Health Reform, Decentralization, and Participation in Latin America: Protecting Sexual and Reproductive Health

POLICY Project

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Contents

Foreword

Much of the work undertaken by the USAID-supported POLICY Project in Latin America and the Caribbean (LAC) has been based on the premise that improving partnership between governments and civil society and strengthening participatory processes in the region can help improve the decentralization of the health sector. Working in Bolivia, Peru, Mexico, and Guatemala, the project has helped governments and civil society clarify their roles and strengthen decision making at the central, state, and municipal levels. The project has used its limited funds to intervene strategically to motivate citizens and build capacity of civil society organizations to participate as partners with governments in policymaking and governance and to convince government officials that sharing power and collaborating with civil society serves the interests of the country and its government.

The POLICY Project's overall goal in the LAC region has been to strengthen participatory processes as a means of creating a policy environment favorable to sexual and reproductive health. POLICY's experiences in the region reflect differences in the degree to which governments have decentralized and the degree to which citizens are accustomed to participating in policymaking and civil society organizations. A common set of principles, however, has guided POLICY's work over the past four years:

❖ Work as partners with local counterparts, not in isolation from them. We respect and trust our counterparts and seek to earn their respect and trust in return.

❖ Facilitate a process that enables counterparts to carry out an activity such as advocacy, policy dialogue, or research. In this way, we are cooperating in development of the region by creating an enabling environment for people to assist themselves.

❖ Look for ways to create synergy, recognizing that projects have limited resources. We seek to add value to ongoing processes and bring together key people and organizations. Wherever possible, we leverage our resources by working collaboratively with local counterparts, donors, and other USAID collaborating agencies.

❖ Start with listening to those who have a stake in the process. We educate ourselves and respect and respond to locally identified needs.

❖ Bring skills and tools to a country, state, or municipality, but tailor the project's approach to local needs, understanding that context and needs differ in each country (and even within regions of a country).

This book represents the voices of project staff and local counterparts alike in telling the story of progress made in Latin America in forging national and local partnerships to promote sexual and reproductive health in the context of decentralization.

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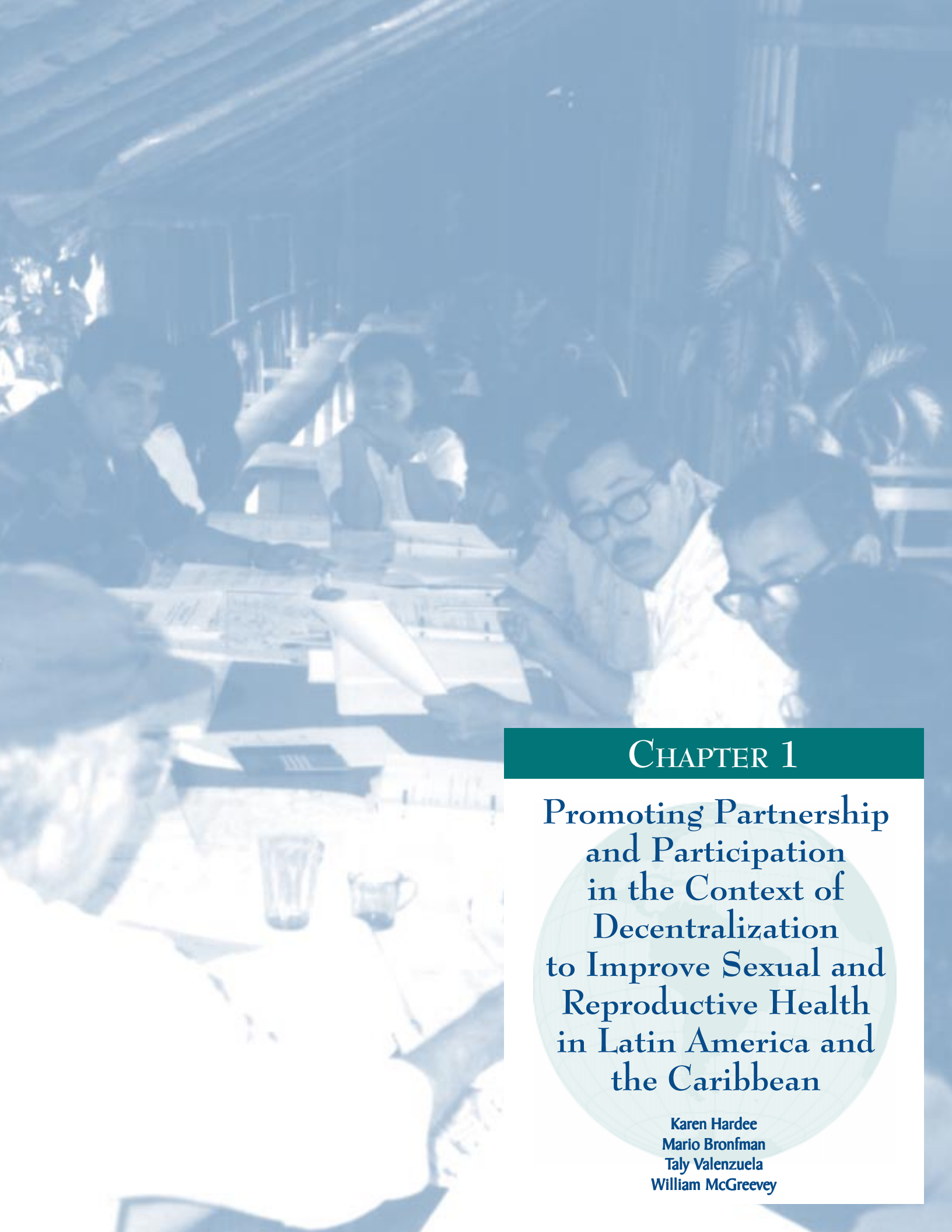
CHAPTER 1

Promoting Partnership and Participation in the Context of Decentralization to Improve Sexual and Reproductive Health in Latin America and the Caribbean

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Introduction[1]

The International Conference on Population and Development (ICPD) urged nongovernmental organizations (NGOs) to work in partnership with governments to implement the ambitious 20-year *Programme of Action* (United Nations, 1994). At the same time, it also challenged civil society to participate in policymaking, program design, and implementation to ensure that local health care needs, including reproductive health needs, were met. Many countries in Latin America and the Caribbean (LAC), as elsewhere in the world, are implementing the ICPD *Programme of Action* in the context of health sector reform, which embraces a set of sweeping initiatives, including decentralization, theoretically designed to meet the health needs of communities (Hardee and Smith, 2000; McGreevey, 2000). The *Programme of Action* supported the trend toward decentralization by recommending that governments promote community participation in reproductive health services by decentralizing the management of public health programs and encouraging growth in the number of NGOs and private providers. The POLICY Project, a five-year USAID-funded project launched in 1995, incorporated the ICPD mandate to improve the policy environment for sexual and reproductive health through participation of civil society.

This chapter begins by presenting experiences in the LAC region directed to promoting national partnerships of governments and civil society to implement the ICPD *Programme of Action*. The discussion sets the stage for a review of experience with decentralization and participation of civil society in the policy and planning process at the local level in the LAC region, focusing primarily on the health sector. Chapters 2 through 5 discuss in detail the POLICY Project's activities aimed at fostering participation within a decentralized setting in Bolivia, Mexico, Peru, and Guatemala. Chapter 6 presents lessons learned from efforts to improve the policy environment for sexual and reproductive health through participation at the decentralized level within the LAC region.

Government and Civil Society Partnership to Implement the ICPD *Programme of Action*

In the years since the ICPD, most activities designed to promote civil societies' role in implemenation of the ICPD agenda have occurred at the international and national levels. NGOs have gained increased legitimacy as formal representatives of civil society capable of working in partnership with governments to define reproductive health needs, design policies, and implement and monitor programs (UNFPA, 1999a). In a 1998 UNFPA field inquiry, 13 of 23 countries in the LAC region noted that they had taken measures to involve civil society in implementing the *Programme of Action*, moreover, five of the 23 countries in the region reported that they had taken significant measures to strengthen civil societies' ability to participate in policy and program implementation (UNFPA, 1999b). In eight of the 23 countries in the region, civil society has led major initiatives. In fact, countries such as Brazil, Chile, Colombia, and Peru, already had evolved a strong advocacy community before the Cairo ICPD. In countries such as Argentina, the advocacy community emerged or strengthened in preparation for Cairo while in others it has developed since Cairo (DAWN, 1999).

"Governments, in collaboration with civil society…donors and the United Nations system, should…give high priority to reproductive and sexual health in the broader context of health sector reform."

(UN, 1999, Para. 52)

"Decentralization should not be viewed as a single act of giving up power from the center to local governments, nor should it be seen as a permanent transfer of authority. Not only do countries assign different ranges of choice over different functions, but these ranges of choice change over time."

Bossert, 2000: 38

To strengthen their position since Cairo, groups have built broad alliances. In Argentina, for example, alliances of health professionals, community members, and the church have worked successfully in a highly conservative environment. In Brazil, the National Council on Women's Rights was revitalized in 1995 (Sadasivam, 1999). In Mexico, the National Forum of Women and Population Policy, a network of 70 Mexican women's NGOs and academic institutions, has worked to improve relations with the government through its partnership efforts (Bissel et al., 1998). Also in Mexico, the National Safe Motherhood Committee has grown into a group of over 28 representatives from the Senate, national public health institutions, UN agencies, NGOs, the media, and women's groups. Eight states now claim their own safe motherhood committees (Catino, 1999). In Peru, a group called the Tripartite Table, established to follow through on the commitments made at the Cairo conference and to address allegations that the government was coercing women into sterilization, comprises representatives of NGOs, donors, and government institutions.

Networks of civil society organizations, such as the Latin American and Caribbean Women's Health Network in Brazil, Chile, Colombia, Nicaragua, and Peru, are playing a role in monitoring governments' progress in implementing the *Programme of Action.* Their monitoring has thus far revealed great difficulties in including civil society and women in particular in the implementation process. The network has also pointed to several other deficiencies in the implementation of sexual and reproductive health activities (Bianco, 1998).

The LAC region's agenda to promote partnerships between governments and civil society at the international and national levels is extremely ambitious. Little has been done to promote participation of civil society at the decentralized level to improve sexual and reproductive health. Nevertheless, initiatives at the international and national levels can help pave the way for participation at the local level.[2]

Decentralization

While policies and program direction often originate at the national level, reproductive health services are provided, though not necessarily administered, at the local level. In a move to bring administration and direction of health (and other) services closer to communities, many countries in the LAC region have turned to a variety of mechanism to decentralize health and other services. The expressed goals of decentralization (and broader health sector reform) are to better meet local needs, improve the efficiency and quality of services, and ensure equity in health care.

Decentralization involves the transfer of decision-making power from a central agency to peripheral agencies or subunits or the delegation of functions formerly carried out by central bureaucracies to organizations distinct from the central government. Rondinelli (1981) offers the most widely used definitions of four types of decentralization. Deconcentration gives local areas greater responsibility within a sector, such as health. Through devolution, political power is transferred to autonomous regional or local authorities empowered with legal decision-making power and capable of generating and controlling financial and human resources. The agencies that implement projects are responsible to local or provincial governments rather than to national ministries. Delegation involves the

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[2] The POLICY Project is involved in promoting partnership and strengthening the capabilities of national NGOs in a number of countries around the world by strengthening and building networks, providing advocacy training and training of trainers, helping analyze the policy environment, assisting in organizing and conducting advocacy campaigns, distributing small grants to networks and NGOs, providing technical assistance, and promoting south-to-south exchange (Valenzuela et al., 1997; POLICY, 2000).

transfer of some of a sector's implementation functions to semi-autonomous or semi-official entities that deliver a service. Privatization involves the transfer of property and administration of services to nongovernmental entities, either private or nonprofit. In practice, decentralization in the LAC region, as elsewhere, is often "hybrid" in its implementation (Silverman, 1992), with combinations of types of decentralization in the same country, state, or sector alongside functions that continue to be largely centralized.

In the health sector, the most common type of decentralization is a combination of deconcentration and devolution (Mills, 1994; Silverman, 1992; Bronfman, 1998). For example, decentralization often entails deconcentration to local governments associated with local teams of the Ministry of Health or devolution to mixed bodies such as local health committees, made up of both elected and assigned members. These mixed bodies can command wide powers such as planning, implementation, control of human and financial resources, collection of some resources, and the promulgation of some regulations, but they tend to remain under central control. Alternately, they can hold narrow powers such as coordination and transmission of information to the center. Bossert (1998) characterizes the range of powers and responsibilities as the decision space given to local governments on issues of finance, service organization, human resources, access rules, and governance rules.

The World Health Organization (WHO) has advocated the use of district health councils, which consist of a combination of local representatives and health officials with managerial responsibility in the area (Smith, 1997). The councils have both political and administrative authority to determine health policy and approve district health budgets. In addition, they have financial

accountability for the program and are responsible for program evaluation. Representatives on the councils can include elected community representatives, the district health officer, the senior health nurse, the district administrator, hospital directors, representatives of NGOs, and departmental district heads from other sectors, including education, agriculture, and social services (WHO, 1994).

Many countries in the LAC region have made significant efforts to transfer both authority and responsibility to local authorities. Bolivia passed sweeping laws in 1994 and 1995 to decentralize both government decision making and financial control and to strengthen the participation of local communities in the public policy process. Mexico began decentralizing its health sector in 1982; the process was interrupted between 1988 and 1994 and completed in 1995–1996. The federal government still provides most funding, but local governments are responsible for planning and implementation to ensure that programs respond to local health needs. Peru promulgated a decentralization law in 1983; however, today the government remains highly centralized, particularly with respect to setting standards, strategies, and budgets. In 1996, Guatemala revitalized its decentralization process and local development councils with the signing of a peace accord, after 36 years of civil war. In Paraguay, decentralization was legislated through the 1992 constitution. Since then, decentralization of the health sector has consisted of deconcentration of authority, with an expanded role for the local community in shaping programs. The municipalities remain dependent on the central Ministry of Health for service delivery, although with increased oversight by local officials and citizens. Venezuela has devolved responsibility to its state governments. Nicaragua has deconcentrated power to the local health districts of the Ministry of Health. In Ecuador,

"Effective decentralization cannot rest simply on the transfer of authority, functions and resources from national to local authorities but must be accompanied by a range of measures, including adequate training, designed to support the newly empowered localities."

Forman and Ghosh, 1999: 17

"Depending on the policy conditions, decentralization can give rise to either greater equity or inequity. In order to give rise to equity, programs of decentralization have to be linked to policies on, for example, national health planning, resource allocation, and community participation."

Collins et al., 2000

decentralization floundered due to lack of commitment to implementation on the part of the central government.

Decentralization has economic and administrative facets, but the primary motivation, regardless of the sector under decentralization, is political. Dillinger (1994:1) has written that decentralization "is not a carefully designed sequence of reforms aimed at improving the efficiency of public sector service delivery; it appears to be a reluctant and disorderly series of concessions by central governments attempting to maintain political stability." Smith (1997: 409) adds, "Without doubt, the most serious mistake any reformer can make is to assume decentralization to be a managerial exercise devoid of political cause and consequence." Writing about Latin America, Bronfman (1998) notes that the processes of decentralization and participation both occur within the political system. The two processes are related but not always mutually reinforcing. In the LAC region, decentralization has been part of the reform processes instituted by governments themselves rather than a response to popular demand. Reforms have been implemented in contexts where the potential for democratic participation was initially considered extremely limited. Decentralization was introduced to counter "over-centralization," which has historically characterized the region (Apthorpe and Conyers, 1982, in Bronfman, 1998). For example, the populist politics of the 1930s through 1960s in Argentina, Brazil, and Chile began as democratic revolutions but ended in strengthened, though often corrupt, central authority (McGreevey, 2000).

Stakeholders at the central and local levels in many Latin America countries have found decentralization difficult to fully understand and successfully implement.

Politicians and bureaucrats often fear the loss of power and control implied by decentralization. In practice, central governments have transferred responsibility to local administrative levels for political reasons without proper planning and training for implementation and without allocating adequate resources or revising the necessary legal and regulatory guidelines (Dillinger, 1994; Kolehmainen-Aitken and Newbrander, 1997; Sadasivam, 1999). Decentralization can simply reinforce local patronage systems (Brinkerhoff, 2000). Case studies conducted in several countries, including Mexico, found human and technical resources underdeveloped at local levels, which are generally incapable of providing reproductive health services (Forman and Ghosh, 1999).

Given that equity is often compromised in the decentralization process, a certain degree of centralization in the health sector has proven necessary to ensure equitable access to health care. Inequity is exacerbated in countries with wide regional disparities in resources and wealth (Vaughan et al., 1984; Knippenberg et al., 1997; Gilson, 1998; Collins et al., 2000; Hardee and Smith, 2000). In writing about one aspect of reproductive health, Abrantes (1996) contends that the trend in Latin America toward universal coverage under health sector reform should benefit people with HIV/AIDS by increasing their access to health services. Urbina-Fuentes (1995) counters that certain areas exhibit higher concentrations of HIV/AIDS prevalence and these must bear an unequal burden of providing services to the affected group. In Chile and Colombia, Bossert (2000: 39) found that the gap in per capita health expenditures between richer and poorer municipalities seemed to be narrowing over time, suggesting that "some improvements in equity may have emerged under decentralization in these two countries."

Participation of Civil Society at the Decentralized Level

Civil society is now becoming a stronger force in the LAC region. Politics are more participatory both to avoid criticism of centralized decisions and to increase the efficiency of governments in the face of decreasing resources and growing demand (Tehranian, 1982; Bazdresch, 1997). Participation, sometimes called democratic governance, is justified as a means of promoting democracy and the exercise of individual liberties (Brinkerhoff, 2000). In addition, participation is considered a means to achieving efficiency in the implementation of local programs (Bronfman and Gleizer, 1994).

