

**USAID Development  
Information Services**

**Selected Literature on Decentralized Family Planning and Health Service Delivery**  
(Response to an Information Request)

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## **Selected Literature on Decentralized Family Planning and Health Service Delivery**

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*Search of: USAID Development Experience Clearinghouse, Reproductive Health Gateway, PopLine, World Bank Publications and Reports*

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### **1. Decentralizing Health and Family Planning Services**

*The Family Planning Manager*

<http://erc.msh.org/mainpage.cfm?file=2.2.1.htm&module=health&language=English>

#### **Introduction**

In recent years, some ministries of health around the world have embarked on a process of decentralization. Many non-governmental organizations are also interested in transferring decision-making powers to the field level, and donors are promoting decentralization by supporting initiatives that increase the management capacity of field-level managers, so they can use their new powers wisely and effectively.

Whether your government or organization is planning a decentralization initiative or decentralization has already begun, you should know what the goals of the decentralization initiative are, how it can benefit your clients, and how your job and your role in the overall program will be affected. This issue of *The Family Planning Manager* explores the changing roles of managers at the central and local levels and the management skills they must have to function effectively in a decentralized environment.

Guest editors for this issue are Saul Helfenbein, Riitta-Liisa Kolehmainen-Aitken, and Bill Newbrander. Saul Helfenbein is Deputy Director of the Population Program at Management Sciences for Health. Riitta-Liisa Kolehmainen-Aitken is Senior Evaluation Analyst in FPMD's Evaluation Unit, and Bill Newbrander is a Senior Associate in MSH's Health Financing Program. They have assisted the governments of Bangladesh, Indonesia, Madagascar, Senegal, Papua New Guinea, the Philippines, and Zimbabwe to decentralize their health and family planning services.

### **2. Implementing Reproductive Health Services in an Era of Health Sector Reform**

Karen Hardee, Janet Smith

March 2000, POLICY Project

<http://www.policyproject.com/pubs/occasional/op-04.pdf>

#### **Executive Summary**

The countries that agreed to the ICPD Programme of Action face a tremendous challenge in its implementation. Additional funds will help; however, in the face of scarce resources, countries also need to find ways to make existing resources go further. As countries strive to implement the reproductive health initiatives to which they agreed at Cairo, many are also undertaking health sector reform, a set of sweeping initiatives that affects all components of health, including decentralizing the management and provision of care, concentrating resources on cost-effective interventions (often through minimum or essential services packages), improving the performance of providers, expanding the role of the private sector, shifting the function of central ministries of health and improving their regulatory capacity,

broadening financing, and shifting donor financing to support sector-wide health programs rather than vertical programs, such as family planning.

Reproductive health initiatives and health sector reform share the goals of equity and quality. The question of interest to those working in reproductive health is whether the reform measures aimed at increasing efficiency will be sufficient to ensure universal access to high-quality reproductive health services by 2015, as outlined in the ICPD Programme of Action. This paper reviews evidence that addresses the question of the complementarity of reproductive health initiatives and health sector reform.

### Decentralization

While decentralization is sound in theory, it is not easy to implement in practice and may take as long as 10 to 20 years. Thus, the effect of decentralization on health care, including reproductive health care, is unclear. While some experiences with decentralization have been favorable, central governments have often transferred responsibility to local administrative levels without planning properly for implementation and without allocating adequate resources. In fact, existing human and technical resources are often underdeveloped at the local level. Decentralization may not promote equity, at least not in the short term. Local areas may have variable access to resources; thus, residents of poorer areas may receive less care than residents of wealthier areas. The need is clear for further analysis of health and equity outcomes related to decentralized management and provision of reproductive health.

### Integration

The ICPD promoted integration of services to ensure greater responsiveness to meeting clients' reproductive health needs. In the context of health sector reform, integration is more broadly defined; to reformers, integration of reproductive health as envisioned at the ICPD is just another vertical program.

Integration is best suited for services targeted to a similar clientele, for example, family planning linked with postpartum services. A few examples of successful integration of reproductive health services can be found, most notably in programs of nongovernmental organizations (NGOs). Since ICPD, family planning and STD/HIV/AIDS are the two main reproductive health components that have undergone integration, particularly in Africa. However, many family planning clinics are not equipped to offer services for the detection and treatment of sexually transmitted diseases (STDs), and staff members are not properly trained.

