the government gave the district councils independent powers to develop priorities for health and family planning services. The Ministry of Health provides secondary and tertiary health care and still serves as the key source for policy formulation, professional guidance and supervision. The district and town councils plan and manage primary health care.

The government felt that devolved powers would: allow local staff to respond appropriately to problems within communities; encourage greater community participation and intersectoral collaboration; expand coverage; and assist in cost containment by reducing the duplication of services and using resources more efficiently (Mandevu and Ndombi, 1993).

Ethiopia

The current transitional government in Ethiopia has been restructured into 14 self-governing regions with separate legislative, executive, and judicial powers. Family planning (along with maternal and child health) is covered by the Family Health Department of the Ministry of Health, and similarly structured departments exist in all 14 regions. Service delivery is split among six tiers, and family planning services are provided in all of these tiers, from referral hospitals down to community health services. The Family Guidance Association of Ethiopia, an affiliate of IPPF, plays an important role in the training of providers and also provides services through its own clinics. As the formal health care network does not reach a significant proportion of the population, it will be necessary to establish additional networks for the provision of family planning services.

Ghana

Decentralization is occurring in varying degrees in all ministries in Ghana. In 1988, the government of Ghana passed Law 207, which established 110 districts, each with an elected District Assembly that will set program and budget priorities at the local level. The Local Government Act of 1993 mandates that the present field staffs of virtually all central ministries be shifted to the district assemblies. Each district assembly is responsible for preparation of its development plan, formulation of strategies and projects, and mobilization of resources in the district with sectoral ministries providing technical assistance (Ministry of Local Government, 1993). Twenty-two departments of central ministries are to decentralize to the district level to implement decisions of the local assemblies (Fiadjoe et al., 1993). The decentralization process is ongoing and both the formal and de facto relations between the center, regions and districts are unclear at this point. Resource allocation responsibilities have not yet been resolved, but each district has the authority to raise its own revenues, recruit and pay for its own staff, and finance its activities with marginal support from the central government.

Family planning issues are addressed in Ghana by both the Ministry of Finance and Economic Development and the Ministry of Health. Family planning receives high priority in the MOH health policy, both as an integral part of reducing maternal and infant and childhood mortality, but also within the context of a fertility reduction strategy as laid out by the National Population Policy. The Ministry of Health has begun decentralizing management to the regional and district levels; District Health Management Teams have assumed greater autonomy in setting priorities and delivering services. Nonetheless, several constraints have been encountered. There is ambiguity concerning the roles of the central and other levels as well as the role of donors. Ghana also has concerns about the costs of decentralization, and about whether greater decentralization will lead to increased efficiency.

The National Population Council (NPC) has central authority for implementing and coordinating all aspects of Ghana's population policy. NPC has conducted regional workshops to obtain input from districts on the revision of the population policy. The NPC secretariat will likely play a role in assisting districts and providing leadership and developing guidelines for district

population coordinating groups. NPC is also considering carrying out needs assessments and inventories of services available at the local level to facilitate its planning for implementation of decentralization. District Assemblies will need to be educated about the importance of population so that they can make informed decisions regarding program support and administration. District Health Management Teams also must be assisted in making a strong case for family planning programs within their proposed health budgets and identifying possibilities for integration of family planning into other community development programs and activities.

Tanzania

The provision of family planning services in Tanzania occurs in a deconcentrated program structure. The majority of services are provided through the Family Planning Unit, under the Directorate of Preventive Services of the Ministry of Health. Recent attempts at service expansion are intended to work through this system of field administration. Two family planning trainers will be identified in each of the 20 regions, and district training teams will train health workers. The District Medical Officers will also be involved in program planning and in training district managers. Tanzania is at the earliest stages of developing the management structures at the regional and district level needed to ensure local authority for providing family planning services.