Barnett et al. (1997) provide a framework for situating the role of participation in decentralization. They relate participation to decentralization through democratic local governance. The box below shows the role of civil society, through democratic local governance, in decentralization.

Participation, including that to promote sexual and reproductive health, can take various forms, as shown in the box on the following page.

The role of civil society organizations (generally considered to include private, nonprofit organizations that pursue social welfare goals related to human rights, the environment, health, and women's rights) is increasing as the role of government is diminishing. "In addition to providing ideas and suggestions for policy, civil society is expected to fill some of the gaps caused by government reduction of its traditional role as provider of 'safety net' services" (Isaacs and Solimano 1999: 71). The role of civil society is growing increasingly important to counter the trends of health sector reform through decentralization and globalization of health care in the region, which are exacerbating inequitable access to health services. At a 1999 meeting of the Civil Society Forum of the Americas in Chile, which was convened to examine the effects of health sector reform in the region, participants concluded that governments should play a more active role in ensuring

"An informed and responsible public that demands quality sexual and reproductive health care, and holds governments and facilities accountable for providing it, is crucial for the effective reform of existing services."

Catino, 1999: 27

Characteristics of Democratic Decentralization

- Instituting constitutional and legal reforms to develop power to local structures (changes in relationships among levels of government)
- Increasing local government's ability to act (human and financial capacity and significant responsibility)

- Increasing local government accountability, transparency, and responsiveness (changes in the relationship of government to citizens)
- Enhancing the role of civil society (individual and collective participation)
- Improving the quality of life (citizens empowerment, service quality, and equitable access)

Source: Barnett et al., 1997

"Relatively stronger groups will have louder voices, thus reducing the likelihood that the needs of the poor will be heard unless specific measures are taken to assure that relatively disadvantaged and/or marginalized groups' perspectives are taken into account."

Brinkerhoff, 2000: 604

"The proposal that decentralized management of health care will be more responsible to local needs in part depends on decentralization being accompanied by increased involvement by the catchment population in some way in order to define those needs."

Atkinson et al., 2000: 628

Forms of Participation for Civil Society to Promote Sexual and Reproductive Health at the Decentralized Level

- Advocacy to influence decision making on national or local priorities and the priorities to be funded
- Involvement in decision making by helping to set national or local priorities and make resource allocation decisions
- Involvement in implementation through NGO activities or networks, client committees, and service delivery
- Involvement in oversight and evaluation
- Sharing expertise with other locales and national coalitions of NGOs, helping to replicate good programs at local levels, or supporting local participation initiatives

equitable access to health care and that civil society should actively promote equity in the delivery of health care services (Isaacs and Solimano, (1999).

Given the limits of communication within the political system, promoting the participation of all stakeholders in all decisions is a challenge (Smith, 1985). One specific problem is the inability of various groups (organized or nonorganized civil society organizations along with representatives of the public sector, including legislators) to carry on political dialogue since the groups use different codes of communication (Bronfman, 1998). How to provide civil society with the capability to participate in political dialogue? Ideally, public individuals should be able to put into office officials who support their interests (through the official circuit). Alternately, they should be able to become organized around specific issues to advocate and/or pressure governments for change (through the alternative circuit). "Having interests" is unequally distributed and where it is not guaranteed, elements must be introduced to promote participation.

Types of Decentralization that Promote Participation

Modes of decentralization have implications for the ability of civil society to participate in decision making related to program priorities and funding. Deconcentration and delegation may not favor community participation, largely because the authorities or agencies to whom or which the responsibilities are devolved are not elected or assigned and therefore report to the central level rather than to the community. Bronfman (1998) writes that devolution has the greatest potential for promoting participation, but it requires the operation of democratic processes at the local level. Deconcentration can promote democracy, for example, district health committees composed of workers assigned by the central ministry and of government and NGO representatives drawn from the community. The fact that some representatives are elected democratically and others are appointed creates a balance in reporting. According to Gonzalo Sánchez de Lozada, former president of Bolivia, participatory decentralization can work, provided that strong local governments are created in partnership with civil society and that local areas are granted authority, particularly authority over human and financial resources (Sánchez de Lozada, 2000).

Participation can exacerbate local political factions and tensions. Smith (1997: 409) notes that "participation is widely recognized as a problem in poor countries because of political inequality and dependency, illiteracy, poverty, poor communications, physical insecurity, professional and bureaucratic hostility, political centralization and tokenism. 'Communities' are not socially homogeneous and the greater the inequality the more difficult participation is likely to be. Programmes aimed at strengthening the position of the poor may exacerbate conflicts with local and national elites, which may have to be coopted before a

programme can run smoothly." In a study in Italy, Putnam (1993) made an intriguing connection between decentralization and community participation. He found that the density of civic institutions (for example, choral societies and soccer clubs), which he termed "social capital," predicted improved performance of local government. The more social organizations in an area, the better the performance of local governments. Bossert (1998: 1516), extending the analysis to health care, writes "This approach suggests that those localities with long and deep histories of strongly established civic organizations will have better performing decentralized governments than localities which lack these networks of associations. In Colombia, anecdotal cases suggest that some regions, such as Antioguia and Valle, might have more dense social networks, which might explain why they have better performing institutions." Atkinson et al. (2000) agree that to understand decentralization fully and recognize why it succeeds in some areas rather than in others, it is important to understand the effects of local social organization and political culture on the reform process.

Smith (1997: 403) writes that multisectoral decentralization seems to be necessary for the promotion of community participation. Reviewing a survey conducted by Rifkin (1986) of 200 primary health care projects, Smith noted that "programmes that sought to promote only health and health-related services actually limited community participation because health is not necessarily a top priority, lay people see little scope for their own involvement, and professional planners tend to define the problems and present communities with the solutions. Participation in which people bear responsibility rather than just reap benefits is effective when a range of community needs is being addressed."

Participation does not always result in an improvement in efficiency at the decentralized level; in fact, participation can prolong the decision-making process as all interested organizations are entitled to voice their position on an issue. The dilemma between participation and efficiency is that the smaller the community chosen, the greater the potential for participation but the greater the degree of participation, the greater the potential for inefficiency and lack of coordination. Often, countries choose the provincial or state level for decentralization and then seek mechanisms to promote participation in smaller communities (Mills et al., 1990).

Furthermore, not all civil society organizations promote participation. Brinkerhoff (2000) writes that the assumption that civil society organizations are by nature participatory is not always true. He notes that "some civil society organizations are exclusionary and authoritarian" (p. 609). Speaking about his government's experience in promoting participatory decentralization, past president Sánchez de Lozada of Bolivia (2000) noted that he learned to distrust NGOs that did not have a "territorial" (regional or community) base because such NGOs are not accountable and their own agendas can overshadow their work.

Still, participation can help promote successful decentralization. Panama established village-level health committees in the 1970s to share responsibility with the Ministry of Health for planning, implementation, and evaluation of health programs. An evaluation of the village health committee system showed that while over 90 percent of the committees were inactive by 1983, several factors, including active local participation, led to success among the other 10 percent (Smith, 1997: 405). Thus, decentralization of health services was most successful when civil society participated in its implementation at the local level.

The effects of decentralization and participation on the provision of health care, including reproductive health, are not clear.

"We [the government of Bolivia] didn't give communities authority. We didn't allow them to hire and fire teachers, health workers, and others. The local communities should have the right themselves. They can better observe how the work is being completed…and a vital connection of responsibility and authority will be established."

Sánchez de Lozada, 2000

"Opening up the policy process to more participation rarely proceeds smoothly or without serious conflicts, backsliding, and politico-bureaucratic game-playing."

Brinkerhoff, 2000: 609

"In the case of Brazil, the two main reform strategies are to increase space for local autonomy and local voice…. The processes by which these strategies are assumed to transform into greater empowerment, accountability, responsiveness and quality of health care are moderated at every point by the local social organization and political culture in which the local health system is embedded."

Atkinson et al., 2000: 631

Bossert (2000) concluded in his study of decentralization in Chile, Colombia, and Boliva that decentralization yields mixed results, with indications of increased equity but no indication of major changes in performance. A study group at WHO (1996: 61) noted that "empirical evidence suggests that greater caution should be used in estimating gains. In Mexico, regional disparities have heightened; in Latin America, there have been increases in the influence of dominant groups…." Aitken (1999: 124) contends, "Where resources are scarce, new health problems and challenges, such as reproductive health, are particularly threatened under a decentralized system." With little data disaggregated by sex, particularly at the decentralized level, it is difficult to say if women are at a disadvantage in terms of access to and utilization of services, although indications suggest that they are. Decentralization can lead to local priorities that fail to reflect the needs of women–and, by extension, children–because women are often excluded in the decision-making and priority-setting processes.

Continued Challenges to Promoting Partnership and Participation

While governments have increasingly included civil society in the policymaking and program implementation processes, participation generally has been limited to the national level. Therefore, to ensure that all stakeholders participate in promoting sexual and reproductive health policies and programs, governments, civil society organizations, donors, and technical assistance projects such as the POLICY Project share a continued challenge to promote partnership and participation at the international, national and decentralized levels. The following box lists the recommendations that emerged from a 1998 roundtable meeting on the importance of

partnerships with civil society as a means of implementing the ICPD *Programme of Action.*

The challenges facing partnerships at the international and national level in improving sexual and reproductive health are likewise relevant at the decentralized level. Indeed, McGreevey (2000) notes that a central dilemma in the decentralization of health services is that it requires political decentralization to ensure its full effectiveness. Several countries in the LAC region remain highly centralized; yet realization of the benefits of decentralization requires not only the

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Recommendations to Promote Partnership with Civil Society to Implement the ICPD *Programme of Action*

All governments should adopt measures to facilitate the involvement of civil society in the formulation, implementation, monitoring, and evaluation of policies, strategies, and programs by

- creating common forums for dialogue;
- reexamining concepts, assumptions, agendas, priorities;
- listening to and respecting the experiences of other partners;
- identifying and building on the comparative strengths of various partners and using existing relationships;
- identifying key issues, players, and institutions;
- developing mutual accountability and transparency among partners;
- developing joint plans of action at various levels;
- strengthening capacities at all levels and ensuring sustainability;
- encouraging coalition building and networking; and
- continuing to monitor implementation of the *Programme of Action.*

Source: UNFPA, 1998

ceding of greater functions to lower levels of government but also the institution of electoral accountability, local revenue-raising capacity, and the involvement of local community groups and NGOs in decision making and implementation (Birdsall and Haggard, 2000). These changes are more than just administrative. They involve a local replication of the national process of democratization, including the formation of responsible and accountable governments, the formation of local party organizations that can recruit leaders and politicians, and the institutionalization of accountable and transparent government. These are clearly long-term tasks, but they are likely to be advanced by the development of local civil society groups.

Substantial effort will be needed to strengthen the capabilities of local stakeholders to participate at the decentralized level. Some observers contend that the level of participation is evidence of whether a process is effectively decentralizing (Fuenzalida, 1993; Cabrero and Lira, 1992; Collins and Green, 1994; Gawryszewski, 1993; Bronfman, 1998). Nevertheless, many decentralization policies that claim to include participation are not in fact designed to promote it, even when they imply some degree of transfer of responsibilities from the center to the periphery (Barnett et al., 1997). The changes that can be detected in power relationships (especially the empowerment of formerly marginalized groups) can serve as indicators of effective participation.

The four case studies in the following chapters illustrate participation in the context of decentralization in Bolivia, Mexico, Peru, and Guatemala, as well as the POLICY Project's role in facilitating participatory policy and planning processes. The case studies highlight the activities undertaken by the POLICY Project to promote participation at the decentralized level, the unique challenges faced by the project in each country, and the extraordinary results achieved by counterparts given the tools and skills available to empower them to participate in shaping local agendas to meet their needs. It is still too soon to assess the impact of civil society participation on sexual and reproductive health outcomes at the decentralized level; however, we contend that engaging civil society in defining its own needs is an important outcome in itself. The following chapters, while not formal evaluations, provide evidence of the value of promoting participatory policy processes that empower civil society, particularly women who have not often been heard in the past, to be part of the local decision-making process-both defining their own health needs (including reproductive health) and seeking the means of meeting those needs.

CHAPTER 2

Bolivia
Case Study

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Introduction

The Bolivia case study illustrates a process for ensuring that civil society groups have the opportunities and skills needed to participate effectively in decentralized decision making. In a country where an explicit law mandates popular participation in decentralization, it is reasonable to expect that citizen involvement in local decision-making processes is a matter of routine. However, when local communities are unaware of the responsibilities that laws impose on them and when they lack the skills necessary to participate in policy processes, decentralization fails to be participatory even amid a favorable legal and institutional climate. Bolivia faces such a situation, especially in its peripheral municipalities where large portions of the country's rural and poor populations reside.

This chapter describes efforts to realize the true potential of Bolivia's Popular Participation and Decentralization laws. The overarching approach was to inform citizens of their rights and responsibilities under the two laws and to provide them with skills and knowledge in the areas of planning, advocacy, and leadership so that they could translate those laws into action. Within the context of participatory decentralization, efforts concentrated on working with civil society groups and municipal governments to bring community sexual and reproductive health needs to the forefront of local agendas. These approaches would ensure that decentralization paved the way for joint decision making whereby civil society and local governments together developed policies and programs that responded directly to community needs, particularly in the area of sexual and reproductive health.

Context

Geographic, Social, and Economic

Bolivia is a landlocked country situated in the middle of South America. It has a population of 8 million, 63 percent of whom reside in urban areas. Urban populations are concentrated primarily in the departments of La Paz, Cochabamba, and Santa Cruz, whose capital cities, until recently, received the largest share of the country's financial resources. Similarly, health, education, and other social services are concentrated in these urban areas. Bolivia's rural population of over 3 million lives far removed from the country's epicenters of political and economic power. Rural residents rarely participate in political decision-making processes and have little access to social services. Forty-two percent of Bolivia's rural inhabitants are indigenous, namely, Aymará, Quechua, and Tupi-Guarani.

A low per capita income ($1,000) and a highly inequitable income distribution render Bolivia one of South America's poorest countries. Over 40 percent of urban families and 92 percent of rural families live below the poverty line. One-fifth of the population is illiterate; however, the rate is worse in rural areas, where illiteracy is 36 percent overall, and 49 percent among rural women.

Similar patterns are reflected in health and reproductive health conditions. Although Bolivia has seen considerable improvement in its sexual and reproductive health status during the past decade, it still lags behind in the Latin America region and significant rural-urban disparities exist within the country. Bolivia's total fertility rate is 4.2, 50 percent above the regional average. Fertility among rural women is almost twice as high as that of their urban counterparts. Less than half of married women use contraception, and only 32

percent in urban areas and 11 percent in rural areas use modern methods. Skilled attendants assist with 60 percent of births, but the maternal mortality rate, at 390 per 100,000 live births, is among the highest in the region. Maternal mortality in rural areas is almost double that of urban settings.

Decentralization and Participation: A Favorable Legal Climate

In 1994 and 1995, the government of Bolivia passed two groundbreaking laws that significantly transformed Bolivian society. The laws were intended to further democratization in Bolivia by bringing local communities into the public policy process. The Popular Participation Law (PPL) of 1994 and the Administrative Decentralization Law (ADL) of 1995 laid the foundation for a political, institutional, and legal framework that transferred decision making and financial control to local governments, *and* gave citizens the legal right and responsibility to participate actively in this decentralization process.

The ADL transferred many central government functions to Bolivia's nine departments. Most important, it gave departmental governments control over human resource management. The PPL, on the other hand, strengthened the powers of Bolivia's 316 municipalities through several mechanisms. First, the central government guaranteed municipalities an equitable, population-based share of tax revenues. Within this system, the Department of Treasury distributed one-fifth of total tax revenues among local governments. Second, the central government transferred control of all social and cultural service infrastructure (e.g., health, education, and sports) to municipal governments. Finally, the PPL gave legal recognition to civil society organizations called Base Territorial Organizations (OTBs), which include citizen oversight committees, neighborhood

councils, and indigenous organizations. The law empowered OTBs to participate actively in local decision making and thereby ensure that plans and policies reflect local needs; oversee the implementation of these plans and policies; and monitor municipal governments to ascertain that resources are spent in a transparent and effective manner. Through the OTBs, local communities for the first time had the opportunity to give voice to their concerns, shape local agendas, and ensure that municipal funds were used to address community needs.

Sexual and Reproductive Health Policy: A Changing Landscape, 1970–2000

Between 1970 and 2000, the government's attitude toward sexual and reproductive health changed from hostile intolerance to active support. In the early 1970s, Peace Corps volunteers were expelled from Bolivia for allegedly sterilizing rural women without their consent; ProFamilia's family planning clinics were closed down; and a ministerial decree eliminated the family planning component of the Ministry of Health's (MOH's) maternal and child health program. Despite the adverse policy conditions of the 1970s, private clinics made timid efforts to provide contraceptives to the well-to-do while some NGOs attempted to serve low-income clients (Olave, 2000).

Between the 1980s and 2000, health policy in Bolivia evolved slowly, moving from an exclusive focus on child survival and safe motherhood to the reinstatement of family planning as a priority and, eventually, to a broadened perspective on sexual and reproductive health consistent with the 1994 ICPD agenda. In 1989, the Bolivian government established the National Program on Reproductive Health to ensure that the work of different institutions and agencies, both public and private, are coordinated and complementary. The

program has evolved into today's National Forum for Sexual and Reproductive Health.

As a result, sexual and reproductive health is now an important component of Bolivia's development and poverty alleviation efforts. As such, it receives attention in programs and policies at the national level. The current administration has included sexual and reproductive health and women's health priorities in its Strategic Plan for Health. Also in place is a Basic Health Insurance Scheme (initiated under the previous government and expanded by the current one) designed to cover infant, maternal, and child health care; the diagnosis and treatment of sexually transmitted diseases (except HIV/AIDS); and family planning.