### Essential Services Packages

Under health sector reform, more and more countries are implementing minimum or essential care packages of cost-effective interventions designed to reduce the burden of disease among the population. Essential services packages developed to date have generally included reproductive health components.

### Making Better Use of Existing Program Capacity

More efficient, high-quality care could attract additional clients for reproductive health services and thus save money. Without improvements in quality, however, utilization of reproductive health services may suffer, particularly if cost-recovery schemes are introduced. Further evaluation is required to determine whether improvements in quality (as distinct from the availability of drugs) will lead to increased demand for services, which, in turn, can translate into increased revenue.

Evaluation of operational policies, including those affecting the provision of reproductive health services, often uncovers procedures that involve unnecessary and burdensome steps. Streamlining operational policies could make services more efficient. In addition, medical and other service barriers often inflate the cost of services. Many countries are updating their service delivery guidelines to reflect the recent international consensus on more streamlined but medically safe protocols for contraceptive and reproductive care.

## Role of Public and Private Providers

Health sector reform promotes separation of the financing of services from the provision of services. In theory, governments should delegate service provision to organizations closer to communities, including local governments and the private sector, if one exists. Family planning programs have had some success in encouraging wider participation of the private and commercial sectors in service provision. Ministries of health should focus on sector management by developing legal and regulatory frameworks that direct the actions of both local governments and private providers and promote preventive care. Many countries regulate the behavior of private health providers and the distribution of drugs; enforcement of regulations, however, is another matter.

If governments remain in the business of service delivery, including reproductive health care, they should ensure a level playing field, by providing similar subsidies and incentives to the private sector and NGOs as they provide for public sector services.

## Broadening Health Care Financing

Results of initiatives in cost recovery, particularly the use of user fees, have been mixed, even for family planning. Some studies show that small increases in user fees do not affect health care utilization rates, particularly if quality of care (and drug availability) is improved. Other studies, however, have shown that user fees have adversely affected women and children, forcing them to forgo needed health care. Some countries are seeking to promote equity in health care through prepayment schemes and risk-sharing mechanisms.

## Sector-Wide Assistance Programs

Donors and international financial institutions are testing various sector-wide assistance programs (SWAPs) to support health sector reform, in order to move from a narrow project focus to a sectoral focus and to help establish joint instead of donor-driven priorities. As with other aspects of health sector reform, SWAPs are not easy to implement and tend to function best in politically and economically stable environments, conditions absent in many developing countries.

## Discussion

Health sector reform is complex and to be successful, requires time, political commitment, an initial investment of resources, and a favorable policy environment. Without proper planning and implementation, reform is unlikely to be successful and may even waste resources.

Within the context of health sector reform, several challenges exist in the design and implementation of reproductive health programs, including setting priorities, costing integrated services, determining new approaches for financing and providing services, and redefining the roles of central maternal and child health (MCH) and family planning divisions. With few current examples of successful reform positively affecting reproductive health programs, it is too soon to say whether health sector reform will promote efficient, effective, and equitable reproductive health care delivery, or whether reforms will result in the neglect of reproductive health in the face of other pressing health care issues. It is imperative that reform processes, including the reform of reproductive health services, be monitored, documented, and evaluated.

Equity and access issues often get lost in the details of implementing programs to increase efficiency. Those involved in reproductive health programs, including client advocates at the local, national, and international levels, need to be at the table when decisions on reforms are made. In addition to promoting more efficient programs and services for reproductive health, those involved in decision making must ensure that equity and access to high-quality services are primary goals of reform programs if the ICPD Programme of Action is to be achieved.

### 3. DECENTRALIZATION AND REPRODUCTIVE HEALTH

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June 24, 1998

<http://www.reprohealth.org/unfpa/Oct31Th/Session4/Reading2.pdf>

Decentralization and greater attention to reproductive health care are two key changes that have affected health services in the decade of the 1990s. The decision to decentralize has generally been a political one. In a few cases, it has been an intentional and well-considered aspect of health sector reform, but usually its implementation in the health sector follows the political changes, and health services organizations have had to adapt themselves to the new decentralized structures as best they could. The commitment to the new policies of reproductive health, undertaken at the International Conference on Population and Development (ICPD) in Cairo in 1994, also involves significant changes and reorganization of health services. For many people around the world, some of those policies are considered controversial. Their implementation involves the introduction of new programs, integration of previously separate activities, and the need for the acquisition of new skills by many health professionals. The purpose of this chapter, therefore, is to consider both the process and the goals of the changes that are required by the implementation of reproductive health services and to assess the extent to which they are compatible or in conflict with those of decentralization.