Uganda

Although it is not yet fully operational, the Government of Uganda's plan for decentralization is based on the devolution approach. Uganda plans to begin implementing decentralization during fiscal years 1993 and 1994. Plans for devolution fit in well with the existing Resistance Council (RC) structure, consisting of "peoples" committees that operate in a hierarchically organized system from villages to districts. Decentralization will result in improved local capacity for planning and resource allocation, improved accountability at all levels, and greater popular participation. Decentralization will be implemented one level at a time. For example, once decentralization is successfully implemented at the district level, it will progress to the county level.

Decentralization must specify and define all relationships between the local authorities and the national level. For example, planning is needed to determine which RC level should provide funding for the various types of services, including family planning programs. It is also critical for the national government to formulate policies, provide guidelines and standards, define strategies, and provide training for consistent programs in all areas of the country. It must also monitor and provide technical assistance for activities at the district level.

There are several preconditions to and constraints on decentralization in Uganda. As preconditions, the country has demonstrated a strong commitment to decentralize; districts and sub-counties should have participated and cooperated in the planning process; and districts have been given authority and autonomy to raise resources. The major constraints include a lack of human, financial, and technical resources; a poorly structured civil service that employs too many

people at low wages, rather than fewer people at high wages (high wages are more motivating); and the existence of districts that are not financially or administratively capable of supporting the programs. Uganda will "phase in" decentralization to try to avoid these problems. Initially, three districts in each of the four regions will be decentralized. The government will also decentralize one "special needs" district (i.e., a district with a big HIV/AIDS problem). The Ministry of Finance and Economic Development will choose districts to be decentralized based on existing infrastructures and capabilities of district officials.

Major areas of concern in the Ugandan experience include:

- generating and allocating resources;
- manpower constraints, such as how to smoothly eliminate jobs at the national level and create jobs at the local level; how to eliminate inefficient and ineffective staff and motivate talented staff; how to deal with staff loyalty and resistance to change, especially at the senior levels; and how to clarify the chains of command and supervision; and
- devolution and "phase in" of funds; specifically, how districts will be accountable to the central government and what their "political" versus administrative responsibilities will be.

Uganda has decided to phase in a change whereby money would go directly to districts rather than being funnelled through the ministries. This would reduce losses due to corruption. Districts must then apply the money directly to specific line items in their activity budgets. Furthermore, local authorities would have access to local taxes. Local finances would be controlled by an Executive Secretary, an Accounts Committee, an Auditor General, and the Department of Internal Auditors.

Population activities in districts would be the responsibility of District Population Officers (DPOs) who report to the district manager. DPOs work with local authorities to plan and implement population objectives, mobilize resources and generate revenues to achieve their population goals in concert with the national population policy (Atiku, 1993). Thus far, the Ugandan DPOs have been able to keep to their mandate of working on broad-based population issues, rather than becoming focused on family planning efforts as has happened in Kenya. This may, in part, be due to the perceived overlap between the post of DPO and District Medical Officer (family planning is considered as the responsibility of the District Medical Office). The family planning program in Uganda is also at a much earlier stage of development. In an attempt to carve out a clear niche, some DPOs have focused on awareness raising on more general population issues, which minimizes the "turf battles" between population and medical officers over family planning issues. This experience emphasizes the need for strong district-level liaisons between ministries.

Zambia

Decentralization has been a key factor in Zambia's national health plan since the installation of a new government in 1992. As part of the preparations for decentralization, Zambia is sending teams to districts, privatizing parastatal organizations, and moving administrative functions and health boards to districts (deconcentration and devolution). Zambia anticipates that central-level responsibilities will be limited to those activities not carried out by the districts, namely policy making. Zambia, like many of the other countries, has concerns about sustainability and donor withdrawal, retrenchment of workers, unclear roles of the central and district levels, and the cost sharing implications of decentralization.

Zimbabwe

Zimbabwe has strong government support of its population programs and a strong decentralization program. In Zimbabwe, responsibility for family planning has been delegated to the Zimbabwe National Family Planning Council (ZNFPC), which became a parastatal under the Ministry of Health in 1985. This move was made in part to increase access to funds and resources that were not directly available to the Ministry (Mugwagwa, 1989).