Challenges

Despite a political and legal environment favorable to both participatory decentralization and sexual and reproductive health, several factors have impeded citizen participation in policymaking at the decentralized level, particularly with respect to sexual and reproductive health.

❖ First, local communities were unfamiliar with the content of the PPL and ADL and hence unaware of their rights and responsibilities vis-à-vis local decision making. Thus, they voiced little demand for entry into policy and planning processes.

❖ Second, citizens lacked the skills necessary to participate effectively in policy processes, particularly populations that have habitually been marginalized and excluded from decision making, namely, rural populations, women, and indigenous groups. In addition, local governments lacked the administrative capacity, technical skills, and political will to translate laws into action, often tending to favor party needs over community needs.

❖ Third, neither local communities nor authorities viewed sexual and reproductive health issues as priorities that merit local-led policy attention. The support for reproductive health programs at the central level had yet to trickle down to subnational levels, where problems associated with the economy, agriculture, education, and epidemics such as malaria take precedence, especially in the minds of men, who have traditionally controlled policy processes.

❖ Finally, vocal advocates who could propel sexual and reproductive health to the forefront of municipal agendas were few and far between. Although more aware of sexual and reproductive health problems than their male counterparts, many Bolivian women consider high maternal and infant mortality rates, chronic reproductive health problems, unwanted pregnancies, and domestic violence part of "normal" life and something beyond their control. Therefore, they are rarely vocal in advocating for change. However, ignorance about reproductive rights is only part of the reason for women's passivity. Cultural constraints and lack of confidence, advocacy skills, and leadership models play an equally important role in keeping women from taking advantage of opportunities to identify and prioritize their needs in local planning processes.

Interventions and Results

Recognizing the above challenges and taking into consideration recommendations from local counterparts, the program in Bolivia focused on the following goal: to support and facilitate the improvement of sexual and reproductive health by ensuring that decentralized decision making is participatory as envisioned in the laws and that local plans and policies respond to community sexual

Learning to Participate in Remote Areas of Bolivia

"This is the first time that technicians from the department level and high-level officials from La Paz have visited this forgotten village."

[President of a neighborhood association in Exaltación]

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and reproductive health needs. Within this context, the strategy has been to

❖ inform citizens of their rights and obligations under the PPL and ADL *and* to provide them with the skills and knowledge necessary to participate in the decentralization process;

❖ raise awareness among both community members and policymakers about sexual and reproductive health problems, their impacts, and means of addressing them in the policy arena; and

❖ strengthen civil society groups and grassroots organizations so that they can become effective advocates for sexual and reproductive health.

Making Municipal Planning Processes Participatory

Many municipalities receive little, if any, attention from the outside world. Making local decision making more participatory for remote municipalities with large indigenous and rural populations involved a multifaceted approach. Working with the Vice Ministry of Popular Participation, the approach consisted of training workshops, extensive follow-on technical assistance in developing municipal development plans (PDMs), and preplanning workshops to raise awareness about sexual and reproductive health and reproductive rights among prospective participants in the planning process.

Training workshops

The first step involved conducting three-day participatory planning workshops in 11 municipalities between May and December 1998.[1] The workshops were

designed to ensure that participants were aware of their rights and responsibilities under the PPL; knew how to exercise those rights in the municipal planning process; and understood the importance of integrating community sexual and reproductive health needs into local plans. Over 450 women and men attended the workshops. They were affiliated with Base Territorial Organizations, Neighborhood Vigilance Committees, indigenous groups, local NGOs, women's groups, youth groups, and local governments.

Participants hailed from notably different socioeconomic backgrounds; they had different levels of education, and some were illiterate. Few were familiar with the contents of the Popular Participation and Administrative Decentralization laws. Many had never participated in local decision-making processes; those who had done so were accustomed to a confrontational approach of making demands regardless of their impact and feasibility. Each of these realities posed a challenge to effective and cooperative participation.

The workshops sought to address these challenges. They began with a presentation and discussion of the laws to lay out clearly the role of civil society vis-à-vis the municipal government in decision making. Using participatory training methods that engaged participants in debates and discussions, facilitators covered a large amount of ground in three days. Participants reviewed data on the health, sexual and reproductive health, education, and economic status of their municipality; they learned to use the information to identify problems and their causes; they identified strategies and projects for addressing key community needs and problems; and they prioritized strategies on the basis of financial, political, and cultural viability. In short, by using examples, exercises, and actual data on sexual and reproductive health, participants walked through the various stages of a planning

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[1] Riberalta, Trinidad, Exaltacion, Santa Ana, Magdalena, Baures, and Huacaraje in the department of Beni; Oruro in the department of Oruro, Cobija in the department of Pando, Comarapa in the department of Santa Cruz, and La Paz.

activity, learning how to participate effectively in a pivotal municipal decision-making process. In the process, they also learned about the health and sexual and reproductive health status of their municipalities.

Continued technical assistance

Following the workshops, local authorities in six of the 11 municipalities received continued assistance during formulation of their PDMs. The municipalities were Riberalta, Trinidad, Exaltación, Santa Ana, Comarapa, and Cobija. With the exception of Cobija and Comarapa, the municipalities belong to the department of Beni. The period of PDM formulation provided the opportunity to ensure that PDMs were developed in a participatory manner, based on data, and gender-sensitive, and responsive to community-articulated sexual and reproductive health needs.

Throughout the municipal planning process, it was necessary to work closely with the Population Policy Unit (UPP) of the Ministry of Sustainable Development to disseminate to municipalities and departments data and information on local sexual and reproductive health status. In 1998, under a newly launched Modems-to-Municipalities Program,[2] 50 municipalities received modems and training in their use, providing access to population databases from the MOH, Vice Ministry of Popular Participation, UPP, and the census bureau. Thus, with some technical assistance, local authorities and community representatives in target municipalities were able to use the data to highlight and prioritize community sexual and reproductive health needs during the formulation of PDMs.

Gender and sexual and reproductive health workshops

One-day workshops on gender and sexual and reproductive health for community members—men and women who were prospective participants in the municipal planning process—complemented the ongoing technical assistance. The workshops were designed to provide information and raise awareness about gender and sexual and reproductive health issues as well as to provide a forum for participants to reflect on their reproductive rights and reproductive health status, often for the first time. The ultimate goal of the workshops was to help ensure that PDMs demonstrated gender sensitivity, reflected the needs of women, and addressed community sexual and reproductive health needs. Indeed, following the workshops, many participants decided that sexual and reproductive health programs should be a priority for their communities and subsequently worked to include them in their municipal plans.

As a result of the training workshops, continued technical assistance, and awareness raising about sexual and reproductive health—all within the framework of decentralized participatory planning, the PDMs of Riberalta, Trinidad, Exaltación, Santa Ana, Comarapa, and Cobija included, for the first time, programs and funding for sexual and reproductive health. For example, the PDM of Santa Ana included three such programs: a training program for teachers, health personnel, and NGO staff; an information, education and communication (IEC) program for sexual and reproductive health; and the creation of municipal office for women's affairs. By contrast, the PDM of the neighboring municipality of San Borja, which received no external assistance in participatory processes, neither included nor made any reference to sexual and reproductive health.

Four Days Go a Long Way: Causing a Ripple Effect in Beni

Following a 4-day advocacy-training workshop in Riberalta, a municipality with 698,710 inhabitants, the women of Riberalta mobilized and on June 21, 1998 created the Casa de la Mujer/Riberalta, an entity whose objective is to advocate for and advance the empowerment of women, with a focus on sexual and reproductive health. During the following year, members of Riberalta's Casa de la Mujer worked with counterparts in the neighboring municipality of Guayaramarin, providing them with advocacy and gender training, as well as the guidance necessary to create an equivalent Casa de la Mujer in Guayaramarin. On May 5, 1999, the Guayaramarin Casa de la Mujer opened its doors.

Building a Cadre of Leaders and Advocates for Sexual and Reproductive Health

To create core groups of advocates for women's issues, including sexual and reproductive health, throughout the country, participatory planning efforts were extended in 1997 by working with the Coordinadora Nacional de la Mujer (CNM), an established network of women's NGOs. CNM was undertaking an ambitious project to provide women in leadership positions with the skills necessary to become active participants in policy processes. The project developed three training modules in political participation, advocacy, and leadership. Each module consisted of one national-level training-of-trainers (TOT) workshop for CNM representatives from different departments and subsequent replica training workshops in Bolivia's nine departments. CNM members who participated in the TOT served as co-facilitators in the department-level workshops, expertly demonstrating their newly acquired skills.

The advocacy and leadership workshops were designed to provide participants, who were primarily women, with the knowledge and skills necessary to become effective participants in local decision-making processes. Participants learned about political structures and processes that they must deal with as advocates for women's rights and issues; effective advocacy techniques, including how to develop compelling messages, target audiences, organize campaigns, and use data in advocacy efforts; and concepts and techniques of leadership. The leadership workshops included a component on the municipal planning process to ensure that participants know when and how to use their new skills during the formulation of PDMs.

Almost 200 participants, virtually all of them women, participated in the advocacy workshops, which took place between March and November 1998. The leadership workshops took place the following year between July and November; 132 women, many of them alumnae from the advocacy workshops, participated. In each department, an established and well-regarded local women's NGO cosponsored the training workshop. These NGOs continue to be responsible for the continuity and sustainability of the processes started in the nine departments of La Paz, Oruro, Potosí, Cochabamba, Chuquisaca, Tarija, Beni, Pando, and Santa Cruz.

Supporting Advocacy for Gender and Sexual and Reproductive Health Issues: From Skills-Building to Action

Supplementary funds in the form of small grants provided opportunities for local women to use their advocacy skills to promote gender equity and sexual and reproductive health in their communities. Workshop participants accessed grants after preparing proposals to replicate advocacy training workshops and/or carry out advocacy activities of their own.

In Sucre, during the 1999 elections, women from the Centro Juana Azurday used a small grant to work with youth groups and implement a series of advocacy activities designed to convince candidates to incorporate sexual and reproductive health issues, particularly concerning the needs of adolescents and youth, into their election platform. In Riberalta, the Casa de la Mujer used a grant to lobby members of the Vaca Diez Consumer Cooperative to donate a building, thereby allowing the organization to establish a stable presence in the community. Recipients used a portion of the grant to develop brochures and organize meetings to educate the community about the need for community-based family planning and reproductive health programs.

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Members of the Santa Cruz Casa de la Mujer used a grant to lobby the municipal government successfully for the creation of municipal Gender Office. These are but a few examples of how women's groups in Bolivia used grants to translate their newfound advocacy and leadership skills into concrete actions and results.

Collecting and Using Information at the Local Level

In the past five years in Bolivia, several research activities, most of them pilot endeavors at the department level, provided crucial information that ultimately influenced policy decisions and program development. For example, in 1998, findings from a survey-based study of adolescent sexual and reproductive health behavior and attitudes were presented to and endorsed by department leaders. The results were subsequently incorporated into a pilot sexual and reproductive health education program in six local high schools. The department of Chuquisaca allocated additional resources in the form of six staff members to this activity.

Also in 1998, a study in Oruro identified factors that interfere with the delivery of sexual and reproductive health services at the local level. The survey-based study delved into the knowledge and attitudes of the local population toward sexual and reproductive health and addressed access to and coverage of sexual and reproductive health in Oruro. The findings pointed to a pervasive lack of knowledge and information about sexual and reproductive health problems and care options and an apparent mismatch between the supply and demand for sexual and reproductive health services. The results of the study were disseminated and used in participatory planning workshops at the municipal level.

In the rural community of Achacachi, findings from another study on the impact of the Popular Participation Law on women's participation in decision making showed the marginalization of women in community decision making, particularly with respect to sexual and reproductive health. The study also identified sociocultural issues, the predominance of traditional gender roles, and male dominance in society as the factors contributing to such marginalization.

The results of such studies have demonstrated to community members and policymakers alike the need to emphasize sexual and reproductive health and gender issues in planning, policy formulation, and advocacy.

Conclusion

Efforts to improve civil society participation in decentralized decision-making processes in Bolivia involved forging partnerships with civil society organizations, community leaders, and municipal officials and building their capacity and willingness to work together to ensure that municipal plans and policies would truly reflect and respond to the needs of the population. Through a combination of awareness raising, training, technical assistance, and small grants, hundreds of citizens throughout the country have built new skill bases. They are better able to lead, advocate for their needs, and participate in the public arena, thus fulfilling the roles and responsibilities laid out for them in the decentralization and participation laws.

Through informed and effective participation at the decentralized level, civil society groups have achieved much. In the municipalities of Riberalta, Exaltación, and Santa Ana and the departments of Beni, Potosí, and Santa Cruz, to name just a few, civil society groups are successfully using their new skills not only to identify and voice their concerns about sexual and

A Gender Office in El Torno, Santa Cruz

Women from the Casa de la Mujer/Santa Cruz used small a grant to convince municipal officials of the need for an office within the municipal structure devoted to women's issues. Grant recipients initiated their advocacy activities by collecting information on the forms and functions Gender Offices elsewhere in Bolivia, as well as the structure of the Municipality of El Torno. They conducted one-on-one meetings and workshops with municipal officials and community representatives to raise awareness on the importance of gender sensitivity and women's participation in municipal planning processes. Together with community leaders, they developed a proposal for the creation of a Gender Office in El Torno. Finally, they lobbied and negotiated with the municipal council to make this proposal a reality. Their advocacy efforts were successful. In July 1999, the Gender Office of El Torno was officially inaugurated with the mandate to guarantee a gender focus in all municipal policies, a municipal program to educate the population on their sexual and reproductive health rights, and a budget to implement these activities.

reproductive health and gender issues but also to create entities and participate in decision-making processes that will allow them to address those concerns. In Riberalta and Guayaramarin, local women came together to create Casas de la Mujer, centers whose objective is to empower women and to work toward improving their reproductive rights. In Santa Cruz, women advocates successfully lobbied the municipal government to establish within the official municipal structures an office devoted to gender issues. In the department of Chuquisaca, six high schools introduced sexual and reproductive health education programs in their curriculum. In six municipalities, communities and municipal officials who received training in participatory planning and gender/sexual and reproductive health workshops worked together to include, for the first time, sexual and reproductive health programs in their five-year municipal plans. Thus, with training and technical assistance, civil society groups in Bolivia have been able to surmount many of the challenges to participation in decentralized decision making and have gradually formed a network of advocates with the skills and commitment necessary to keep sexual and reproductive health at the forefront of local agendas.
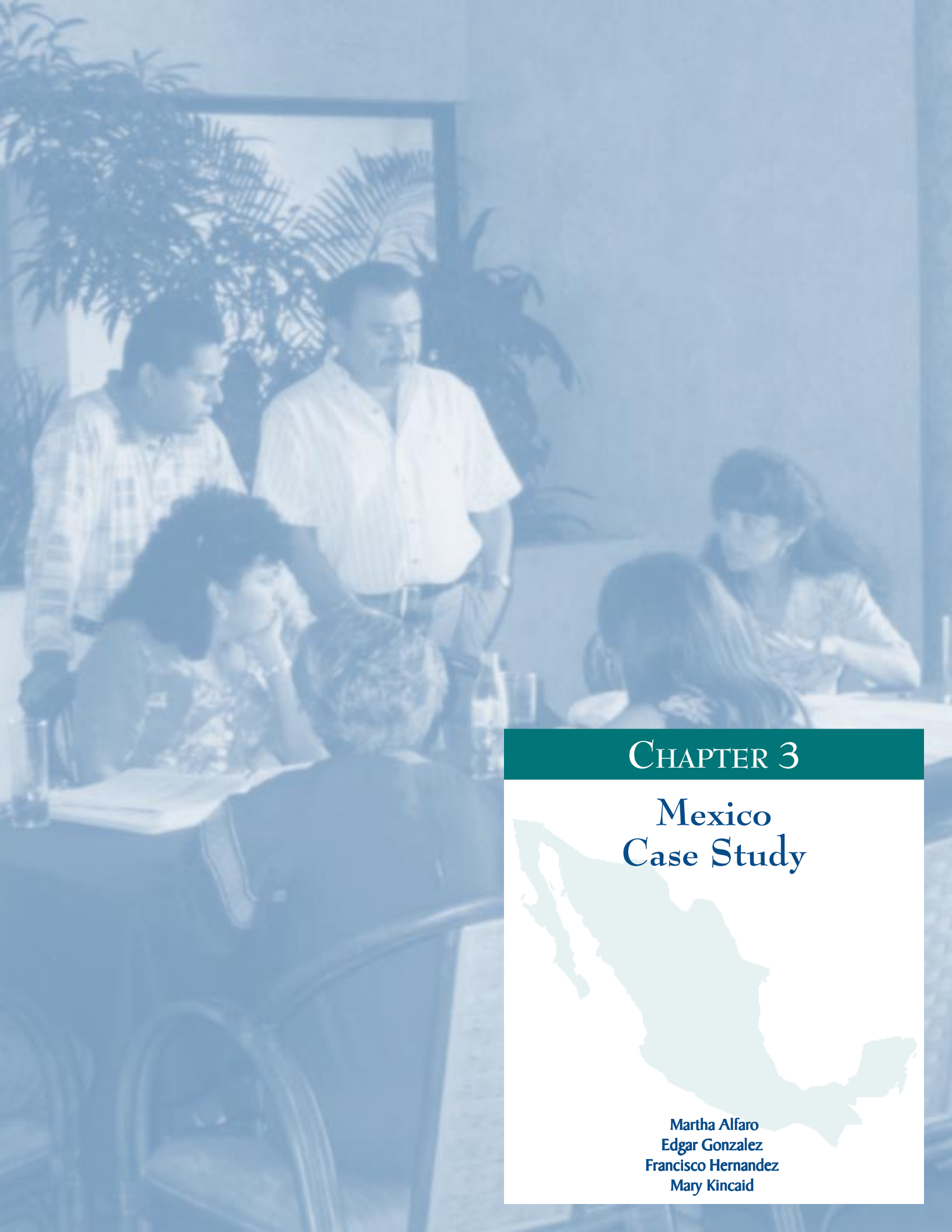
Chapter 3

Mexico
Case Study
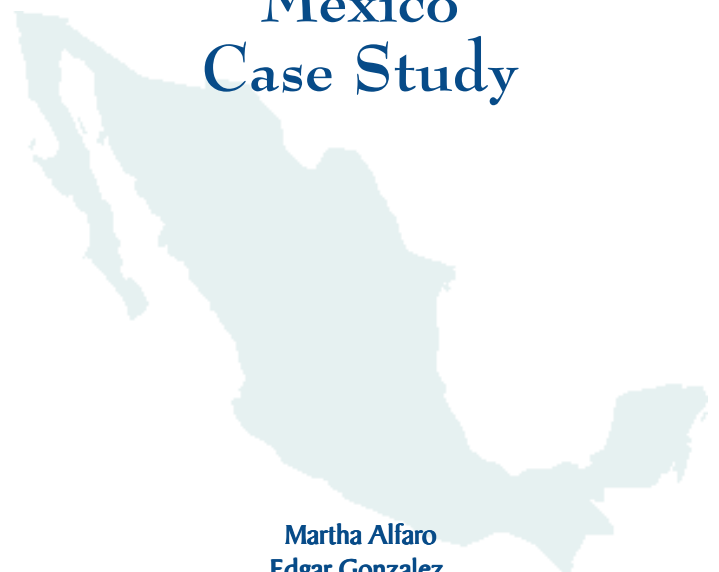
Martha Alfaro
Edgar Gonzalez
Francisco Hernandez
Mary Kincaid

Introduction

The Mexico case study describes a participatory methodology for multisectoral strategic planning at the state level in the context of a decentralized health sector. Decentralization of the health sector provides Mexico's states with the opportunity for improved targeting of financial resources according to local needs. In the case of HIV/AIDS, however, it also carries the risk that local policymakers will decide not to provide funding for HIV/AIDS programs in the state. In particular, HIV/AIDS prevention and treatment are not included as part of the federally mandated basic package of health services.

