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**The Decentralization of Family Planning Programs:  
Selected Experience in Asia**

by

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## THE DECENTRALIZATION OF FAMILY PLANNING PROGRAMS: SELECTED EXPERIENCE IN ASIA

There has been growing interest in decentralization in recent years. Part of this interest is an outgrowth of the extensive literature documenting experience with decentralization in the context of rural development programs over the past 20-30 years (Rondinelli, 1981 and 1983; Cheema and Rondinelli, 1983). Decentralization has also received increased emphasis in the context of new organizational approaches to implementing primary health care (Mills et al., 1991; Godinho, 1990; Kohlehtainen-Aitken, 1992). However, the subject has not been widely or systematically addressed in the context of population and family planning programs. Recently, attention has been focused on decentralization efforts in Africa (see Vriesendorp et al., 1992; Kabore, 1992; OPTIONS Project, 1993; Lacey et al. 1994; and McGirr et al., 1994 forthcoming). In addition, a number of family planning programs in Asia, based on their experience with field administration or deconcentration in health or rural development programs, are transferring increased authority for family planning program management to subnational units.

Decentralization is a massive undertaking that often involves rethinking the service delivery system and taking into consideration new jurisdictional, legal, personnel, funding and lines of authority. Given this, it is instructive to examine the experience with decentralization in Asia, which includes some of the largest countries, some very successful programs, and some of the longest experience with decentralized program development. Family planning programs in much of Asia are fairly well developed, have reached moderate to high levels of contraceptive prevalence, have a long history of implementing population policies within the broader context of development plans and for the purpose of lowering the growth rate to improve socioeconomic development.

In undertaking this review of country experience with decentralization of population and family planning programs in Asia, we were surprised at how little experience there was in decentralization of family planning programs and how recent many of the initiatives were. Indeed, none of these countries has implemented decentralization to its fullest extent; there is no end-state experience. This paper describes the different forms of decentralization and reviews the experience accumulated thus far by five countries: the Philippines, Indonesia, Thailand, Bangladesh and India. The paper concludes with an assessment of the current status of decentralization in these countries and an assessment of prospects for the future.

### Background

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, with the central ministry or organization dictating how the programs will be run, determining what objectives will be met, and providing the resources with which to implement desired interventions.

In addition to geographic expansion, programs have also expanded in terms of the variety of service delivery channels (Sanderson and Tan, 1992). They began with a strong clinical orientation to the provision of family planning services, most often using the available network of Ministry of Health service outlets to provide family planning services. Many programs also have increased the degree of service integration, coordinating activities closely with maternal/child health programs. Outreach activities have now become an adjunct to clinic-based services, and programs have increasingly diversified to include significant community-based distribution. Forms of private sector participation include contraceptive social marketing, insurance and employer-based services, and private physician services.

Rapid social and economic change in Asia, including rapid urbanization, is having an impact on governments' ability to manage those changes. As a result, central governments face mounting difficulties in managing the process of growth and development, in addition to the maintenance of services and infrastructure. Local governments are increasingly becoming the focus of decentralization experiments (Johnson and Rahman, 1992). Central governments are also giving renewed attention to private sector participation.

The countries selected for review in this paper (Philippines, Indonesia, Thailand, Bangladesh and India) represent a range of experiences in terms of demographic characteristics, levels of contraceptive prevalence, and stages of family planning program development as shown in Tables 1 and 2. The case studies also represent different administrative structures, types of government and forms of decentralization as summarized in Table 3. 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. Decentralization in these countries has both political and administrative dimensions that may or may not be closely intertwined.

## DEFINITIONS

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). 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 authority to raise revenues 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 controlled by, the central government such as a parastatal organization; and d) and **privatization** where select government functions are transferred to the private commercial sector or nongovernmental organizations.

The approaches to decentralization vary according to the amount of responsibility transferred and the legal context for the transfer. 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, and several forms may be present and functioning governmentwide, or even within the same sector (Silverman, 1992).

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. Decentralization occurs when the central government transfers some degree of authority for managing and delivering the services to nongovernmental organizations, or to local authorities or field offices in the geographical or administrative areas where the services are provided to the population. The different forms of decentralization are discussed in greater detail below.