The Ministry of Health provides approximately 59 percent of all family planning services in its hospitals and municipal clinics, whereas ZNFPC provides 37 percent of services through its community-based distributors and, secondarily, from its static and mobile clinics. ZNFPC has the mandate for providing technical support and quality control for all public and private family planning services, training, IEC, youth programs, research and contraceptive procurement and logistics (Zinanga, 1992). These services are directed at the national level but are implemented from the provincial down to the village level. Management activities occur through a deconcentrated program structure at the provincial and district level.

The ZNFPC, however, is responsible for coordination and implementation of all family planning services in Zimbabwe. It has clearly designated responsibilities at each level—central, regional, provincial, district, ward and village. For example, the central level leads in policy formulation, standardized training, procurement of commodities, research and supervision. The regional level distributes commodities and continues with training. Program planning, monitoring, and evaluation; management of resources (human, financial, and material); IEC activities; localized research; training of trainers; youth advisory programs; and service provision are all implemented at the provincial level. At the district level, District Medical Officers are in charge of health and family planning activities; they also offer training for service providers and assist the District Health Officer with program planning and evaluation. The ward and village levels have more limited resources and thus smaller responsibilities, which has led to concerns about loss of power and authority at these levels.

8.2 Asian Countries

Asia has long experience with family planning programs and implementation of national population policies. In most of the countries considered here, the national family planning program is the responsibility of the Ministry of Health or its equivalent ministry. Only Indonesia has a national coordinating agency that has primary responsibility for coordinating all the different components of the national program. The last 30 years have given rise to dramatically decreasing fertility in many countries and steady, sometimes rapid, expansion of family planning programs. Many of the countries, in the course of expanding their programs geographically, have created management structures at lower levels of administration to facilitate program management. In most cases, these field offices have responsibility only for day-to-day management of the family planning program within their jurisdiction, while the central ministry or organization dictates how the programs will be run, determines what objectives will be met, and provides the resources with which to implement desired interventions.

Tables 7–9 illustrate the demographic characteristics, organization of family planning programs, and forms of decentralization in five Asian countries including the Philippines, Thailand, and Bangladesh. Country experiences with decentralization range from governmentwide devolution of service provision in the Philippines to the use of field personnel to manage family planning activities at the state or provincial levels with varying degrees of central control in the other countries. The deconcentration model has served Asia moderately well for several decades. Recent social, economic and political changes, however, have shifted thinking toward expanded involvement of local governments and community groups, either for the sake of increased participation or in an attempt to reduce some of the burden on central government expenditures.

Indonesia

The National Family Planning Program is planned and coordinated through the BKKBN, a nonministerial organization that is now placed under the recently created Ministry of Population and Environment. BKKBN receives 80–90 percent of its operating funds from the Government of Indonesia and interfaces closely with the Ministry of Health and the Ministry of National Development Planning and other ministries associated with the implementation of population and family planning activities (BKKBN, 1993). The family planning program is largely a vertical program with BKKBN responsible for coordinating activities and for IEC, staff training, community-based distribution and outreach. Most clinical family planning services are delivered at Ministry of Health facilities by staff who provide other health services.

Since its origin in 1970, BKKBN has systematically expanded its program during a number of stages corresponding to the government's five-year planning cycles (*repelita*). Initially the program expanded geographically to eventually include field offices in each of Indonesia's 27 provinces and 301 districts or regencies. In addition, BKKBN employs an extensive network of fieldworkers and supervisors at lower administrative levels. At each level of administration, BKKBN personnel are responsible to the local civil authority, but remain under technical control and supervision of the next higher level of BKKBN (Suyono and Shutt, 1989). Thus, the chief

of each local office of BKKBN maintains close ties with the local authority, be it the governor at the province level or the mayor/bupati at the regency level.