The program described in this chapter attempted to reach out to multiple sectors in selected states to increase participation in the policymaking process for HIV/AIDS at the state level. The goal was to improve planning and coordination and to build sustainable partnerships among NGOs and public sector organizations already involved in HIV/AIDS as well as to attract new organizations to the fight against HIV/AIDS, including the education and tourism sectors, churches, universities, and indigenous organizations. The principal approach was to carry out background research at the state level on the policy environment for HIV/AIDS (AIDS Policy Environment Score), the main stakeholders, the current state of the epidemic (situation analysis), and the response of the government and others to the epidemic (response analysis). The research phase was followed by week-long strategic planning workshops with representatives from the key sectors, with the objective of forming multisectoral planning groups with workshop participants. The final stage of the approach was to provide follow-on technical assistance and training to the planning groups, at their request, to ensure the sustainability of the groups, the quality of their strategic plans,

and the effectiveness of their advocacy and related activities. The long-term vision for the planning groups is that they will serve as permanent policy advisory boards in the states, helping to guide the formulation of state policies on HIV/AIDS prevention and treatment as well as the coordination of programs across sectors.

Context

Geographic, Social, and Economic

Mexico is a diverse country of nearly 100 million inhabitants, including an estimated 8.7 million indigenous people (INI, 1999) concentrated in largely rural areas and in the southern region bordering Guatemala. The 32 states, including the Federal District of Mexico City, range in population from 375,000 in Baja California Sur to 11.7 million in the state of Mexico, which surrounds the Federal District. The country had a total of 2,426 municipalities in 1999. Approximately 22 percent of the population lives in rural areas (PAHO, 1998), and many communities in the mountainous areas of both the east and west are difficult to reach by road, leaving their inhabitants economically and socially isolated. With both a thriving economy and income from oil production, Mexico is relatively well off economically. The average per capita income in this middle-income country was US$4,180 in 1999, but inequities abound and almost one-fourth of the population still lives in extreme poverty.

Access to health care facilities is considered adequate for most of the population, with the public sector serving 51 percent of residents nationwide (Saavedra, 2000) either through the social security system hospitals and primary care centers or public facilities for the uninsured.

Decentralization and Participation

Responding to requests from the states that they be allowed to plan, budget, execute, and allocate resources to their own programs, Mexico accelerated the decentralization of its health sector under the Health System Reform Program (1995–2000). In 1996, the Health Secretariat signed the two agreements: the National Agreement for the Decentralization of Health Services, and the Agreements for Coordination for the Complete Decentralization of Health Services. These agreements establish a framework that allows federal entities to operate autonomously in the states, identify priorities in relation to health care services at a local level, and commit the state to participating and taking responsibility at the municipal level. The decentralization movement was reinforced in 1997 through reforms to the National Health Law and the Social Security (IMSS) Law and with presidential decrees regarding "New Federalism" and "Decentralized Public Institutions." While the federal government is still the main source of funding, state governments and local elected officials are now responsible for local planning and program implementation and for ensuring that resources respond to local health needs.

Increasingly, the role of the HIV/AIDS/STI[1] coordinator in each state is to address the impact of and opportunities associated with the decentralization of services and to build partnerships among organizations working in HIV/AIDS and STI.

HIV/AIDS Policy: Preventing the Spread of the Pandemic

Mexico has an HIV prevalence rate estimated at about 0.5 percent, which is similar to that in the United States. Through the mid-1990s, the epidemic was largely limited to men who have sex with men. Several states, however, now face a growing epidemic as tourism and circular migration from Central America and the United States spread HIV to new populations, including rural populations, indigenous groups, and women. Poverty, low literacy rates, and the low status of women compound the problem. The ratio of male to female AIDS cases in the state of Mexico, a largely rural "sending" state, is 5:1 compared with 9:1 in nearby Mexico City, with heterosexual transmission accounting for one-third of cases registered by risk factor[2] in the state (Ramirez, 2000). An estimated 40 percent of HIV-positive persons do not have access to trained care providers, and only an estimated 30 percent have access to antiretrovirals, which are essential for survival and for improving the quality of infected persons' lives (Saavedra and Uribe, 2000).

In 1996, the National AIDS Council (CONASIDA) developed a four-year plan (1997–2000)—as part of the Ministry of Health's decentralization plan—to transfer several of its functions to the state level. Under the new plan, the states were made responsible for the following activities and services:

❖ coordination among public, private, and social sectors in the HIV/AIDS area;

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[1] Throughout this chapter, the reader will see references to both HIV/AIDS and HIV/AIDS/STI programs, reflecting the recent integration of the HIV/AIDS and STI programs at the state level in Mexico. The integrated approach has not been adopted by many of the NGOs working in HIV/AIDS; subsequently, many of the references in this case study are to HIV/AIDS, not to HIV/AIDS/STI. When a program specifically addresses STI as well as HIV/AIDS, the authors have used the term HIV/AIDS/STI.

[2] "Risk factor" refers to the category of behavior or exposure to HIV reported by the infected person. Factors include men who have sex with men, intravenous drug use, unprotected sex (i.e., without a condom) with multiple sexual partners, and blood transfusions, among other factors.

- development of norms in collaboration with each state's Commission on Human Rights;

- development and dissemination of educational materials tailored to the local context and culture to inform citizens about means of transmission and methods of preventing HIV;

- programs targeted to high-risk groups;

- training for health care personnel to improve the quality of medical and social services provided to HIV-infected persons;

- oversight of implementation of and adherence to the national norms for prevention and control of HIV/AIDS within the state's health care system; and

- establishment of a telephone hotline service with local access to provide information and referrals to the public about HIV/AIDS.

Challenges

With the decentralization of the health sector, each State Health Secretariat is now charged with developing its own plans and budgets for presentation to its respective state legislature. The legislature can then approve or amend the plans and budgets. Mexico's decentralization offers an opportunity for states to develop programs that are more responsive to the needs of their populations; however, it also carries the risk that political interests and limited knowledge of technical issues on the part of state-level decision makers may lead to decisions that fail to serve the interests of the local population. The concern for responsible, decentralized governance is particularly acute with respect to HIV/AIDS because many state officials have little understanding of the disease. Furthermore, conservative Catholic Church leaders exert a strong influence over local politics in some states, and local policymakers are frequently prejudiced against individuals with HIV. In fact, they often deny the extent to which HIV/AIDS affects their local communities. While CONASIDA formed state-level AIDS councils (COESIDAS), the councils in many states have been inactive such that responsibility for state activities has fallen to the State Coordinator for HIV/AIDS. Typically, the state HIV/AIDS coordinators have no direct budget control, and therefore are limited in their efforts to comply with CONASIDA's four-year plan and to carry out programs designated as the responsibility of the states.

A further challenge comes from the lack of community involvement and coordination in many high-risk states. Although Mexico City has seen a vigorous and sustained, albeit often uncoordinated, response to HIV/AIDS from the NGO community (nearly 70 NGOs work on the issue), such is not the case throughout Mexico. In states such as Yucatan and Guerrero, the NGO community is much less active on the issue: in those areas, between three and five NGOs work on HIV/AIDS issues. These and other high-risk states also face a lack of coordination on HIV/AIDS programs within the NGO community; between the public and private sectors; and across sectors such as health, education, tourism, and indigenous affairs.

Interventions and Results

Since 1998 and in response to CONASIDA's mandate to strengthen decentralization, POLICY developed a pilot strategic planning program to foster the development of multisectoral state planning groups for HIV/AIDS. In the first two years, the project focused its work in the states of Guerrero, Yucatan, and Mexico and in the Federal District (Mexico City). In early 2000, the team initiated activities in the states of Oaxaca and Vera Cruz.

Developing a Participatory Planning Approach to HIV/AIDS at the State Level

Around the time the program was starting in Mexico, UNAIDS released a new series of manuals to guide developing counties' strategic planning efforts in HIV/AIDS. The manuals, designed to "help plan and manage a broad response to HIV, with contributions from all sectors of society" (UNAIDS, 1997), were intended for use with a national strategic planning committee for country-level planning. The project team[3] reviewed the manuals and modified the planning methodology to promote enhanced participation in the planning process. In addition, the team adapted the methodology for use at the individual state level. The strategy focused on forming groups composed of a broad range of state and local organizations already working in HIV/AIDS and related fields and collaborating with them to develop an integrated strategic plan for HIV/AIDS that would address the needs of the states' vulnerable populations.

The original UNAIDS approach included four steps: an analysis of the situation, analysis of the response, strategic plan formulation, and resource mobilization. Before the start of any strategic planning activities in the selected state, some preparatory steps ensured broad-based support for the process and a thorough understanding of the policy environment and to reach out sought involvement of those working in related fields. The steps included dialogue with and/or lobbying the State Secretary of Health to gain support for opening the planning and policy process to participation from civil society; conducting a comprehensive stakeholder analysis to identify potential participants in the strategic process; measuring the AIDS Policy Environment Score[4] through the application of a survey to approximately 25 key informants in each state; and holding a press conference held by state leaders and the head of CONASIDA to announce the start of activities and to invite the state's media to participate in the process. The adaptation of the UNAIDS methodology continued over a two-year period. Responding to requests from participants at the end of the first two workshops, the team developed a new component that called for providing substantial, continued assistance to the planning groups after their formation.

Each step of the process—from initial interviews and data collection to the workshops and follow-on assistance—was carefully designed to incorporate a participatory approach. The local experts who prepared the situation and response analysis spent much of their time in face-to-face interviews with key informants in the states to ensure that the collected information was current and accurate. At the state level in particular, written sources of information are weak or nonexistent, making field visits all the more important. The team sent drafts of the situation and response analysis reports to the respondents to validate the information and repeated the process with participants at the strategic planning workshops. The workshop design itself included minimal presentation formats

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[3] The POLICY Project team for Mexico consisted of Mexican and U.S.-based project staff as well as local Mexican expert consultants and advisors who provided additional guidance and input to the program.

[4] The AIDS Policy Environment Score (APES) is a composite score for measuring change in the policy environment over time in a country and, in some cases, across countries. The APES is distinct from the situation analysis and response analysis reports, both of which are part of the UNAIDS strategic planning methodology. The APES is used primarily for evaluating the impact of the entire POLICY program in Mexico while the situation and response analyses are elements of the strategic planning process in each state. They provide the basis for much of the work carried out by participants in the week-long planning workshops and in the planning groups thereafter.

and focused instead on participant discussions and small group work, letting the group determine the eventual outcomes of the workshop (i.e., form a multisectoral planning group, develop a strategic plan, take a different course of action, or nothing at all).

Journalists as Allies and Participants

From the outset, one of the principal strategies in Mexico was to involve journalists and the media in the program both as allies to help build political and public support and as participants in the strategic planning process itself. The approach was simple and low-cost but highly effective. After gaining approval from local authorities to start work in a particular state, the team and/or State HIV/AIDS Coordinator for AIDS invited local journalists, television stations, and newspapers to attend a press conference where the state Secretary of Health and the Coordinator General of CONASIDA would announce the start of the planning initiative for HIV/AIDS in that state. The press conferences served several other purposes: to educate media representatives about HIV/AIDS, to convince them to increase coverage of the issues and in an unbiased manner, and to attract at least one journalist to attend the strategic planning workshop and become part of the state's multisectoral planning group. An attractive press kit included up-to-date information on HIV/AIDS-related issues, such as condom use and its effectiveness in HIV/AIDS/STI prevention, human rights and HIV/AIDS, and statistics and other information about the epidemic in the state and country. It also provided contact information so that interested journalists could interview state or federal HIV/AIDS experts and keep abreast of the planning initiative.

The strategy worked well in terms of both increased quality and quantity of media coverage and as a way to involve journalists as participants in the planning process. The most interesting experience so far has occurred in the state of Guerrero, where two well-known journalists joined the planning group and succeeded in dramatically increasing coverage of HIV/AIDS in the state. Clips from the evening television news on TVAzteca/Guerrero, the most popular station, feature interviews with policymakers, physicians, and social workers involved in HIV/AIDS issues; relevant statistics about the epidemic in the state; interviews with persons living with HIV/AIDS who speak about the social isolation, discrimination, and poverty they have endured since falling ill; and interviews with people on the streets of Acapulco asking about prevention methods, why they think prevention campaigns do not work, and other relevant issues. The two journalists also convinced colleagues who host weekly talk shows to invite members of the multisectoral planning group onto their shows, gaining valuable exposure for the group's work and bringing much-needed airtime to the HIV/AIDS issues in a socially conservative state. The sustained interest of these media representatives and their involvement with the planning groups is an excellent example of how journalists can be effective advocates for a social issue as well as part of the solution and how they can use their communication skills to expand the discussion on controversial topics such as HIV/AIDS.

Bringing Key Actors Together to Forge Alliances and Develop a Multisectoral Plan

Results of the stakeholder analysis identified participants for attendance at a week-long state-level strategic planning workshop. State leaders reviewed the list and usually added other names and institutions. As a result, the workshops drew

In a speech in Acapulco in August 1999, Dr. Patricia Uribe, the Coordinator General of CONASIDA, commented on the assistance provided to CONASIDA and the states. In particular, she commended the local team for having "the flexibility and creativity to undertake the modifications necessary [to work] in each different locale."
She continued, "The POLICY Project has contributed to the process of decentralization and strengthening the interaction between key actors in each community where it has worked. Apart from the hoped-for results from the collaboration with POLICY, we had several areas of value added from the project:
- *empowerment of the state HIV/AIDS program coordinators;*
- *awareness raising and motivation of personnel in the field;*
- *improved coordination and relations among participants in the process; and*
- *deepening of the planning process to involve operations personnel from the primary level."*

an average of 30 participants per state. To date, workshops have been held in Yucatan, Guerrero, and the state of Mexico. The workshops included presentations on the situation and response analyses in that particular state; training in strategic planning methods; presentations and exercises on thematic topics of relevance, including human rights, gender, and men who have sex with men; and small group sessions intended to rank the issues and needs in each state and to identify strategies for addressing the issues. At the end of each workshop, the participants agreed to form groups that would continue to meet to coordinate activities, share expertise, and develop a common strategic plan for HIV/AIDS in their respective state.

Even though workshop participants agreed to form planning groups and tackle the issues of HIV/AIDS in a coordinated fashion in their states, the outcome was not a given. Workshop participants had to overcome prejudices against each other and/or their organizations as related to sexual orientation, political affiliation, institutional policies, and other issues. To reach the decision to work as a group, many factors had to come together. For example, rival NGOs had to put aside past differences; the public and NGO sectors had to get beyond a tradition of mutual dislike for the other's approach; and Catholic priests had to engage in dialogue with outspoken representatives of the gay community. In addition, some workshop participants had to be convinced of the value of a participatory planning process and the wisdom of involving representatives from other sectors in developing strategies that affect how the health or education sector, for example, tackles a crosscutting issue such as HIV/AIDS. Similarly, some public sector representatives had to be convinced of the value of listening to the recommendations of an NGO about which actions are most appropriately the province of state institutions. In short, facilitators had to

guide the group through an inevitable period of conflict during the first few days of the workshop to help ensure that participants would eventually accept each other's differences, learn about the work of others in the area of HIV/AIDS, and develop the mutual trust and respect that is a necessary precursor to collaboration.

In Guerrero, Yucatan, and Mexico, where so few state and local organizations are working on HIV/AIDS, it was crucial that most of these organizations decided to join the planning group and that new organizations joined with them to fight the disease. The groups, two of which are well into their second year of existence, have the potential to influence state-level policies on HIV/AIDS across multiple sectors and to make a difference in the course of the disease in their communities. The goal is to help the planning groups achieve sufficient credibility among policymakers so that they eventually become a permanent advisory group offering a coordinated response to HIV/AIDS and thus serving state government, the private sector, and civil society organizations in their communities.