### 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 and adapting national directives to local conditions. 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.

This form of decentralization has characterized, to varying degrees at some point in time, all the countries represented in this paper. Philippines has gone a step further, however, and has devolved responsibility for most government functions to local government. Bangladesh and India have legislated government structures to take over the provision of selected government services, but the structures and their mandate have not evolved to actually take on these duties.

## Devolution

Devolution is a more extensive form of decentralization and involves a more radical change in government structure. It usually pertains to all government ministries, except for those few functions deemed national priorities such as national defense, customs, foreign affairs, immigration, etc., although it also can occur within a single sector. 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). Selected staff from central ministries are often devolved to local government offices.

## Delegation

Delegation involves 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, regional authority, or special service district (Rondinelli, 1989). Delegation increases autonomy of the parastatal organization, and sometimes frees the organization from civil service constraints and restrictions on revenue generation. Delegation does not occur governmentwide, but is limited to one or a few organizations. 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, however, the parastatal can be organized on a very centralized basis (all planning and budgeting at headquarters) or on a very decentralized basis — with delegation of planning, budgeting, and even revenue generation to regional or district affiliates. Therefore, delegation of responsibilities does not automatically imply that services will be provided in a decentralized form.

## 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 decentralization, governments can also 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. National 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. In the absence of government involvement (or minimal involvement), the private sector has taken responsibility for providing these services. Also, when government services do not reach the lowest levels in the administrative hierarchy, such as in remote areas, the private sector, either commercial (including indigenous providers) or NGOs, may be "the only game in town." In India, for example, the commercial sector is active in providing services to consumers who do not have access to primary health care centers.

Privatization may also play a more explicit role in government policy. 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 may 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. In these cases, government has usually made the assumption that the private sector can carry out a government function in a more cost-efficient manner.

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 the National Population Council, a parastatal, is responsible for policy activities and coordination.

## COUNTRY EXPERIENCE

The experience of countries reviewed in this paper focuses primarily on the deconcentration and devolution forms of decentralization. While certain elements of delegation for some functions and privatization may be ongoing, to date, these countries have not relied heavily on delegation or privatization. Therefore, these forms of decentralization will not be a major focus of this paper. However, the potential of private sector development to reinforce decentralization is so great in Asia that we will allude to its role in future program development in the concluding section.

## PHILIPPINES: Devolution of the National Family Planning Program

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. Earlier program expansion efforts included, in addition to clinic-based services, a system of outreach fieldworkers working at the lowest administrative levels. They were supervised by officers who reported to population offices in provinces and cities funded by POPCOM. Local health offices were also providing outreach services, which lead to conflict and confusion as to which officer was responsible for family planning outreach and nonclinical service provision. Prior to devolution, POPCOM and the structure of family planning service provision by the DOH were essentially deconcentrated.

In 1991, the Philippines passed the Local Government Code (Republic of the Philippines, 1991a), devolving virtually the responsibility for providing social services in all sectors to local government units (LGUs), with the exception of education and national security forces. 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. In addition, LGUs can now keep taxes they raise, and have the authority to introduce new taxes.

Thus, the responsibility for provision of most government services, including family planning, has been devolved to local government units (LGU): provinces, cities and municipalities. Although local population offices (previously established by POPCOM but taken over by the local governments prior to devolution) exist in most LGU, the majority of DOH personnel have been devolved to LGU health offices in provinces and cities. The transfer of funds to LGU has taken longer. The Code gives specific instructions as to what the central ministry would be responsible for and which functions would be the responsibility of local authorities (Republic of the Philippines, 1991b and 1992). LGUs are now responsible for developing plans (including targets and budgets), monitoring and coordinating activities at the local level, delivering services and IEC. 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. DOH is responsible for monitoring and evaluating local programs, setting standards for service delivery, and providing technical support services including logistics, training, and parts of IEC and MIS.

The Philippine example is among the most extreme attempts at decentralization in a developing country. Despite early difficulties in implementing devolution (see Associates for Rural Development, 1992), central ministries and LGUs are well on their way to devising strategies to cope with their new responsibilities (Rimon et al., 1992). It will be important to monitor progress overall, but also in the context of whether the family planning program gets back on 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.