While BKKBN maintains central control over many program functions, including the formulation of policy, it relies on operational decentralization, through deconcentration of certain activities to provincial offices, local officials, family planning workers and community groups. The implementation of program activities takes many forms according to region, culture and local organization and there is a fair degree of latitude in developing the specific forms that policy implementation takes.

In the mid-80s, pressures to decentralize further began due to the drop in oil prices leading the government to begin to think of shifting various types of government activities to local levels (Bossert, 1989; BKKBN, 1993). An integral part of Repelita IV was the focus on increasing community participation and management of programs. In 1987, a government decree formalized national commitment to shifting authority to lower administrative levels. This was embodied in Repelita V, which stressed the decentralization of administration and the development of local-level capacity to assume greater responsibility and control over funds and implementation. The specific policy of BKKBN has been to encourage decentralization and flexibility in planning. Although BKKBN provides central direction and guidance, it delegates considerable decision-making authority to its 27 provincial offices. It has developed provincial and district-level technical capabilities to solve local problems and has increased provincial capability to negotiate with the center over goals, policy program activities and evaluation of activities funded by the center. It has also established mechanisms for involvement of a number of local government and village organizations to contribute to and participate in program management.

Central BKKBN remains responsible for overall coordination of the program, policy, commodities, motivation and promotion. Population issues are integrated into development plans at the national and local levels through the local planning development boards. Political commitment to family planning has been established at all levels and in all sectors and is embodied in the specific responsibilities of the head of government at each level. Grassroots community organizations also actively participate in the local management of the program, which is fostered through a subdistrict management unit in villages and through acceptor groups in which women assume a portion of the responsibility for designing and managing the local family planning program. The village family planning management unit assists the village chief in family planning activities and is supervised by family planning fieldworkers. They serve as volunteers to motivate the local community, encourage continuation and to resupply methods. It is an extensive network comprised of 76,000 village distribution centers and 315,000 subvillage distribution centers (BKKBN, 1993).

The country in its most recent five-year plan is shifting even more control for planning and development of local strategies to the subnational level through the use of a three-dimensional planning process that includes elements of top-down, bottom-up and horizontal planning (Suyono and Shutt, 1989). Central BKKBN convenes an annual program planning meeting with local BKKBN and implementing agency representatives to set plans, programs, objectives and establish

budgets. Operational program management guidelines are then sent to the provinces where the process is repeated and repeated again at the regency level. Regencies and provinces also prepare input, suggestions and project plans for the next planning cycle, which are developed in lateral consultation with the planning board, implementing agencies and provincial administration. Local groups also feed into this process. These inputs are incorporated in a second planning meeting convened by BKKBN outside of Jakarta to refine budgets, receive inputs for the next planning cycle and make modifications to the existing plans to finish out the planning year.

Thus, BKKBN has developed a broadly-based organization for the implementation of family planning, coordinating with associated ministries, building political support of all tiers of government, and developing a performance-based system for evaluating job effectiveness in the family planning program as well as for the local political leaders. BKKBN has also encouraged local ownership of the program and has provided local leaders and community groups with a formal structure for participation in the achievement of program goals.

Problems that beset this structure are typical of those of other large developing countries; despite tremendous achievements, a primary limitation seems to be the varying quality of staff at subprovincial levels to effectively participate in and benefit from the participatory planning process (Suyono and Shutt, 1989). Planning and budgeting skills are often lacking, as well as a basic knowledge of data collection and how to use data to best advantage to understand what is going on in the program at the local level. Nonetheless, Indonesia, through the BKKBN, seems to have adopted an extremely effective approach to decentralized program planning. It has done this gradually as capabilities and infrastructure have been available, while actively encouraging participation of all tiers of government in a truly multisectoral program.

India

Since 1958, political and administrative structures below the state level have been embodied in the Panchayat Raj, local government councils with popularly elected membership. However, many states never conducted elections to these bodies rendering them effectively defunct. In 1992, the government amended the constitution making a 3-tier system of government (district, block and village) mandatory in all major states. By early 1994, all states had enacted legislation constituting the council, which increased the number of elected representatives who administer the country to 2.25 million, compared to the existing 5000 representatives at the national and state level. Responsibilities to be transferred to the district-level Panchayat Raj include primary health care and education.