Helping to Sustain the State Planning Groups

As requested by the planning group, the strategy in Mexico has included continued assistance and training on group structure and organization, conflict resolution, strategic planning, technical aspects of HIV/AIDS, and review and comment on the strategic plans developed by the groups. The multisectoral planning process has allowed the groups to carry out a comprehensive analysis of HIV/AIDS needs in each state, the overall resources available to address needs, and the appropriate role of the various stakeholders in optimizing the use of available resources.

In the states of Guerrero and Yucatan, the planning groups spent almost one year

developing their strategic plans; they are devoting much of the second year to the approval process. In Guerrero, the group was slowed down initially by a lack of training in strategic planning techniques. Much of the technical assistance provided to CEMPRAVIH (Coordinación Estatal Multisectorialde Prevención y Atención en VIH/SIDA) during 1999 was geared toward building skills in planning techniques. In Yucatan, planning group members initially directed much of their energy to awareness raising and policy dialogue activities, reacting to the immediate needs they identified in the strategic planning workshop. Although this approach delayed progress on the strategic plan itself, it provided group members with an opportunity to work through various conflicts that arose (common to most groups in the formative stages) and to reach agreement on what they would eventually include in the strategic plan. Therefore, the technical assistance requested by the Yucatan group was a combination of training and speakers on thematic topics, skills building in group formation techniques and conflict resolution, and, finally, help in refining their strategic plan and accompanying dissemination/approval strategy. In the state of Mexico, the planning group is still in its first months of existence, although its strategic plan is expected to come together relatively quickly. The group left the workshop with a well-developed outline of problems, strategies, and priority areas.

Outcomes

Multisectoral planning in Mexico has yielded impressive results.

❖ In the states of Yucatan and Guerrero, where the planning groups have been functioning for nearly two years, diverse groups such as the Catholic Church and gay rights advocates have come together to work on the issue of HIV/AIDS.

❖ The traditional enmity between government institutions and NGOs working in HIV/AIDS has dissipated in the state of Guerrero. Since the creation of a multisectoral planning group in that state in 1998, the state Secretariat of Health and the NGO community have jointly developed a strategic plan that encompasses the health, education, and tourism sectors; conducted local IEC campaigns and events to raise awareness, including substantial coverage of HIV/AIDS in the state through state and national television news; and reached out to the state's large indigenous population with the first local-language educational materials.

❖ A recent internal evaluation (Wilson, 2000) of the work in Guerrero stated, "It is clear from talking to respondents that having a coordinating group has significantly strengthened and improved the response to HIV/AIDS in the state of Guerrero in a variety of ways. The primary impacts of this multisectoral group as perceived by the participants are improved coordination, a change in their own perspectives that has altered the way they work within their own institutions, and the creation of new programs devoted to HIV/AIDS."

❖ The Yucatan planning group is working to gain approval for its strategic plan from the various public and private sector organizations identified in the plan. The state Secretariat of Education and of Tourism as well as the state's NGO community and CONASIDA have endorsed the plan, which was presented to the new State Secretary of Health in June 2000 for approval. During the past two years, the group has carried out a broad range of advocacy and educational activities, including a training course for 120 health care providers. The group obtained funding for the five-day course from 22 sources, including the state and federal governments, private sector

Constructing Spaces for Dialogue on HIV/AIDS in Guerrero

In his keynote address to the Mexico National AIDS Congress in November 1999, Dr. Roberto Tapia, Under Secretary of Health, stressed the need to construct spaces for dialogue between the public sector, civil society, and persons living with HIV/AIDS and to find new forms of participation. He promised that the Federal Secretary of Health would continue to strengthen the state HIV/AIDS programs to broaden the response to multiple sectors and to reach out to all regions of the country. Noting that the national congress this year was being held in the state of Guerrero, Dr. de la Fuente took the opportunity to applaud the efforts of CEMPRAVIH, the state's multisectoral planning group: "One of the principal reasons the state of Guerrero was asked to host this conference is because it is an example of a state-level program that has significantly improved in the last few years, demonstrating a great political commitment and creating a multisectoral group for the fight against HIV/AIDS, which includes the state Secretary of Education, the state Commission on Human Rights and civil society organizations."

Changing Attitudes among Health Care Providers and the Public in Yucatán

Asked about the impact of their work in the state, three members of the Yucatan planning group offer their own observations and experiences since joining the group.

- "In one of my volunteer trips to the hospital to visit HIV patients, the nurses were wearing masks to enter that section and even asked visitors to do the same to avoid getting infected. One of the nurses offered a mask to me to wear, and I responded, "I know what I am here for," showing her the red bow. On subsequent visits, I observed that none of the nurses was wearing a mask to enter the HIV patient area."

  — *Q.F.B. Adriana Berzunza Coello, Member of the Yucatan GMC*

- "I have noticed that HIV+ patients in the [local facilities of the] Mexican Social Security Institute now speak about their ailments with more confidence. In other words, the moral prejudice among care providers has diminished, and as a result, the doctor can offer better care, something that did not happen in the past. This is solely the result of the information health care providers have received recently about HIV/AIDS."

  — *Dr. Salomon Gallegos, Member of the Yucatan GMC*

- Jose Manuel Polanco, a member of the Multisectoral Citizen's Group of Yucatan, spoke about one of his experiences from a workshop the Yucatan GMC conducted with students in their last semester at a teacher training school (1999). According to Jose Manuel, the students were very receptive to the topic, and, at the end, one of them suggested that to lend more realism and enrichment to their learning experience, someone with the AIDS virus should speak to the class about living with the disease and the problems that person faces on a daily basis. Upon hearing the suggestion, Jose Manuel responded, "In fact, you have spent a week with a person living with HIV; I have the AIDS virus." His announcement was met with much emotion and achieved a great deal of sensitivity among the students for the problem.

companies (such as Coca Cola, Glaxo Wellcome, and many local businesses); and NGOs. Most recently, members successfully advocated for state funding of a local laboratory and clinic capable of HIV/AIDS testing and treatment in accordance with federal guidelines for treatment of HIV+ patients.

❖ Advocacy by the planning groups in both Yucatan and Guerrero has resulted in an increased line item for HIV/AIDS/STI in the 2000 annual state budgets. This is the first time state funds (2 million pesos) in Yucatan have been allocated specifically to HIV/AIDS/STI. This year's budget in Guerrero includes a 6 percent increase for HIV/AIDS/STI. The Guerrero State Secretary of Health credited the planning group, CEMPRAVIH, with influencing the decision to increase funding for HIV/AIDS/STI.

❖ In the Federal District, where no state AIDS program existed, local advocacy efforts called for the creation of a district government program to address HIV/AIDS. As a result, in February 2000, the Federal District government opened the offices of the HIV/AIDS Council for the Federal District (CODFSIDA). The CODFSIDA includes representatives from a broad range of private and public organizations, civil society, and sectors such as education, health, tourism, and others. It has also initiated a multisectoral strategic planning process.

Conclusion

In sum, the support provided to HIV/AIDS stakeholders in the targeted states has strengthened public/private sector coordination, helped build partnerships among diverse organizations, and attracted new organizations to the fight against HIV/AIDS in Mexico. In the states of Guerrero and Yucatan and in the Federal District, the approach has improved the policy environment for HIV/AIDS, as evidenced by the increase in resources allocated to prevention and services in 2000. This represents a substantial achievement in light of decentralization of the health sector and the lack of federal requirements for state-level funding of HIV/AIDS programs. The state planning groups' efforts to finalize and gain approval for their multisectoral strategic plans also demonstrate their commitment to making decentralization work on the ground. By coordinating their efforts and leveraging resources, they can help ensure that HIV/AIDS receives adequate attention in their states, despite conservative political and social interests that would prefer to ignore the disease.
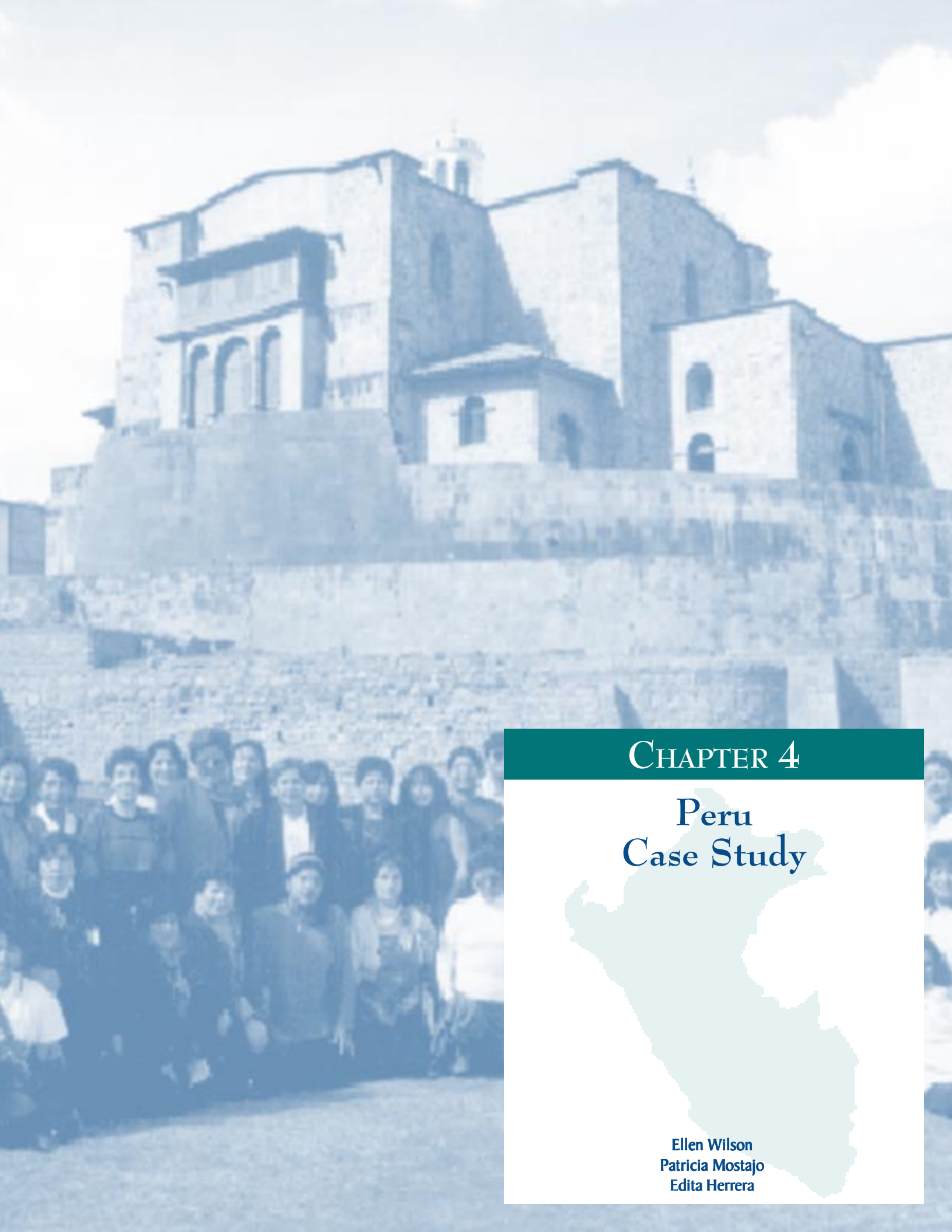
CHAPTER 4

Peru
Case Study

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Introduction

The Peru case study offers an example of enhancing participation at the local level in a country that has so far decentralized to only a limited degree. It also demonstrates the ability to achieve nationwide impact at the local level through an alliance with a decentralized network of women's organizations with branches in all of Peru's 25 departments.

Local governments have the potential to develop reproductive health programs that are responsive to the needs of local communities. However, this potential is frequently not realized due to several challenges that are similar to those in the other countries studied: local leaders' limited understanding of reproductive health issues, civil society's weak advocacy skills, and the public sector's lack of recognition of the value of civil society participation. In Peru, the strategy was to build the advocacy skills of local women's groups through a tiered advocacy training program and to provide technical and financial assistance to the group to design and carry out advocacy campaigns in support of sexual and reproductive health.

Traditionally in Peru, civil society participation in health programs has meant that civil society groups are encouraged to collaborate in campaigns developed by the Ministry of Health and to support its policies. A more active form of participation encourages civil society to act as an equal partner with government representatives, working together to identify problems and to develop and implement solutions. In community after community, groups have successfully mobilized the support of municipal councils for reproductive health programs, motivated government officials to establish new reproductive health programs, and established mechanisms such as Citizen Oversight Committees for ongoing partnerships between civil society and local government.

Context

Geographic, Social, and Economic

Peru is a heterogeneous country both geographically and culturally. It has three distinct geographic regions (coast, mountains, and jungle). Its population of 25 million is unevenly distributed, with 72 percent residing in urban areas, primarily in the coastal region. Political and economic power is concentrated in the capital, Lima, which alone counts a population of 7 million. Culturally, Peru has a large indigenous population,[1] and it is estimated that 7 million Peruvians maintain their native language, primarily Quechua or Aymara.

Significant disparities in standard of living, income, and access to services are apparent. Nationally, the illiteracy rate is 8 percent, but it masks substantial differences based on gender and regions. Illiteracy among women is three times higher than among men, and in the departments of Ayacucho, Huancavelica, and Apurímac, illiteracy rates are more than four times the national average (between 33 and 37 percent). High poverty levels are one of the most dramatic signs of inequality in Peru. Although the proportion has decreased since 1991, half of the population still lives in poverty, and 4.5 million Peruvians (27 percent of the population) live in conditions of extreme poverty. The proportion of people living in poverty is higher in rural areas, although, in absolute numbers, more people live in poverty in urban areas.

Health statistics are similarly variable. Infant mortality in rural areas (62 per 1,000 live births) is more than double the rate in urban areas (30 per 1,000). In Lima, more

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[1] According to the Census of Native Communities, there are seven Andean ethnic groups and 65 Amazonian ethnic groups, although the latter represent less the 4 percent of Peru's native population.

than 90 percent of births are attended by trained health personnel, but less than 40 percent of births are attended by trained health personnel in the mountain and jungle regions. Limited access to care contributes to Peru's high maternal mortality rate, which is estimated at 265 maternal deaths per 100,000 live births. Fertility is relatively low in Lima and the rest of the coast (2.5 and 2.9) but much higher in the mountain and jungle regions (4.6 and 4.7, respectively). Use of modern contraception is 41 percent overall; it is over 40 percent in all regions except the mountains, where it is 29 percent. Traditional methods of contraception are used by over 20 percent of women in union in both urban and rural areas.

Decentralization and Participation

According to its constitution, Peru is a unitary state divided into 24 departments (plus one constitutional province), 188 provinces, and 1,808 districts. In 1998, the government of Peru enacted a decentralization law creating Transitory Regional Administration Councils (CTARs) at the departmental level. The CTARs are responsible for administering the funds assigned to the department and coordinating the execution of sectoral policies. The councils have little autonomy, however, and are not representative of the local population. Specifically, they are attached to the Ministry of the Presidency, and council presidents are not elected but rather assigned by the executive branch. The decision-making power of the councils is limited to making adjustments within the budgetary and policy frameworks previously determined at the central level.

In contrast, authorities at the provincial and municipal levels are elected by the local population from among local candidates. Traditionally, provincial and municipal governments have limited their role to urban development while the interpretation or implementation of sectoral policies has been the responsibility of the local offices of executive ministries (such as regional health offices). In 1999, however, President Alberto Fujimori proposed that local governments expand their roles by assuming responsibility for managing services in the health and education sectors.

Despite attempts at decentralization, the government of Peru remains highly centralized. The CTARs have little power, and no progress has been made on the proposal to assign the management of health and education services to local governments. Some officials in the Ministry of Health resist the transfer of authority because they believe that local governments are ill equipped to take on responsibility for health care and would need extensive training before they could do so effectively.

Nevertheless, the government has made some efforts to promote community participation in the management of services at the grassroots level. In 548 communities, the Ministry of Health has created Local Health Administration Committees (CLASs) composed of community representatives and local health personnel. In practice, however, this type of participation asks civil society representatives to help the Ministry of Health carry out its campaigns and support its programs. The committees have little opportunity to propose their own initiatives or to work with the Ministry as equal partners to identify problems and develop solutions. In addition, each CLAS focuses on a small community, and therefore does not provide an opportunity to influence health programs in larger municipalities or in regions as a whole.

Sexual and Reproductive Health Policy

Since President Fujimori came to power in 1990, the central government has strongly supported sexual and reproductive health programs, particularly family

planning. The government has placed particular emphasis on increasing access to family planning services in response to unmet need. As part of this effort, in 1995 the Congress modified the National Population Law to legalize surgical sterilization as a family planning method, making the service available for the first time to many women who wished to limit family size. In the same year, the Ministry of Health began offering free family planning services in an attempt to eliminate financial barriers to contraceptive use.

In 1997, however, the government family planning program came under sharp criticism. Many NGOs and other civil society groups felt that the program generally emphasized quantity of services over quality and did not respect the rights of clients to a free and informed choice of contraceptive methods. The strongest criticism was related to sterilization. Civil society organizations, including the Catholic Church and many NGOs, accused the government of setting targets for the number of sterilizations doctors had to perform. They also cited cases of women who were pressured into sterilization against their will as well as a number of botched sterilizations that led to health problems and even death.

Various factors in program design contributed to the problems, including

❖ the lack of mechanisms to ensure the quality of sterilization services;

❖ local health authorities' lack of understanding of reproductive rights and client rights; and

❖ inadequacy of monitoring mechanisms and lack of indicators related to quality and gender.