While the preexistence of health and population administrative structures in most provinces and cities provide an infrastructure for management and coordination of family planning activities at the local level, their evolving responsibilities over time has led to some confusion and lack of coordination in field activities. Past decisions and policies affecting the Philippine family planning program have perpetuated rivalries between POPCOM and DOH that are visible at the local level. It is hoped that these 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.

At the local level, commitment to family planning varies among LGUs. Obviously, LGUs that have officials committed to the program, and are willing to put resources into the program, 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.

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 additional funds for local activities. 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. At the central level, employees of DOH will need to adapt to new roles and responsibilities and to focus more on technical skills needed for determining and monitoring program direction rather than on managerial skills used for program implementation.

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.

## INDONESIA:

The National Family Planning Program is planned and coordinated through the BKKBN, a nonministerial organization which 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. 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.

## THAILAND: Deconcentration of the National Family Planning Program

Thailand provides an example of administrative deconcentration. The Family Health Division (FHD) of the Ministry of Public Health (MOPH) is responsible for implementing the national family planning program. There are MOPH administrative offices in all provinces and districts for the management of health and family planning activities. The provincial chief medical officer oversees all health and medical services in the province, including family planning. The officer reports to MOPH/FHD for all technical matters, but is responsible to the provincial governor, the most senior civil servant official in the province.

Central FHD is responsible for national program planning, setting national priorities, and maintaining national statistics (Bennett et al., 1990). 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 support. Despite the availability of program management personnel in provinces and districts, FHD sets targets to raise CPR in provinces and districts and specifies the types of interventions used to attain those goals. Provinces and districts implement these interventions within the fixed budget allocated by FHD.

Provinces work with FHD to develop work plans, and monitor the implementation of interventions at the district level. Money from FHD is used for planning, implementing, and monitoring program interventions, paying for related expenses (such as travel, per diem, supplies and IEC materials). Program interventions include outreach activities, case recruitment for sterilization or vasectomy campaigns, and promoting use of other long-term methods.

A pilot project implemented from 1988-90 tested the feasibility of implementing decentralized program management in four provinces in northeast Thailand (Kamnuansilpa et al., 1992). Provincial managers were given the authority to plan activities, set targets, determine budgets, and make adjustments as necessary to improve program performance. Ultimately, the four experimental provinces were also given block grants to fund program activities.

Because of the existing administrative infrastructure, no new staff were required to implement decentralized management. Provinces were given assistance in setting up a provincial MIS, setting priorities, developing work plans and budgets, and assessing and monitoring service delivery and interventions. With increased decentralization, provinces showed considerable variation in how they programmed resources and selected interventions. The pilot project demonstrated that decentralized management of family planning programs resulted in improved responsiveness to local needs, more efficient management of resources, and better coverage of the client population.

As a result of the pilot project, FHD policy toward decentralization began to shift. FHD asked for assistance in developing guidelines for implementing increased decentralization of management authority for each level of government (MORE Project, 1992). Agreeing in principle to the concept of increased decentralization, FHD would need 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 provide assistance in developing and using a provincial MIS, and in conducting needs assessments, planning and monitoring of activities. However, funds were ultimately not available to extend results to other provinces or continue reforms in the pilot areas.

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. However, Thailand's experience with deconcentration and its experiment with increased decentralization of planning and resource allocation shows that, under certain conditions, increased autonomy for decision-making, planning and resource allocation at subnational levels can further increase a family planning program's responsiveness to local needs, result in more efficient management of resources, and extend coverage of the program. Although Thailand's experience with the success of its family planning program is unique, its experience with deconcentrated management, with the potential for granting increased autonomy to provincial managers, illustrates the importance of having well-trained personnel at the local level, mechanisms in place for providing training and adapting to new procedures, a good information system to guide local decision making, strong commitment of central leadership, and the potential for bottom-up pressures to be exerted on the decision making process to grant additional authority to persons with demonstrated capacity.