Although the planning infrastructure at the state level is not very well developed, in 1982 a central scheme of strengthening planning capacities was extended to states, which resulted in setting up district planning boards, clearly demarcating planning functions, disaggregating funds for planning, and encouraging community participation in the planning process. This effort has not succeeded in India for a variety of reasons, including a lack of qualified personnel to develop plans, lack of data available at the district level, no devolution of financial powers, lack of knowledge for mobilizing resources at the local level, and frequent inconsistency of local plans

with state-level plans leading to rejection of local plans (Narayana, 1994, personal communication).

Although decentralized planning has been a topic for discussion and attempts at decentralized planning have been made in other sectors, the health and population sector has remained relatively untouched by efforts to promote decentralization. UNFPA has recently funded a demonstration project in decentralized program management in health and family welfare in four states. USAID has also funded efforts to foster district-level planning in Uttar Pradesh through the IFPS Project. The focus is on developing the planning capabilities of district family planning program managers by collecting data for program planning, using the data to set program objectives and preparing district plans. The plans are coordinated at the state level and district managers are encouraged to look at the total pool of resources available in the district rather than focusing exclusively on public resources, as done in central planning. The project has involved a real participatory effort to determine how to develop plans and prioritize actions in each district. In developing this capacity, the project had to overcome initial resistance from district managers who questioned the need or were reluctant to take on additional responsibilities that the center once performed. But the outcome has been encouraging. By retaining and using data at the local level, program managers are reported to have become more interested and involved in program planning and in monitoring their progress in achieving objectives. State-level managers have also been involved in monitoring the process, although the planning exercise has been conducted entirely by the district managers. The results of this planning exercise will be presented to central authorities. These activities, together with the recent revitalization of the Panchayat Raj and the transfer of responsibilities to the elected councils, may signal a new beginning for district-level planning.

Table 4a. Descriptive Characteristics: Anglophone African Countries

Characteristic	Botswana	Ethiopia^a	Ghana	Kenya	Nigeria
Total Population (in millions)	1.4	55.2	16.9	27.0	98.1
Percentage Rural Population	75	85	66	75	84
Total Fertility Rate	4.9	7.5	6.4	5.4	5.7
Contraceptive Prevalence Rate	33	4	13	33	6
Percentage Modern Method Users	32	3	5	27	3.5
Prevalence for Modern Methods					
Pill	14.8	2.2	1.8	9.6	1.2
IUD	5.6	0.3	0.5	4.2	0.8
Injection	5.4	—	0.3	7.2	0.7
Female Sterilization	4.3	0.3	1.0	5.6	0.3
Condom	1.3	0.1	0.3	0.8	0.4
Vaginal	—	—	1.3	—	—
Percent Distribution for Sources of Modern Contraception					
Government	94	n/a	35	68	37
Private	5		44	27	47
Other	1		21	5	9
Year of latest DHS	1988	1990	1988	1993	1990

Source: PRB 1994 World Population Data Sheet and latest available DHS or similar survey.

^a In Ethiopia, contraceptive prevalence is based on contraceptive use among nonpregnant married women of reproductive age; fertility and prevalence estimates are based on a 1990 national fertility survey similar to the DHS.

Table 4b. Descriptive Characteristics: Anglophone African Countries

Characteristic	Tanzania	Uganda	Zambia	Zimbabwe
Total Population (in millions)	29.8	19.8	9.1	11.2
Percentage Rural Population	79	89	51	73
Total Fertility Rate	6.3	7.3	6.5	5.3
Contraceptive Prevalence Rate	10	5	15	43
Percentage Modern Method Users	7	2.5	9	36
Prevalence for Modern Methods				
Pill	3.4	1.1	4.3	31.0
IUD	0.4	0.2	0.5	1.1
Injection	0.4	0.4	0.1	0.3
Female Sterilization	1.6	0.8	2.1	2.3
Condom	0.7	—	1.8	1.7
Vaginal	—	—	—	—
Percent Distribution for Sources of Modern Contraception				
Government	73	47	56	58
Parastatal	—	—	—	38
Private	22	45	43	8
Other	5	8	1	2
Year of latest DHS	1991/92	1988/89	1992	1988

Source: PRB 1994 World Population Data Sheet and latest available DHS or similar survey.