The Ministry of Health has recognized that the flaws resulted in part from a design process that was not participatory—civil society organizations were not given an opportunity to provide input based on their understanding of the needs of the communities with which they work.

As a result of the criticism and to prevent further abuses, the Ministry of Health instituted safeguards in February 1998 to ensure that women would be able to make free and informed choice. The Ministry of Health solicited input from various public and private institutions, and it incorporated that input into modifications to the National Reproductive Health and Family Planning Program and the Manual of Standards and Procedures for Voluntary Surgical Contraception Procedures. These modifications include improved counseling, a waiting period before the sterilization procedure, and close monitoring of sterilization practices. The Ministry also informed health workers that there are no targets for sterilization. Finally, it has begun to work more closely with NGOs to help design programs that respond to client needs, monitor the implementation of those programs, and train ministry personnel in issues related to client rights, reproductive rights, and gender awareness.

Challenges

While both decentralization and effective collaboration between government and civil society hold potential for the development and implementation of sexual and reproductive health programs that are more responsive to the needs of local communities, several obstacles prevented realization of such potential.

❖ Local elected officials demonstrated little understanding of sexual and reproductive health issues and were unaware of needs in their communities. Partially as a result, they did not consider that they had a role to play in improving the sexual and reproductive health of their constituents.

❖ Civil society groups lacked the skills to participate effectively in decision-making

processes related to policies and programs intended to improve women's status, particularly with respect to sexual and reproductive health. Specifically, they could not identify community needs, develop effective strategies, and present their ideas convincingly to local authorities.

❖ Local authorities in the Ministry of Health and other sectors did not recognize the value of civil society participation, and few opportunities existed for collaboration between authorities and civil society representatives.

Interventions and Results

Beginning in 1997, the response to the above challenges involved strengthening the capacity of civil society groups to participate in decision-making processes, engage local authorities, and mobilize local elected officials to address sexual and reproductive health needs. In most community participation efforts, civil society groups merely help government agents implement their programs. The broader concept of participation envisions civil society working as equal participants with government agents to design, implement, and evaluate programs to meet the needs of their communities. In order for civil society groups to be able to influence programs in their communities, they would need training to gain an in-depth knowledge of the situation, strong technical and advocacy skills, and an opportunity to apply the skills they have learned.

Building Skills at the Decentralized Level

The National Network for the Promotion of Women (RNPM) is a decentralized, democratic network of women's organizations with bases in all 25

departments. A significant advantage of working with the RNPM was that its nationwide presence permitted the provision of training in tiers to eventually achieve an impact at the decentralized level throughout the country. Training began with a training-of-trainers for 25 women representing 16 different departments (representatives of the remaining nine departments were trained in 1999). Courses focused on sexual and reproductive health policies and issues, advocacy skills, and training methodologies. Following the workshops, participants returned to their departments and trained over 500 people on the same themes highlighted at the decentralized level. The departmental workshops included not only community leaders and representatives of NGOs but also representatives of the ministries of Health and Education and local government. By involving representatives of the public sector in the workshops, the RNPM was able to enlist the various representatives as allies to help them reach key decision makers, such as the regional directors of ministries, mayors, and the heads of regional councils.

Advocacy facilitators benefitted from continuous support, including annual update workshops to relay information about new policies, to share experiences, and to develop and coordinate strategies. In this way, each department updates its annual plans based on changes in the context, prioritization of themes, and appearance of new stakeholders.

Putting Lessons into Practice

Following the training, each departmental branch of the RNPM received financial and technical support to develop advocacy campaigns related to sexual and reproductive health, violence against women, and political participation and citizenship. Each of the departments organized forums to generate dialogue on these themes and to develop proposals to

increase awareness and improve services. Among the 16 departments, close to 1,000 people participated in each of three forums.

Supplemental funds in the form of minigrants enabled six departments during the first year and 21 departments during the second year to carry out advocacy campaigns on selected themes. The opportunity to apply the newly learned advocacy techniques was crucial in helping the groups consolidate their new skills. A representative of one group said, "When you participate in a workshop and you don't put what you learned into practice, you forget, no?" All groups drew heavily on their new skills in the design and implementation of their campaigns, including

❖ needs assessment;

❖ identification of primary and secondary audiences;

❖ identification of key messages and channels;

❖ forging of alliances;

❖ facilitation of meetings;

❖ analysis and effective presentation of data; and

❖ policy dialogue.

The advocacy campaigns have not only helped the groups further develop their advocacy skills, but they have also achieved significant results, including the official commitment of local authorities to address the issues, the development of proposals to improve municipal policies, the formation of intersectoral committees, and the establishment of ongoing collaborative relationships between local authorities and civil society representatives such as citizen oversight committees.

Achieving Results

The advocacy campaigns employed a few key strategies that called for involving local elected leaders in programs related to sexual and reproductive health, coordinating with government officials to improve services, working with the media to increase awareness and generate support, and running for political office.

Involving local elected leaders

Many activities have focused on municipal governments, encouraging them to expand the scope of their activities to include sexual and reproductive health. As a result, other municipalities are for the first time addressing the sexual and reproductive health of their communities. One example comes from the department of Ayacucho, where a branch of the RNPM, in alliance with the NGO COTMA, used a range of strategies to win the support and commitment of local elected leaders for sexual and reproductive health programs. The Ayacucho RNPM began by forming an alliance with a local radio station that aired a series of programs highlighting women's health and sexual and reproductive rights and the importance of women's participation in local and national development. The programs helped raise public awareness of and interest in these topics in advance of a symposium held on March 6, 1999. The symposium was specifically designed to address newly elected municipal councilwomen and to win their support for placing women's issues on the municipal agenda. The RNPM took advantage of several facilitating factors to help broaden the scope of the local government's agenda. First, ever since President Fujimori proposed the expansion of municipal responsibilities to include the management of health and education services, local governments have been eager to expand their roles in these areas. Second, the newly elected councilwomen were still looking for an agenda to promote, and the RNPM was able to help them not only with the issues they could support, but also the information and skills to address the issues effectively.

The symposium began with presentations by several former councilwomen who shared their experiences in municipal management, particularly in relation to the themes of violence against women, women's health, and the promotion of sexual and reproductive rights. By presenting the work of grassroots social organizations, the symposium also sought to increase the councilwomen's appreciation for the work of local civil society organizations and the potential for effective collaboration. At the end of the symposium, participants agreed to form a Network of Councilwomen of Ayacucho and pledged to develop a strategic plan to incorporate women's issues into the municipal agendas. As part of that effort, they will count on organizations such as the RNPM for technical assistance. Thus, the councilwomen gain influence and participate more effectively in their municipal councils as a consequence of the technical and political support they receive from the women's organizations, while the women's organizations gain valuable allies in the government who will promote policy changes in favor of women.

Other branches of the RNPM have been interested in the strategy employed in Ayacucho and are implementing similar campaigns. Sponsoring study tours to Ayacucho is one means for other RNPM branches to learn how to replicate Ayacucho's successful experience. For example, a team from Amazonas had the opportunity to meet with councilwomen from various municipalities and learn how they are incorporating the themes of women and reproductive health into the municipal agenda.

Coordinating with government officials to improve policy implementation

In addition to promoting sexual and reproductive health on the agendas of local governments, the RNPM has been working with local government officials, particularly in the ministries of Health and Education, to improve policy and program implementation. One example of collaboration is the creation of citizen oversight committees.

In May 1998, a Symposium on Citizen Oversight for Healthy and Safe Motherhood conceived the concept of citizen oversight is "an attitude of ongoing commitment, participation and awareness to create change in favor of my community and influence decision makers so that policies and their application are truly to our benefit." As a result of the symposium, the RNPM received a donation from USAID to carry out a pilot project to form citizen oversight committees in three departments. One year later, a national forum on sexual and reproductive rights concluded that the RNPM should extend the formation of committees to all of Peru's departments in response to the emerging controversy over voluntary surgical contraception.

El Callao, the constitutional province of Peru, is one political subdivision where a citizen oversight committee has been created. The local branch of the RNPM organized a forum on March 8, 1999, on sexual and reproductive rights. The objective was to generate dialogue between civil society organizations and local Ministry of Health authorities and to develop proposals regarding the application of policies favorable to sexual and reproductive rights. The regional Ministry of Health officer, health care providers, local government officials, and representatives of grassroots community organizations attended the forum. Speakers presented information on the sexual rights of women, free choice of family planning methods, and the experiences of communal work, thus demonstrating the importance of citizen participation for effective implementation of sexual and reproductive health policies. As a result of the dialogue initiated at the

forums, the regional health officer endorsed the creation of a citizen oversight committee that will work jointly with the departmental Ministry of Health to monitor and improve health services. The director also committed to respect sexual and reproductive rights and to provide high-quality services in a nurturing environment.

A year later, three more committees have been formed in El Callao, and all of the committees continue to meet monthly. Committee members are drawn from grassroots organizations such as community kitchens, "mothers' clubs," and "glass of milk organizations." The Ministry of Health has supported the committees by distributing the standards of care as parameters for the oversight they should exercise. The committees have focused on monitoring pregnant women and collecting information on the women's perceptions of available health services.

This model for civil society participation is now being applied nationwide. Currently, citizen oversight committees are operating in 11 of Peru's departments, and the United Nations Population Fund is supporting similar initiatives in the remaining departments.

Working with the media

One of RNPM's successful strategies has been to forge alliances with the local media to increase awareness of sexual and reproductive health issues and to hold local authorities accountable to the public. The alliances have been much easier to establish at the decentralized level than they would be at the central level, where the media generally have their own agenda.

In most cases, collaboration with the media has been part of a larger advocacy campaign, as in the case of the RNPM's efforts to improve sexual and reproductive health services and information for youth. At the central level, government policy promotes services for youth, in practice,

however, the policy has been slow to be implemented nationwide. In 12 departments, branches of the RNPM have been working to raise awareness of the issue and to generate the political will to take action to improve programs in part through effective use of the media. One example is the department of Moquequa, where the local branch of the RNPM and the Institute of Women and the Family carried out a campaign to raise awareness among educators and parents of the need for appropriate and timely information for adolescents on sexual and reproductive rights. The groups began by interviewing education authorities in several provinces throughout the department to gather information about adolescents' sexual and reproductive needs. They then compiled the information into a motivational packet for local officials and developed a pamphlet entitled "Breaking the Silence" for adolescents and the media. To generate broad-based support for the campaign, the groups carried out several interviews on local radio stations in the period leading up to a three-day workshop from September 27 to 29, 1999. Coordinators, specialists, directors, and teachers from the Ministry of Education attended the workshop, during which participants developed an action plan to initiate sex education activities in the schools. The media again supported the campaign by disseminating the commitments made by the authorities. As a result of the campaign, participants have repeated the workshop in their schools to raise the awareness of other educators. In addition, one school has initiated a counseling program, and another has formed an Adolescent Defense Committee.

Running for office

The advocacy training has also helped and encouraged some members of the RNPM to participate in local politics not only through advocacy activities, but also by running for office. Several members of the RNPM have been elected as municipal

council members due in large part because their new political skills helped them negotiate a high placement in the electoral lists. These women are now able to work for improved services for women from within positions of power in local government.

Conclusion

Forging an alliance with the RNPM has resulted in the creation of a network of skilled civil society advocates throughout Peru who are capable of generating the commitment of local elected leaders to sexual and reproductive health efforts. The groups in the network have also gained the technical competence to assess needs in their communities and to develop proposals for government authorities and local elected leaders. Recognizing the constructive role that civil society groups are playing, local authorities are beginning to value their participation and are becoming more receptive to working in collaboration with them. The RNPM has gained considerable expertise and has had an opportunity to demonstrate what it can accomplish. At both the national and local levels, government agencies are recognizing the RNPM for its technical competence.

The results achieved by the RNPM branches demonstrate the impact of effective civil society participation at the decentralized level. With the support of minigrants, the departmental branches of the RNPM have carried out several advocacy campaigns that have yielded wide-ranging results. The results include the formation of networks of councilwomen devoted to gender issues such as sexual and reproductive health, the incorporation of sexual and reproductive health issues into municipal government programs, new programs to address the sexual and reproductive health needs of youth, and the creation of citizen oversight committees. Although decentralization poses many challenges to the effective delivery of services, the RNPM is now in a position to maximize decentralization's potential by mobilizing communities to work together to address local needs.

Opportunities for collaboration between the public and private sectors have increased in part because relations between government and civil society representatives are more horizontal than at the central level. As a result, the Ministry of Women and Human Development has contracted with the RNPM to train its staff on the issue of violence against women, and the MOH has likewise contracted with the RNPM to raise awareness among healthcare providers of sexual and reproductive rights.

In conclusion, civil society groups in Peru have been able to establish mechanisms for true partnership with government representatives at the decentralized level and are now working together to design and implement appropriate policies and programs in sexual and reproductive health.

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CHAPTER 5

Guatemala
Case Study

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Introduction

The Guatemala case study is unique. Facing particularly strong impediments after the end of an extremely long and violent civil war, Guatemala has moved toward decentralized and participatory planning by means of a gradual, time-consuming process. The advances to date underscore the critical importance of partnerships and the participation of civil society in dramatically recasting the nature of reproductive health policies.

Context

Guatemala is a multilingual and multicultural country of approximately 11.9 million people. Mayan indigenous people represent approximately 60 percent of the population and Ladino people approximately 39 percent of the population (Ikeda, 2000). The two remaining minor groups, the Garifuna and Xincas, represent less than 1 percent of the total population. Although the official language is Spanish, 21 different languages are spoken in Guatemala. Half of rural women speak only their indigenous languages. Two of every three Guatemalans live in rural areas. Approximately 80 percent of the total population and 93 percent of the indigenous population live in poverty. The highest levels of illiteracy are found among indigenous women in rural areas, with levels reaching 80 to 90 percent in the northwestern parts of the country (GSD Consultants, 1999).

Guatemala is faced with the highest maternal mortality rate in the Central American region and one of the highest in all of Latin America—190 mothers die for every 100,000 births (Guatemala DHS, 1998–99). Women give birth at too young an age and also too late in their reproductive life cycles, and many pregnancies occur within less than 24 months of the last pregnancy. Guatemala's total fertility rate is estimated at five births per woman, and contraceptive prevalence is relatively low at 38 percent. The poor reproductive health status of women is complicated by gender inequities that pervade almost every aspect of Guatemalan society. In addition, reproductive health indicators show dramatic differences for indigenous women, indicating that these women are subject to gender and other inequities. As a result, sexual and reproductive health issues are closely linked to the larger political context of women's and indigenous people's rights.

Guatemala's recent history includes a nearly 40-year civil war that lasted from 1960 to 1996. It is roughly estimated that 180,000 people died during the civil war (Russel, 1996), leaving emotional and psychological scars on Guatemala's peoples and communities.

Participation

On December 29, 1996, the Guatemalan government and the Guatemalan National Revolutionary Unity signed a formal peace agreement to end the civil war—the Agreement on a Firm and Lasting Peace (known as the Peace Accords). Based largely on the Universal Declaration for Human Rights,[1] the Peace Accords set the foundation for a new relationship between civil society and government. The accords clearly set the stage for increased participation and democratization within Guatemalan society; in fact, many of the accord's articles specifically mention women and indigenous women. Among its other provisions, the Peace Accords promised to rectify the inequities facing indigenous groups and

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[1] The Universal Declaration for Human Rights was the first universal document developed addressing human rights; it was developed by the United Nations in 1948 and ratified by many countries following World War II. On December 11, 1998, the document celebrated its 50th anniversary.

women in Guatemalan society and to promote a broader model for economic and social development by involving local leaders and advocating the participation of women (Ikeda, 2000). For example, the accords call for

❖ guaranteeing women's right to organize and participate on an equal basis with men in all levels of decision making;

❖ guaranteeing equal rights for men and women, particularly in the agricultural and household sectors;

❖ strengthening the active participation of local governments, communities, and organized groups in planning, implementing, and executing local programs and services;

❖ guaranteeing women's right to access to integrated health care and adequate medical services without discrimination; and

❖ recognizing the vulnerability and defenselessness of indigenous women due to double discrimination based on the women's gender and indigenous status.

Decentralization

Guatemala is organized into 22 departments and 330 autonomous municipalities. The past three years have seen several normative advances designed to increase the nation's democratization and decentralization. Enacted in 1987, the Law of Urban and Rural Development Councils (Decree 52–87) laid the foundation for a political, institutional, and legal framework that transferred decision making and financial control to local governments through the installation of local Development Councils. The law also gave citizens the legal right to participate actively in local governance activities. It promotes, guarantees, and ensures social participation of all sectors of Guatemalan society. The

Secretary of Planning and Programming (SEGEPLAN) is the government agency responsible for strengthening the Development Councils as the planners for local development. Through executive decree in 1997, the government refined SEGEPLAN's responsibilities so the agency would be able to respond more fully to the needs of the local councils. In addition, the decree strengthened and modernized SEGEPLAN to improve the agency's capabilities (Mora, 2000).

Decentralization has been implemented primarily as part of overall health sector reform started in 1994 (PAHO, 1999). With support from the Interamerican Development Bank, the Guatemalan government launched an initiative to increase the coverage of health care services and to reach populations that had never before received public sector support for health care. The Integrated Health Services System (SIAS) includes a "minimum" package of services as well as the participation of local communities. The SIAS decentralized responsibilities and resources to the local directorates of the Ministry of Health, thereby increasing the autonomy of these bodies in relation to the formulation and implementation of their assigned health budgets and the external contracting of services. Through the SAIS health care model, Guatemala has gradually diversified the number and type of health care services. The number of nongovernmental and private organizations involved in the SIAS model increased from 21 in 1997 to an estimated 90 in 1999 (Mora, 2000).

Despite the above advances, the Guatemalan government remains highly centralized in most sectors. The country is still in the early stages of decentralization. The previous government administration that lasted from 1996 to 1999 failed to make the political decisions required to institutionalize or accelerate the transfer of power.