## BANGLADESH: Deconcentration of the Ministry of Health and Family Welfare

Within a largely unsuccessful government policy of devolution (Khan, 1985 and 1987), the Family Planning Directorate of the Ministry of Health and Family Welfare (MOH&FW) began to develop an approach to decentralized program management, which has involved setting up service delivery and program management structures at the subdistrict and lower levels of government, initially working through the popularly-elected Upazila Parishad, and when this was disbanded through political decree, focusing more on the Union Parishad at the next lower level of administration. Although devolution to subdistricts was never very effective in other sectors, the USAID-sponsored Local Initiatives Project (LIP) tried to work within this context to operationalize the government's devolution process for family planning program management. However, the central ministry retains control over resources, policy and personnel and most aspects of the overall management of the family planning program, transferring only the authority for day-to-day management and implementation to the program managers at the subdistrict level. This represents a form of deconcentration. While recent five-year plans lend support to increased decentralization, the LIP, running from 1987-97, has largely been responsible for giving local program managers in selected areas an increased say in how programs are run in their subdistricts. LIP has always worked through the formal centralized decision-making system of the ministry, but the efforts have been demonstrable informally by decentralizing operations and strategic thinking at the district, subdistrict and union levels. By the end of the project, LIP will have covered approximately 25% of all subdistricts in the country.

The LIP approach operationalizes the government policy of decentralization by building political commitment for population activities at the subdistrict level and below. LIP is responsible for creating or reactivating management committees comprised of managers from the family planning program, elected officials and community leaders. The subdistrict management teams are responsible for the planning, implementation, and monitoring of program activities at the local level. 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 at lower levels of administration. They are also responsible for creation of a management cadre at the service delivery level, embodied by the Family Welfare Assistant who supervises the work of community volunteers in LIP areas. The action plan specifies the supporting roles for the existing family planning field staff, local government administration, and the family planning management committees. A budget for proposed activities is included. All action plans are reviewed and approved by the Directorate of Family Planning before receiving project funds for implementation. To encourage ownership of the programs, subdistricts and unions are required to provide 10 percent of the budget for activities. As a result of the active involvement of senior MOH&FW officials in project activities, action plans are now approved by the Directorate of Family Planning in a matter of days, rather than months.

The management teams selected for participation in the LIP receive training in the development of action plans, preparation and management of budgets, collection of quality data, and

supervision of service providers. The project also provides training to district-level family planning personnel to supervise and monitor implementation of action plans at the subdistrict and union level. Other project training mechanisms include workshops, frequent technical assistance for on-the-job-training, and the development of manuals. The LIP promotes bottom-up capacity building in the development of relevant skills for program managers. At the local level, 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 the information for input to the management information system.

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.

Despite a 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 local-level 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 and resistance to change. Local areas must sometimes demonstrate the capacity to take on increased responsibilities. Results from the project evaluation may go a long way in demonstrating the tremendous gains that have been achieved by building capabilities at the local level.

## INDIA: Sowing the Seeds for District Planning

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 increase the number of elected representatives who administer the country to 2.25 million, compared to 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 monitoring their progress in achieving objectives. State-level managers have 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 the a new beginning for district-level planning.

## SUMMARY OF COUNTRY EXPERIENCE

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. The Philippines has most recently embarked on the devolution of most government functions, and we will have a lot to learn from this experience. Indonesia, in its development plans and in other sectors, is making progress in transferring increased responsibilities to local authorities. Local program managers work closely with local political entities, and an impressive structure has evolved to involve community groups in program management. Thailand has a well-functioning program and has accomplished much within the existing structure of field administration. Nonetheless, a recent pilot study showed that greater gains in efficiency and cost-effectiveness could be realized from granting additional authority for planning and budgeting to provincial program managers. In Bangladesh, involving political leaders and community volunteers and building capacity at lower levels has brought about improvements in local project areas, manifested by increased contraceptive prevalence rates. Other donors are considering providing funds to extend this approach to additional areas. Finally, small demonstration projects in five states in India may provide the cornerstone for decentralized program planning at the district level. If the transfer of the responsibilities for primary health and education to the Panchayat Raj does take place and is treated seriously, India may embark on a dramatic new stage of family planning program development.

### Prospects for the Future

Several Asian countries have dramatic economic potential (Thailand, Indonesia, Philippines, China, India). If these countries are able to realize this potential and show significant economic development, private sector activity will increase exponentially. This expansion will reinforce current movement toward increased decentralization. These countries are all sufficiently large such that, for purposes of economic expansion, they will necessarily be broken down into geographical markets. The evolution of subnational markets is conducive to program decentralization that also involves trying to get local decisions about local problems financed by local resources. Private sector expansion may increase local resources, build local private sector infrastructure for service delivery, and create options for financing and delivery of social services.