Table 5a. Characteristics of Family Planning Programs: Anglophone African Countries

Characteristic	Botswana	Ethiopia	Ghana	Kenya	Nigeria
Year Government Instituted a Formal Population/Family Planning Policy	None, but policy formulation efforts have begun	1993, Second draft	1969 Policy 1970 NFPP 1993 Revised Policy	1967	1988
National Coordinating Agency for Population Activities	National Population Council (1992)	Council of Population	National Population Council	National Council on Population and Development	Primary Health Care Development Agency
Implementing Ministry for Family Planning	MOH*/Ministry of Local Government	MOH/Family Health Dept.	MOH/Ministry of Finance and Economic Planning (through FP Secretariat)	MOH	MOH
Involvement of other Ministries in Family Planning Service Delivery	No	Yes	Yes	Yes	No
Structure: Integrated/Vertical	Integrated	Integrated and vertical	Integrated	Integrated	Integrated

* MOH = Ministry of Health

Table 5b. Characteristics of Family Planning Programs: Anglophone African Countries

Characteristic	Tanzania	Uganda	Zambia	Zimbabwe
Year Government Instituted a Formal Population/Family Planning Policy	1992	No policy	1989	Strong govt. support from 1967, but no explicit policy
National Coordinating Agency for Population Activities	Population Planning Unit (Office of the President)	Population Secretariat	Population Council (being developed)	Population Secretariat (Office of the President)
Implementing Ministry for Family Planning	MOH ^a	MOH	MOH	MOH and ZNFPC ^b
Involvement of other Ministries in Family Planning Service Delivery	Yes	Yes	Yes	No
Structure: Integrated/Vertical	Integrated	Integrated	Integrated	ZNFPC—Vertical Prog. services integrated with MCH/FP ^c

^a MOH = Ministry of Health

^b ZNFPC = Zimbabwe National Family Planning Council (parastatal under the MOH)

^c MCH/FP = Maternal and child health/Family planning

Table 6a. Administrative Structure and Characteristics of Decentralization: Anglophone African Countries

Characteristic	Botswana	Ethiopia	Ghana	Kenya	Nigeria
Constitutional Structure	Unitary	Federal	Unitary	Unitary	Federal
Leadership	President	Coalition Ruling Council	President	President	President
Government Administrative Structure	6 Townships 9 Districts — Villages	14 Regions — Districts — Zones	10 Regions 110 Districts	8 Provinces 14 Districts	30 States 589 LGAs*
Form(s) of Decentralization	Devolution Deconcentration	Devolution	Devolution Deconcentration	Deconcentration	Devolution Deconcentration Delegation
How Responsibilities of Decentralization were Transferred	Legal	Legal	Legal	Administrative	Legal decree
Year Decentralization was Initiated	1973	1993	1988	1983	1976

* LGAs = Local Government Authorities

Table 6b. Administrative Structure and Characteristics of Decentralization: Anglophone African Countries

Characteristic	Tanzania	Uganda	Zambia	Zimbabwe
Constitutional Structure	Unitary	Unitary	Unitary	Unitary
Leadership	President	President	President	President
Government Administrative Structure	— Regions — Districts — Villages	39 Districts (RC ^a -5) — Counties (RC-4) — Subcounties (RC-3) — Parishes (RC-2) — Villages (RC-1)	Provinces	— Provinces — Districts — Wards — Villages
Form(s) of Decentralization	In process	Devolution	Preparatory stages; Deconcentration, later Devolution	Delegation to ZNFPC ^b Deconcentration
How Responsibilities of Decentralization were Transferred	n/a	Legally	n/a	Legally
Year Decentralization was Initiated	n/a	1986 Preparations 1987 RC ^a Law 1993 Implementation	n/a	1984