Sexual and Reproductive Health Policy

In Guatemala, various legal foundations support women's reproductive health rights, including the Constitution; the Law for the Promotion of Dignity for Women; Decree 67–97, which called for the elimination of all forms of discrimination against women; and the mention in the Peace Accords of women's rights to integrated health (although reproductive health is not specifically named). Despite a relatively strong legal framework, political support for reproductive health and family planning from the period of 1996 to 1999 was weak at best. Beginning in1996, the public sector came under the strong influence of an organized opposition movement against reproductive health at a time when the national reproductive health and family planning program suffered from a lack of leadership and orientation and thus was virtually unable to respond. These same forces have struggled to control the public debate on issues essential to reproductive health, such as human sexuality, further impeding the population's access to information and education. As a result, government policies and programs relating to reproductive health and family planning services were ambiguous at best and often nonexistent. In the decentralized SIAS health system, pregnancy and delivery services were virtually the only aspect of reproductive health that received attention and resources. Furthermore, the lack of participation of civil society, particularly of women, in political processes exacerbated the political apathy toward reproductive health and especially family planning programs (Duarte, 2000).

Challenges

In Guatemala, many challenges impeded effective political participation by civil society and by women's groups in particular. Challenges included the lack of a tradition of civil society participation, the low status of women, divisiveness, cultural diversity, lack of advocacy skills, and government resistance (Wilson, 2000). The civil war that affected Guatemala for more than three decades repressed all forms of organized expression. The population learned to be passive, and women in particular lived in a culture of silence perpetuated by their low level of income and educational attainment and the fact that many women do not speak Spanish. The protracted war created deep-seated suspicions about democratic processes and the judicial system. In addition to the perceived risks associated with "speaking out," the population demonstrated an overall lack of awareness about how civil society could take action, what strategies to use, how to mobilize popular support, and how to influence decision making. Many people had no knowledge or concept of how the government worked or where the power resided. Compounding the problem of a lack of a culture of participation was the government's resistance to respond to the demands of civil society. Another major challenge was the relatively fragile political environment for reproductive health issues, especially given the controversy and debates surrounding sexual and reproductive health issues. Even among groups that favored women's rights, some still operated under taboos and prejudices related to sexual and reproductive health, including family planning. Many of these perceptions were related to a lack of accurate information about what reproductive health included—and rumors linking reproductive health to abortion and population control. These rumors biased both conservative and liberal groups against reproductive health policies.

Interventions and Results

Policy-related activities began in 1996 with the initiation of activities with NGOs

interested in ensuring the participatory implementation of the Peace Accords, despite a lack of political support for such activities. At the time, policy decisions were still highly centralized (with little political will to change), and reproductive health and family planning were extremely sensitive issues. These factors created a challenging and precarious environment.

Due to the highly centralized environment, work began at the national level in the capital, Guatemala City, and then in other locations as opportunities presented themselves, gradually moving to integrate organizations from various departments with their counterparts in the capital. More recently, with a changing political environment, departmental offices have also received assistance. Participatory activities in Guatemala have focused on the following interventions:

❖ facilitating the development and formation of networks and coalitions from civil society to support advocacy efforts;

❖ empowering the networks and other civil society and community organizations to participate in the policy formulation process and to articulate their needs by strengthening their technical and advocacy skills;

❖ encouraging a more participatory process for the identification and analysis of needs and the definition of priorities in the health sector; and

❖ creating opportunities for interaction between civil society and government (at both the national and departmental levels) during different stages of the planning and policy process.

Facilitating the Development and Formation of Networks and Coalitions from Civil Society

Women's Network to Build Peace

Despite Guatemala's precarious political environment, there were important opportunities to provide support to key NGOs, which facilitated the pooling of skills and knowledge and increased financial and political leverage. In November 1996, several women's organizations solicited support to facilitate and guide the process of forming a network. The member organizations called their new group the Women's Network for Building Peace—defining its mission as the promotion of policies and actions to improve women's status within a framework of equity, gender sensitivity, and democracy.

Initially, the Women's Network for Building Peace included 13 organizations representing women from academia, women working as physicians and health care providers, other professionals, and indigenous women. Currently, the Women's Network represents 28 organizations with over 5,000 members. The network is legally formed and inscribed in the Public Registry—after three years of dealing with the political bureaucracy. Its structure includes a Coordinating Commission of three members that change every two years and a General Assembly. The network forms work groups according to operational and technical areas and is initiating expansion to the departmental level.

The Cairo Action Group

The Cairo Action Group (CAG) was formed in spring 1999 to bring the sexual and reproductive health agenda to the forefront and to advance Guatemala's official position at the ICPD+5 conference in New York. The CAG is a small network representing only seven organizations

(including the Women's Network, which was the foundation for formation of the CAG) and other organizations interested in reproductive health issues outside the context of the Women's Network. The CAG's focus is to promote the acceptance and implementation of the ICPD *Programme of Action.* The CAG has generated awareness of the contents of the ICPD *Programme of Action* and promoted the importance of supporting the ICPD initiatives contained therein.

Empowering the Network, Civil Society, and Community Organizations to Participate in the Policy Formulation Process

The Women's Network and NGOs interested in social and economic development often found themselves working with limited technical capabilities and a lack of specialization. Because they tended to operate in fear (after so many years of political repression) and isolation, they frequently duplicated efforts (Duarte, 2000). These counterparts encountered resistance from the Guatemalan government (which clearly opposed reproductive health) as well as many administrative obstacles to legally organizing themselves. Gender training combined with participatory exchange empowered women's groups and allowed them to recognize their potential and opportunities. They also needed to be able to analyze and identify a given issue and develop a proposal for action and change. Increasing their technical knowledge with respect to reproductive health statistics and population and development themes enabled them to develop their own materials and presentations.

Women's Network to Build Peace: Strengthening Women's Participation in the Policy Process

Initially, the Women's Network and its members were based in Guatemala City, the nation's capital. They received training designed to improve members' advocacy skills; providing instructions in the use and application of information in the decision-making process; improving negotiating skills, strategic planning, and self-management; and increasing knowledge about sexual and reproductive rights, gender equality, and integrated health. The Women's Network subsequently implemented its own activities, including the design and implementation of advocacy campaigns. The training and technical assistance varied with the network's members. Although more support was required than originally anticipated, the goal has been to ensure that the member groups in the Woman's Network have a solid foundation to support their advocacy and participatory activities.

As a result of its improved skills, the Women's Network has been successful in advocating and ensuring a participatory policy development environment; its main objective has been to ensure the participation of women in the policy process. For example, the network advocated to ensure that the Law on Urban and Rural Development Councils—the mechanism that promotes, guarantees, and ensures social participation of all sectors of Guatemalan society—explicitly included women's participation. Unfortunately, the law, which was part of a package containing various other reforms to the Constitution, was rejected by popular vote in 1998. The network then changed strategies and lobbied for reforms to the local Development Council as provided in the Law for the Promotion and Dignity for Women;

To counter the Catholic Church's systematic opposition to sexual and reproductive health, the Women's Network successfully lobbied for the Church's recognition of the right to information. In January 1998, the Episcopal Conference of the Catholic Church sent an unprecedented letter to Guatemala's Vice President stating: "All persons have the right to be informed before making a decision, for such motive, it should be ensured that the people have access to complete and accurate information about 100% of the family planning methods in order to have the liberty of choosing a method." The network has continued to lobby the Catholic Church through periodic visits, policy presentations, and providing scientific information. Recent declarations from the MOH also seem to reflect the Church's new tolerance for reproductive health.

ultimately, the reforms passed. With increasing skills and leverage, the network's achievements have become increasingly important.

In 1999, the Women's Network played a critical role in developing the platform for women's integrated health that was incorporated into the Civil Society Assembly (CSA)—of which the network is a member—for formal presentation to government and presidential candidates. The CSA is the official mechanism created by the government for decision making related to the Peace Accords.

With a new administration taking office in 2000, the Women's Network was ready to respond to a changed political environment and the administration's commitment to increase the level of participation, to develop the role of the Development Councils, and to pursue the decentralization process. Recognizing the opportunity to influence participatory planning and policies through the councils, the network began working at the decentralized level.

With the benefit of some financial and technical support, the Women's Network implemented an advocacy campaign designed to lobby for fulfillment of both the participation agreement and integrated health for women as described in the Peace Accords. The network's objective was to encourage women to participate in the decision-making process for women's integrated health by networking at both the national and local levels.

The advocacy campaign was implemented in the capital and in the departments of Quetzaltenango, Cobán-Alta Verapaz, Escuintla, Huhuetenango, Sacatepequez, and Sololá and involved local counterparts, including the National Office for Women. In Sacatepequez, the network helped consolidate the Sacatepequez Women's Forum (affiliated with the network), which has succeeded in obtaining financial

resources from the governor to open its own offices. The Sacatepequez Women's Forum is currently developing an advocacy campaign for the installation of maternity waiting homes in each municipality whereby rural women can be attended by capable and trained medical personnel in the several days preceeding delivery. The Sacatepequez Women's Forum also secured a permanent position on the local Urban and Rural Development Council. In Escuintla, the network brought together a group of professional women and physicians who have initiated coordination with the Regional Directorates of the Ministry of Health and the Guatemalan Social Security Institute to increase coverage of reproductive health services in Escuintla. Escuintla has an enormous need for reproductive health services because of the numbers of migrants who pass through from El Salvador to Mexico and because prostitution, sexually transmitted infection, and HIV are on the rise. Although local activities are just beginning, the network's ability to recognize these opportunities and act on them clearly represents a major achievement in promoting participatory decentralization in Guatemala.

The Women's Network has come to represent the voices of many women. The organization has increased women's representation in national and local policymaking and is poised to influence a newly revitalized decentralization process in Guatemala. The growth process has been one of diversification—the network now includes representatives from various departments as well as from various indigenous groups. The process has also been one of learning for the network and its members. It has gradually developed leadership skills, gained the ability to deal with internal conflicts, and learned to put democratic principles and participatory ideas into practice within the organizations so that the views of all members are taken into consideration.

CAG: Promoting political dialogue on reproductive health

Assistance to the CAG has included various workshops as well as a "learn-by-doing" approach designed to improve members' advocacy skills, enhance the use and application of information in the decision-making process, and increase knowledge about sexual and reproductive rights, gender equality, and integrated health. During the ICPD+5 process in 1999, the CAG publicly and for the first time tackled the topic of sexual and reproductive health, contributing to the official recognition of the importance of reproductive health and family planning in the final government document presented at the ICPD+5 meeting.

With some financial and technical support, the CAG implemented a campaign to advocate for implementation of the ICPD *Programme of Action* in Guatemala and to work toward government and civil society agreement to a set of commitments. The geographic reach of the campaign was in Guatemala City and the departments of Quetzaltenango, Escuintla, Santa Rosa, Sacatepequez, and Chimaltenango—where the CAG involved NGOs in advocacy activities with local governments to help accelerate implementation of the ICPD *Programme of Action.* The CAG has gradually expanded its activities and realm of influence beyond implementation of the *Programme of Action.*

In Quetzaltenango, the most important city after the capital, the CAG also played a key role in involving local NGOs in and promoting policy dialogue with congressional candidates on women's and HIV/AIDS issues. More recently, the CAG worked extensively during the elections to increase candidates' awareness of reproductive health issues and to place the issues on the political agenda. Many candidates incorporated terminology from the CAG into their speeches. The change of government in early 2000 has opened up

new opportunities for national and local organizations to exercise their citizenship by persuading political leaders and recently elected officials to pledge their support for women's participation and women's integrated health issues.

CALDH: Supporting legal advances in reproductive health policy

Beginning in 1997, the Center for Legal Action in Human Rights (CALDH) trained 215 indigenous rural women representing 75 different organizations in the conduct of training on sexual rights and reproductive health. The organizations in turn identified their own health priorities and developed local advocacy campaigns in support of government action. CALDH's and its partners' advocacy campaigns for sexual and reproductive rights contributed to the April 1999 passage of the Law for Advocacy and Fundamental Dignity for Women, which confirmed women's right to access to reproductive and family planning services and affirmed the government's responsibility to guarantee access through public health services. The law also reformed the local Development Councils to guarantee the presence of women on the councils. This law provided specific benefits for indigenous women in response to a proposal that originated with the Kabuk indigenous group. CALDH recognizes passage of the law as a first step in improving access to reproductive health.

To ensure that the process continues, CALDH recently initiated a campaign of policy reforms and participation in support of reproductive and women's rights. It has also developed a proposal to reform the National Health Code that includes the revision of eight articles to incorporate a gender-sensitive approach calling for the elimination of discrimination against women and encouraging women's participation. The proposal also includes mechanisms to support reproductive health issues. At the same time, CALDH has equipped NGOs,

In May 1999, the CAG brought together and informed a group of 25 NGOs about the Cairo platform and the health programs in Guatemala related to maternal, sexual, and reproductive health, stimulating this group to negotiate with the government to discuss and analyze specific proposals related to reproductive health. The group elaborated a political declaration from civil society that was published in the media demanding that the government respond to the real needs of Guatemalan women according to the strategic orientation of the ICPD Programme of Action *and that they assign appropriate technical and financial resources to establish a Population and Development policy.*

institutions, interested groups, and individual women with appropriate information to support policy and legal actions for the fulfillment of reproductive and women's rights. It conducted 10 departmental-level workshops that reached representatives of 40 different NGOs and developed a legal guide for women and community organizations that includes actions related to sexual and reproductive rights. CALDH also participates as an active member of both the Women's Network and CAG.

Encouraging a More Participatory Process for the Identification and Analysis of Needs and Definition of Priorities in the Health Sector

Due to the political reticence associated with sexual and reproductive health issues, it was difficult to provide direct support to government agencies, including the Ministry of Health, except for much-needed technical assistance in one important area—the analysis and use of population and reproductive health data for decision making. Part of the assistance included conducting a survey to assess medical and institutional barriers to family planning service delivery. The 1999 survey included interviews with health care professionals as well as with clients from health centers and clinics operated by the Ministry of Health, the Social Security Institute, and APROFAM (the largest NGO providing reproductive health services). The survey was conducted in all departments except Petén.

The survey provided critical information on the reality of reproductive health policy at the service delivery level. It identified 12 different barriers that inhibit access to family planning services. Those barriers are largely associated with service providers' biases and lack of knowledge, the absence or lack of knowledge about the

norms and guides for service delivery, the lack of knowledge about the political and legal context for family planning, and the lack of institutionalization of family planning programs. As a result of the survey, the Ministry of Health issued an advisory letter to all 22 department heads emphasizing the importance of access to family planning information and services for all persons. The MOH has also initiated a process to revise its technical norms regarding family planning and reproductive health services and has initiated a planning process to increase the availability of the operational guides for family planning services.

In early 1999, decentralized activities began in Quetzaltenango, San Marcos, and Cobán by supporting local MOH department heads in using information and data in the formulation of their plans and programs. Activities also included additional training programs for the departmental health councils and department heads of the MOH. Other activities extended to the initiation of a coordinated plan with the MOH, the Association of Guatemalan Female Physicians (AGMM), and the Association of Gynecology and Obstetrics (AGOG) that calls for disseminating information on the reproductive health situation and the results of the medical barriers study, providing an update on contraceptive technology, and distributing information about the political and legal framework for reproductive health and family planning.

Creating Opportunities for Government and Civil Society to Interact at the Departmental Level

In addition to providing assistance at the departmental level in the Ministry of Health in Quetzaltenango, San Marcos, and Cobán Alta-Verapaz, work began on

reinforcing the technical capabilities of local community and civil society organizations to enable them to strengthen their advocacy skills. Nine workshops reached reached 30 different local organizations and resulted in the establishment of a collaborative relationship with six organizations at the departmental level: the Coordinator of MAM Organizations (COMAM), the Union of Industry and Commerce Workers (SINTRAICIM), the Foundation of the Northern Mayan Woman (FUNMAYAN), the Association for the Guatemalan Development Maya (ADEGMAYA), the Association for the Progress of Women (AMVA), and the Organization of Tzutujiles Women Stars (OMET). These organizations initiated policy dialogue and advocacy campaigns with department heads in the Ministry of Health and local governments in order to improve health services and broaden women's participation in the political and decision-making processes related to family planning and reproductive health at the departmental level. In Sololá and Quetzaltenango, OMET and AMVA succeeded in mobilizing private sector resources (local radio and television channels) to support the local Ministry of Health in securing free airtime to deliver messages on integrated and reproductive health.

The advocacy campaigns have created a favorable environment for sexual and reproductive health policies at the departmental level. In Alta Verapaz, ADEGMAYA presented a proposal directly from the MOH to the program director for integrated health that would include and prioritize reproductive health norms and protocols in the SIAS.

An NGO working in Petén, the department farthest from the Guatemalan capital, also received assistance. The NGO REMEDIOS solicited help to conduct a workshop for local organizations on population policy and development. Later, these same groups collaborated with Petén's

Secretary of Planning to conduct a workshop for the local Development Council and government. The participatory planning workshop considered the sociodemographic characteristics of the department, the requirements of civil society organizations, and the interests of the community.

During a two-year period, four local women's organizations in five departments designed and implemented advocacy campaigns. As a result of the campaigns, 13 political and social leaders spoke out in favor of integrated health policies for women. Furthermore, eight additional NGO community organizations elaborated their own advocacy plans.