Looking ahead, what gains can we expect in terms of program development in these countries? In Thailand and Indonesia, the programs have made tremendous gains with a well-functioning central administration and a capable field organization. One can speculate about why Thailand was not able to continue its efforts to extend decentralized program management to all provinces. Would the availability of policy tools and more effective communication strategies have helped to bring about consensus for the use of resources to continue with the efforts? The issue for Bangladesh will be how to make the shift from a donor-financed project to country-supported activities. In the Philippines, the question is whether the family planning program will be able to get back on track in a devolved setting and make continued progress toward increasing contraceptive prevalence.

## CONCLUSIONS

Decentralization is a recent phenomenon, especially as applied to population and family planning programs. However, considerable experience is accumulating, and a number of countries are undertaking organizational reforms leading to increased decentralization. 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.

Considerable central control is still evident in most of the Asian programs considered in this paper, due in part to the recency of experience but also as a result of employing deconcentration to decentralize. This is not necessarily bad. 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. With devolution, in particular, it will also be important to continue working with national staff to help them define and adapt to new roles and responsibilities, focusing more on technical skills needed for determining and monitoring program direction rather than on managerial skills used for program implementation.

The country descriptions also highlight the role of donor resources in getting programs off the ground, often using pilot projects to initiate activities in a limited number of areas. One problem with this approach is that the selected areas are often ones in which the conditions are most favorable for success. 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 try to extend decentralization to other areas. Careful thought needs to be devoted to defining what is an optimal role for donors in this domain. Donors will have important roles to play as facilitators, supporters and conduits for technical assistance. 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.

Decentralization may be inappropriate for some countries. 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. Conditions do not have to be ideal for decentralization to occur, but decentralization will fail without skilled professionals, adequate financial resources and appropriate technology.

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 such broad goals as democratization, and 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.

## REFERENCES

- Associates in Rural Development, Inc. 1992. *Synopsis of Findings of the Rapid Field Appraisal of the Status of Decentralization: The Local Perspective*. USAID/Manila.
- Bennett, Anthony, Carl Frisen, Peerasit Kamnuansilpa, and John McWilliam. 1990. *How Thailand's Family Planning Program Reached Replacement Level Fertility: Lessons Learned*. Occasional Paper No. 4. Washington, D.C.: Population Technical Assistance Project, Dual & Associates and ISTI.
- BKKBN. 1993. Indonesian Country Report on Population and Development.
- Bossert, Thomas. 1988. CHIPPS Final Evaluation. Phase I: Decentralization Lessons. Bethesda, MD.: University Research Corporation. (draft)
- Cheema, G. Shabbir and Dennis A. Rondinelli (editors). 1983. *Decentralization and Development: Policy Implementation in Developing Countries*. Beverly Hills: Sage Publications.
- FPMD Project. 1991. Final Report. The Upazila Initiatives Project: September 1987-December 1990. Boston, MA.: Management Sciences for Health.
- Godinho, Joana. 1990. Tipping the Balance Toward Primary Health Care: Managing Change at the Local Level. *International Journal of Health Planning and Management* 5: 41-52.
- Helfenbein, Saul and Abu Sayeed. 1992. Project Design: Local Initiatives Program 1993-1997. Boston, MA.: Management Sciences for Health.
- Johnson, Ronald W. and Syedur Rahman. 1992. Improved Budgeting and Financial Management as a Tool for Enhancing the Performance of Local Government in Developing Countries. *International Journal of Public Administration* 15(5): 1241-1261.
- Kabore, Joanny. 1991. Decentralization: Types, Reasons to Decentralize; Reasons for Reluctance; Health and MCH-Family Planning Services Decentralization; Training System Decentralization (Section III). In *Report of the Proceedings of the Fourth Annual Francophone Africa Technical Advisory Committee Meeting*, INTRAH Project, November 12- 16, 1991, Lome, Togo.
- Kamnuansilpa, Peerasit, Anthony Bennett, and Paul Richardson. 1992. *Decentralized Management of Family Planning in NorthEast Thailand*. Bethesda, MD: University Research Corporation.