^a RC = Resistance Council

^b ZNFPC = Zimbabwe National Family Planning Council

Table 7. Descriptive Characteristics: Asian Countries

Characteristic	Philippines	Indonesia	Thailand	Bangladesh	India
Total Population (in millions)	69	200	59	117	912
Percentage Rural Population	56	69	81	86	74
Total Fertility Rate	4.1	3	2.2	4.9	3.6
Contraceptive Prevalence Rate	40	53	68	40	45
Percentage Modern Method Users	25	50	66	31	40
Prevalence for Modern Methods					
Pill	9	15	20	14	2
IUD	3	16	7	2	2
Injection	0.1	13	9	3	—
Female Sterilization	12	3	22	9	31
Condom	1	1	1	3	5
Norplant®	—	3	—	—	—
Percent Distribution for Sources of Modern Contraception					
Government	74	76	83	70	
Private	25	22	16	30	n/a
Other	1	2	1	—	
Year of latest DHS	1993	1991	1987	1991	1988 - 1989

Sources:

Philippines, Indonesia and Thailand: PRB 1994 World Population Data Sheet and latest available DHS.

Bangladesh: PRB 1994 World Population Data Sheet and 1991 Contraceptive Prevalence Survey.

India: PRB 1994 World Population Data Sheet and Indian Ministry of Health and Family Welfare.

Table 8. Characteristics of Family Planning Programs: Asian Countries

Characteristic	Philippines	Indonesia	Thailand	Bangladesh	India
Year Government Instituted a Formal Population/Family Planning Policy	1971	1970	1970	1971	1952
National Coordinating Agency for Population Activities	Population Commission	State Ministry of Population—BKKBN (1993)	None	National Population Council	None
Implementing Ministry for Family Planning	Department of Health	Ministry of Health	Ministry of Public Health/Family Health Division	Ministry of Health & Family Welfare/ Directorate of Family Planning	Ministry of Health and Family Welfare
Involvement of other Ministries in Family Planning Service Delivery	No	No	Yes	No	Yes
Structure: Integrated/Vertical	Integrated	Vertical Mix	Integrated	Vertical Mix	Integrated

Table 9. Administrative Structure and Characteristics of Decentralization: Asian Countries

Characteristic	Philippines	Indonesia	Thailand	Bangladesh	India
Constitutional Structure	Unitary	Unitary	Unitary	Unitary	Federal
Leadership	President	President	King/Prime Minister	Prime Minister	Prime Minister
Government Administrative Structure	76 Provinces* 60 Cities* 1,500 Municipalities* 52,000 Barangay	27 Provinces* 301 Regencies* 3,400 Subregencies — Villages	76 Provinces* 700 Districts	64 Districts 460 Thana* (subdistricts) 4,500 Unions 13,500 Wards	25 States* — Districts* — Blocks — Villages
Form(s) of Decentralization	Devolution to LGU (Provinces, Cities)	Deconcentration of BKKBN ^a	Deconcentration of Ministry of Public Health	Devolution to Thana Deconcentration of Ministry of Health & Family Welfare	Devolution via Panchayat Raj Deconcentration to States & Districts
How Responsibilities of Decentralization were Transferred	Legal	Administrative/ Government Decree	Administrative	Legal Administrative	Constitutional Amendment
Year Decentralization was Initiated	1991 Local Government Code	1987	Pilot Project 1988 - 1991	1982 Local Government Ordinance	1992
Donor Role	USAID to provide limited TA in 20 - 30 LGUs	Provides 10 - 20% of program cost and some support to NGOs	Donor support to pilot project ended in 1991	Ongoing USAID support to entire effort	UNFPA support for district planning in 4 States USAID support to 1 State

- * Administrative Level of Decentralization
- ^a BKKBN = State Ministry of Population

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