Conclusion

While most of the outcomes to date in Guatemala have occurred at the national level, interventions are increasingly taking place at the departmental and municipal levels, thereby ensuring adequate attention to reproductive health and gender issues and promoting women's participation in the policy process. The Guatemala experience has demonstrated that a legal and political framework—as defined in the Peace Accords—is insufficient to ensure access to reproductive health and family planning services unless community and civil society organizations engage in advocacy. The participatory process initiated at Guatemala's national and departmental levels ensures that advocacy efforts will continue to support the framework established by the Peace Accords. The incorporation of civil society groups has helped alleviate the central government monopoly on power and processes while diversifying the individuals and groups from various levels involved in dialogue, proposals, decision making, implementation, and monitoring. With these advances, society as a whole is experiencing an increased awareness of the issues, and

"…the health situation is not going to improve by simply increasing the number of doctors in the Ministry of Health. The direct participation of the population and organizations working in health is important…"

Quote from Dr. Nestor Carrillo, Director from the Sololá Area of the MOH, congratulating OMET for their initiative, May 2000

"I want to support your initiatives, but I also need your support to implement the reforms to the maternal and child health program that is trying to achieve integrated health for women and the incorporation of girls and adolescents."

Quote from Dr. Elsy Camey de Astorga, MOH Program Director for Integrated Health for Women, Children, and Adolescents, during ADEGMAYA's proposal presentation, July 2000

the opening of dialogue on reproductive health and family planning has itself been a significant accomplishment.

The technical assistance that counterparts in Guatemala received has laid the foundation for the groups to continue strengthening health sector reform and decentralization. In the future, these groups will be poised to take advantage of new opportunities for advocacy. The administration in power since early 2000 is demonstrating an increased political will to support participation and decentralization activities. The government is addressing the issue of women's integrated health and reproductive health and appears sufficiently broad-minded to recognize its own strengths and weaknesses, to trust the participatory process, and to ask for assistance. The new administration is beginning to draft a document representing a population and development plan for Guatemala. SEGEPLAN has requested technical assistance to train the Development Councils' delegates in participatory planning. The Ministry of Health is also beginning to develop its own reproductive health policies. The result is that the conservative mindset and taboos that dominated sexual and reproductive health issues in Guatemala for decades are gradually giving way thanks to the work of groups such as CAG, the Women's Network, and CALDH in strengthening participatory processes and decentralization.
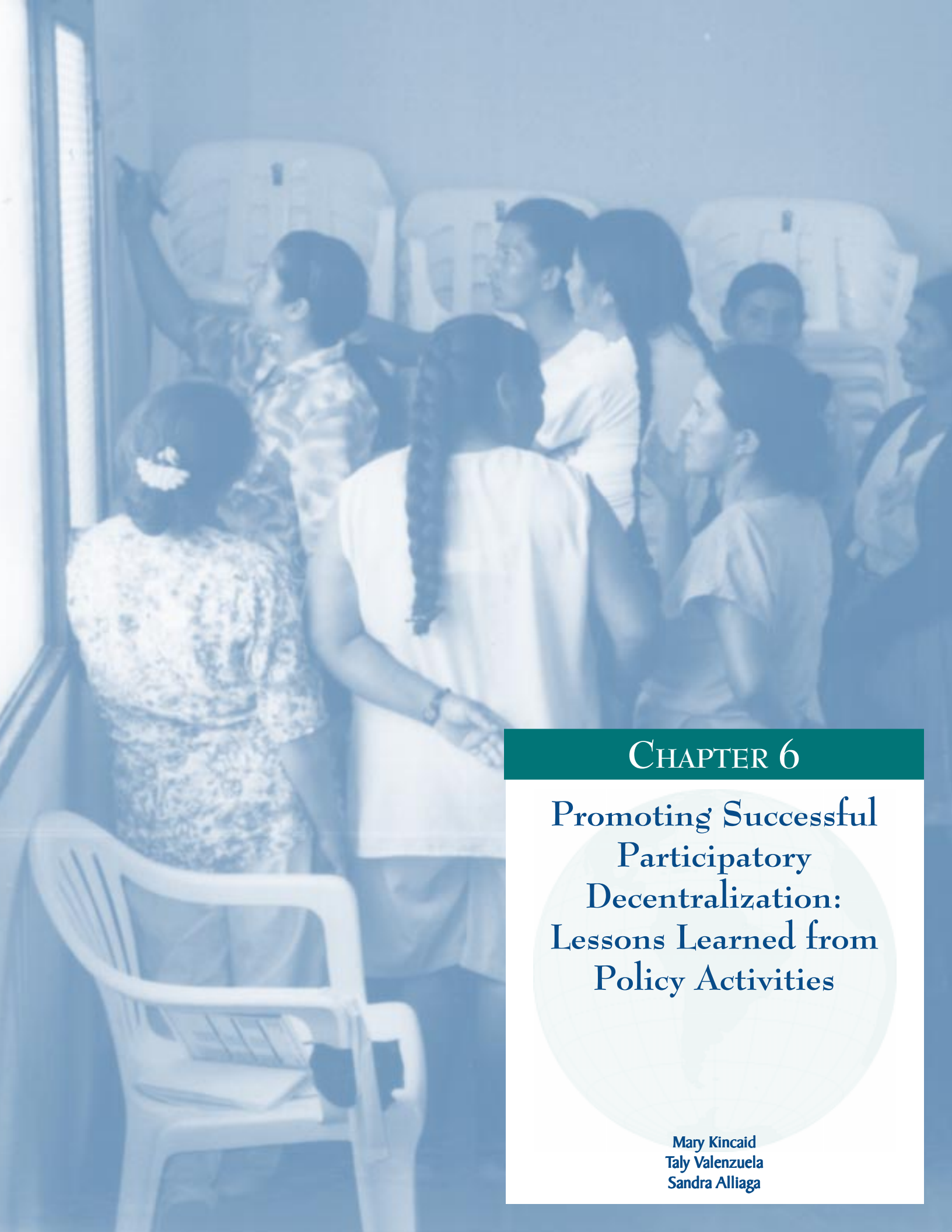
Promoting Successful Participatory Decentralization: Lessons Learned from Policy Activities

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Introduction

As governments in Latin America decentralize their health services, one key to success is to strengthen local citizens' groups so that they can participate in defining the services they need. Whether decentralization is taking place at the state, provincial, or municipal level, empowering civil society to participate in governance is crucial.

Decentralization, as discussed in Chapter 1, is intended to make policies and services more responsive to the needs of the local population and to make services more efficient, equitable, and of higher quality than under a centralized system. Yet, shifting decision-making power from a federal office to a state office does not by itself guarantee a better response. The country case studies in chapters 2 through 5 show that broad participation by citizens in decision making can provide the catalyst needed to ensure more responsive and efficient policies and services.

The purpose of Chapter 6 is to distill the lessons learned by the POLICY Project after five years of helping promote participatory policy processes at the decentralized level in Latin American countries. The lessons are intended to guide continuing reproductive health policy work and to help others promote partnership and participation at the national and decentralized levels in both the LAC region and elsewhere.

Successful Practices

Chapters 2 through 5 described how "small groups of thoughtful, committed citizens can change the world" to influence sexual and reproductive health policy. Based on experiences in Bolivia, Mexico, Peru, and Guatemala, 10 common practices shaped policy work to facilitate participatory decentralization (see box).

Promoting Participatory Decentralization with a Focus on Sexual and Reproductive Health

1. Work at several levels (from national to local) and across sectors.
2. Be flexible; there is no blueprint for fostering successful participation in decentralization.
3. Approach reproductive health through participatory planning and pay attention to process.
4. Maintain a country presence.
5. Empower people to ensure democratic decision making in project activities.
6. Work objectively with a range of groups.
7. Address gender when working on sexual and reproductive health.
8. Make use of information and teach others to do so.
9. Take a short- and long-term perspective and follow up.
10. Include the media in participatory processes.

1. Work at several levels and across sectors.

While it is important to conduct a country assessment and promote partnership at the national level, project activities need to move quickly to the state and local level if they are to prove effective. Many LAC countries have found decentralization difficult in terms of both fully understanding what it is and learning how to implement it. The difficulty with decentralization is mirrored at all levels of administration. Thus, working at the various levels at which policy is made and implemented, often extending down to the municipal levels, is critical.

Assistance should be tailored to whether activities are occurring with national leaders or local communities. For example, policy dialogue and advocacy work frequently involve reducing direct and

Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it is the only thing that ever has.

—Margaret Mead

indirect opposition to decentralization, allaying politicians' and central bureaucrats' professional and personal concerns about transferring power and responsibility to others, and raising awareness about local problems that can be better dealt with by actions at the decentralized or local level. In Peru, for example, a national network of NGOs was able, with assistance, to bring policymakers and the medical community together with a group of women's advocates and rural women. The women recounted how the national system of contraceptive method targets led to violations of sexual and reproductive rights in local public health clinics. The meeting of policymakers, medical professionals, and women was instrumental in spurring a national dialogue on a target-free approach to family planning that would be more responsive to local women's needs and rights.

At the state and local levels, technical assistance and training helped policymakers, civil society organizations, and individual citizens understand civic roles, responsibilities, and opportunities while strengthening citizen's skills for participating in and influencing local decision making. In Mexico, state-level strategic planning groups for HIV/AIDS brought together a range of participants from several sectors. By working together, the groups gained an understanding about the decentralization process in the health sector, decentralization's impact on state funding for HIV/AIDS programs, and the importance of mobilizing the community and its leaders to participate in policy decisions about HIV/AIDS. After week-long workshops and subsequent assistance, the groups initiated participatory multisectoral strategic planning, built a coordinated response to the epidemic, and created momentum to influence state policies.

In Bolivia, two key laws—one on decentralization and the other on citizen participation—had been in place for several years but had been implemented only to varying degrees in many municipalities. With training in participatory planning methods and workshops on gender and reproductive health issues, public officials and community representatives gained a deeper appreciation for the laws. Broader participation resulted in increased local support for reproductive health interventions and gender issues. After two years of assistance, the annual development plans in six Bolivian municipalities emphasized reproductive health and/or related gender issues, with resources allocated for corresponding programs.

Creating consensus between the public sector and civil society is the most effective way to improve the policy environment. In all case study countries, representatives from government and civil society—both at the national and local levels—came together to identify problems and craft mutually acceptable solutions. In most cases, the solutions were built on interventions that government and civil society organizations were already implementing. The solutions not only drew on a broad array of resources, skills, and approaches but also ultimately proved sustainable.

2. Be flexible.

There is no blueprint for fostering successful participation in decentralization. At the state and local levels, cultural and geographic differences as well as differences in power, individual personalities, infrastructure, and other variables influence the extent of participation. Project activities take place in richly varied, intense, and fascinating local settings. Approaches and schedules must be flexible in the face of uncertain, complex, and unpredictable circumstances. The chapter on Mexico puts it succinctly, "A very important part of the process in general has been to find the equilibrium between federal policies and the states' independence, demonstrating this respect for the decentralization process while still complying with federal guidance.

We intervene, yes, but with a low profile as facilitators, respectful of the history and customs in each state. We stimulate local participation at the same time that we demonstrate to the federal authorities the benefits of local participation in decision making."

Fostering the policy process requires the constant monitoring of potential changes in government and leadership and the development of strategic alternatives to deal with slow-downs and even dramatic changes in direction. For example, a conservative minister or governor could replace a liberal one and decree reproductive health and family planning a taboo subject.

3. Approach reproductive health through participatory planning and pay attention to process.

Working in a conservative country or setting does not necessarily mean that sexual and reproductive health and rights, gender issues, HIV/AIDS, and other sensitive areas cannot be addressed. In fact, decentralization can facilitate work on these issues. Sexual and reproductive health—by itself a potentially controversial issue—can be introduced within a larger, more acceptable framework such as participatory planning or women's political participation. Stakeholders work most creatively when they are challenged to visualize their own needs, including sexual and reproductive health services or programs that address violence against women.

In Bolivia, government officials requested help with training in participatory planning. The training was designed to use reproductive health examples for the group-work exercises. The training workshops resulted in a number of requests from municipalities and civil society for technical assistance on reproductive health and gender issues, as participants recognized the need to address these matters in local planning.

Even though it may be difficult to measure and report on adequately, the process of participatory planning is a valuable result in itself. To capture process results, qualitative indicators can be used to assess the degree of participation achieved. For example, a desired result in Peru is to strengthen collaboration between governmental and nongovernmental sectors. Indicators might include the number of intersectoral groups formed that continue to meet on a regular basis and the number of policies and programs developed with the participation of civil society organizations. In Bolivia, a desired result is "a planning process that is participatory." This indicator is measured by interviewing participants in the planning process both at intervention and comparison sites and asking them a series of questions about the frequency, degree, and nature of their participation. In this way, the indicators capture how the policy process was affected in Peru and Bolivia rather than just the outcomes of policy change.

4. Maintain a country presence.

It is difficult to work in participatory decentralization without maintaining an in-country presence. Projects themselves must decentralize to achieve results. In addition, to work in participatory decentralization, project staff must work in secondary cities and towns rather than remaining in the capital. The presence of an in-country team expedites movement out of the capital city and makes projects more cost-effective. In addition, country programs can be more easily designed jointly with local counterparts and then managed by a local advisor. At the same time, assistance from a project manager based in the donor country or elsewhere in the region can reinforce the in-country work. This country team arrangement can allow project staff to share global and regional experience with the local team, capitalizing on the local advisor's in-depth knowledge of the country, its people, and practices and

keeping international travel and other costs to a minimum.

5. Empower people to ensure democratic decision making.

Participation projects will be most successful if activities empower people and ensure democratic decision making and transparency. For example, advocacy training in Latin America that includes a training-of-trainers component gives local leaders the skills they need to replicate advocacy training throughout their country. When engaging in policy dialogue with national, state, or local leaders, civil society representatives and local leaders should be involved in the discussions, giving them access to policymakers they might not otherwise meet. Even in workshops, democratic decision making can occur when the facilitator asks the participants to agree to ground rules and to validate the agenda and workshop objectives, making changes as appropriate.

6. Work objectively with a range of groups.

To forge participatory policymaking, it is important to work simultaneously with several groups rather than to align exclusively with one institution or NGO. By diversifying partners, projects can be perceived as neutral and objective—not part of either the public or private sector and therefore independent of particular goals and biases. Project staff can serve as facilitators, approaching groups that traditionally do not work together and bringing them together under the auspices of a neutral project. In the Mexico case study, the project's neutrality played a major role in the success of participation activities. Because they perceived project staff as free from ideological leanings, church leaders, conservative politicians, radical NGOs, and outspoken citizen activists agreed to discuss together a common strategy for addressing HIV/AIDS in their communities.

7. Address gender.

It is impossible to address sexual and reproductive health without dealing with the underlying gender issues. Inequity in the power and resources accorded to men over women have profound implications for women's sexual and reproductive health and for human rights and development. Projects can also be most successful by helping groups of women and men use a gender lens when identifying and addressing reproductive health needs. In certain parts of Bolivia where local gender norms discourage women's participation in decision making, a workshop venue succeeded in bringing together community women and men to discuss gender and reproductive health issues and to encourage women to participate in the local planning process. As a result, more women participated in the planning process in towns where the project conducted the workshops than in towns where workshops were not held. Moreover, the women advocated for programs and services that addressed both their reproductive health needs and related gender and human rights issues such as violence against women in their communities.

8. Make use of information and teach others to do so.

Access to and use of information are vital to participation. When trained in participatory processes, civil society groups and local government officials understand the need for information. Stakeholders benefit from learning where to find existing data, how to collect or generalize data to answer key policy-related questions and how to apply the information in activities such as for policy dialogue, advocacy, and decision making—a pressing local need. In Peru, advocacy workshops have trained participants in using DHS data to extract relevant information for advocacy goals. As a result, local women's groups subsequently included DHS data in their policy proposals

to local municipal and departmental officials. Similarly, in Guatemala, a national network of women has improved its capacity to influence policymaking by adopting a strong emphasis on accessing and using data to reinforce their arguments and policy proposals to regional and national government officials, and to leaders of the Catholic Church.

9. Take a short- and long-term perspective and follow up.

Taking a long-term perspective and providing adequate follow-up are crucial to the success of programs aimed at strengthening participatory processes. In Bolivia, local groups accustomed to advocating for short-term change learned the importance of formulating and implementing a comprehensive advocacy strategy. The concept of thorough and complete planning for advocacy requires groups to think beyond the short term allows them to identify a range of goals beyond their immediate needs.

Projects must balance short-term project deliverables with long-term sustainable results. Donor-funded projects must deliver on results and products on an annual or biannual basis, thereby demonstrating project impact. Nevertheless, to ensure sustainability, projects also need to focus on achieving long-term results that improve the policy environment for reproductive health. In Peru, for example, measuring the number of groups that become active in the policy process is an outcome that can be measured each year or two, during which time some change is expected in the indicator. The number of policies and programs developed with the active participation of civil society organizations is a longer-term result; reproductive health policies and programs are revised or developed only sporadically.

10. Include the media in participatory processes.

The media is crucial as a vehicle for advocacy and policy dialogue as well as a key participant in improving the policy environment for sexual and reproductive health. Journalists can be policy champions in their own right. In Guerrero, Mexico, a television reporter and a newspaper reporter who are members of the HIV/AIDS multisectoral planning group have dramatically increased coverage of HIV/AIDS in the state news and are actively recruiting other journalists to help raise awareness of the epidemic.

Summary

These case studies show how a five-year policy project worked with local counterparts to build partnerships between the public sector and civil society organizations at the local, regional, and national levels. Project activities served as a stimulus for local groups to engage in advocacy and participatory planning at the national and decentralized levels. The results presented for Bolivia, Mexico, Peru, and Guatemala, speak for themselves: Local organizations are working together with public officials to increase attention to sexual and reproductive health and related gender issues in local planning processes and policies and to increase funding for these programs. Clearly, participation is necessary to achieve successful decentralization in the health sector, that is, decentralization of health services in a way that responds to the needs of people at the local level. Partnership between civil society and governments at the national and local levels is also necessary to ensure that countries attain the ambitious goal they agreed to at ICPD: To accord full access to reproductive health for all women and men and to give civil society a voice in the process.

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