- Khan, Mohammed Mohabbat. 1985. "Process of Decentralization in Bangladesh." In *Decentralization: Local Government Institutions and Resource Mobilization*, edited by Hasnet Abdul Hye, pp. 241-262. Comilla: Bangladesh Academy for Rural Development.
- Khan, Mohammed Mohabbat. 1987. "Paradoxes of Decentralization in Bangladesh." *Development Policy Review* 5:407-412.
- Kolehmainen-Aitken, Riitta-Liisa. 1992. "The Impact of Decentralization on Health Workforce Development in Papua New Guinea." *Public Administration and Development* 12: 175-191.
- Lacey, Linda, Cynthia Woodsong and Nancy McGirr. 1994. "Decentralization of Population Programs in Sub-Saharan Africa: The Case of Anglophone Africa." Paper prepared for the Annual Meetings of the Population Association of America, Miami.
- McGirr, Nancy, Linda Lacey and Cynthia Woodsong. 1994. *Decentralization of Population and Family Planning Programs: Worldwide Experience*. Washington, D.C.: OPTIONS Project, The Futures Group. (forthcoming)
- Mills, Anne, J. Patrick Vaughn, Duane L. Smith, Iraz Tabibzadeh (editors). 1990. *Health System Decentralization: Concepts, Issues, and Country Experience*. Geneva: World Health Organization.
- MORE Project. 1992. "Policy and Procedural Guidelines for Decentralization, Family Health Division, Ministry of Public Health, Thailand." Washington, DC: TvT Associates.
- Narayana, G. 1994. "A Note on Status of Decentralized Planning in India." (Personal communication).
- OPTIONS Project. 1993. Decentralization of Population and Family Planning Programs in Anglophone Africa. Proceedings from OPTIONS II Regional Workshop on Strategic Planning for Decentralization of Population Programs in Sub-Saharan Africa, Kampala, and Mbarara, Uganda. Washington, D.C.: The Futures Group.
- Republic of the Philippines. 1991a. *Local Government Code*. Quezon City, Philippines: Phoenix Press.
- Republic of the Philippines. 1991b. *Rules and Regulations Implementing the Local Government Code of 1991*. Quezon City, Philippines: Phoenix Press.
- Republic of the Philippines, Department of Health. 1992. *Department of Health Rules and Regulations Implementing the Local Government Code of 1991*. Manila, Philippines.

- Rimon, J.G., Mark S. Sherman, and Benjamin J. Lozare. 1992. *The Devolution of the Philippine Family Planning Program: Findings and Recommendations*. The Futures Group/Population Communication Services Report. USAID/Manila.
- Rondinelli, Dennis A. 1981. Government Decentralization in Comparative Perspective: Theory and Practice in Developing Countries. *International Review of Administrative Sciences* 47(2): 133-145.
- Rondinelli, Dennis A. 1983. Implementing Decentralization Programmes in Asia: A Comparative Analysis. *Public Administration and Development* 3: 181-207.
- Rondinelli, Dennis A. 1989. Decentralizing Public Services in Developing Countries: Issues and Opportunities. *Journal of Social, Political and Economic Studies* 14(1): 77-98.
- Sanderson, Warren and Jee-Peng Tan. 1992. Population Issues in Asia: Context, Policies and Prospects. Report No. 10712-SAS/EAP. Washington, D.C.: The World Bank.
- Silverman, Jerry. 1992. Public Sector Decentralization: Economic Policy and Sector Investment Programs. Washington, D.C.: The World Bank.
- Suyono, Haryono and Merrill M. Shutt. 1989. "Strategic Planning and Management: An Indonesian Case Study." In *Strategic Management of Population Programs*, Gayl Ness and Ellen Sattar (eds.), pp. 257-284. Kuala Lumpur: ICOMP.
- Vriesendorp, Sylvia, Bula-Bula Lielle, Ralph Stone, Claire Madden. 1992. *FRAC V - La Decentralization des Programmes de Planification Familiale aux Populations Dispersees: Rwanda*. Boston: FPMD Project, Management Science for Health.