### 4. Delivering Reproductive Health Services in Health Reform Settings: Challenges and Opportunities

October 2000

[http://www.reprohealth.org/turin\\_part/Week1/1Mon19/Ses1/reading1.pdf](http://www.reprohealth.org/turin_part/Week1/1Mon19/Ses1/reading1.pdf)

Many poor countries are engaged in efforts to increase the effectiveness and sustainability of their health systems and to improve the poor reproductive health of their people. They face many constraints, including political and economic instability and the demands created by their rapidly growing populations.

This note addresses two important issues that affect these efforts: health reforms and implementation of the reproductive health approach to services called for by the 1994 International Conference on Population and Development (ICPD) in Cairo. It outlines key features of health reform and the reproductive health approach, identifies points of intersection and possible conflict between them, and discusses how program managers in both areas might work more effectively to achieve their common goals.

### 5. Morocco FP/MCH [family planning/maternal child health] phase V project : safe motherhood pilot project -- project evaluation 1st June to 12 June 1999

USAID, June 1999

[http://www.dec.org/pdf\\_docs/PDABR663.pdf](http://www.dec.org/pdf_docs/PDABR663.pdf)

Final evaluation of a safe motherhood pilot project (1995-99), aimed at increasing the availability, utilization, and quality of emergency obstetric care (EmOC) in selected hospitals

and health centers in Morocco.

The overall result of the project is impressive. The project successfully implemented both basic and comprehensive EmOC in all sites for which definitive plans had been developed, and did so well within the time frame allocated. **As the first decentralized activity of this kind, the project acted as a catalyst for the successful initiation of many other decentralized activities.** In the words of the Regional Delege: the project "has been the locomotive driving the train of decentralization". Although further work is needed in a number of areas, the project's strong leadership and teamwork at the regional and central levels, combined with timely and appropriate TA from the donor agency, has resulted in a major achievement, Includes recommendations to ensure both the sustainability and the replicability of the project. (Author abstract, modified)

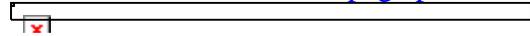
## 6. Kenya - Decentralized Reproductive Health and HIV/AIDS Project

Document Type: Project Appraisal Document

World Bank 11/16/2000

<http://www->

[wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2000/12/20/000094946\\_00112305412221/Rendered/PDF/multi\\_page.pdf](http://www.wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2000/12/20/000094946_00112305412221/Rendered/PDF/multi_page.pdf)



The Decentralized Reproductive Health and HIV/AIDS Project will improve mother, and child health through integral delivery services in reproductive health, child survival, and HIV/AIDS care, and, slow the increased HIV ratio, by decentralizing management delivery services to, and within districts. The components will: 1) support the Government in implementing its decentralization policy, by improving fiscal decentralization, building capacity at provincial, district, and sub-district levels, as well as improving planning and financial management, organizational restructuring, and systems development. Activities include the application of new resource allocation criteria, based on an objective, transparent, poverty-focused rationale; recurrent budgets, simplified to allow increased discretionary control in resource allocation; and, capacity building, to focus on financial management training for District Health, Hospital and Rural Management Boards; 2) focus on the medical aspects of the HIV/AIDS epidemic, to also include preventive medicine, based on behavior interventions, contraceptive uses, blood testing, etc, with special attention to the poor, adolescent, and women; and, 3) address reproductive health, on such issues as family planning, safe motherhood, child survival, and sexually transmitted infections. Training, and procurement of drugs, and equipment will be financed. **Keywords:** Reproductive health; HIV viruses; Acquired Immune Deficiency Syndrome; Maternal health services; Child health; Health care delivery; Decentralization; Districts; Fiscal management; Capacity building; Financial management; Planning, programming & budgeting systems; Organizational structure; Allocation of resources; Poverty mitigation; Recurrent costs; Training assistance; Medical care finance; Medical care for the poor; Medical equipment; Preventive medicine; Behavior modification; Contraceptives; Blood tests; Family planning; Safe motherhood; Medicines; Equipment supply contracts

## 7. Final evaluation of the Niger family health and demography project

USAID, POPTECH

December 1995

[http://www.dec.org/pdf\\_docs/PDABM488.pdf](http://www.dec.org/pdf_docs/PDABM488.pdf)

Evaluates two projects to strengthen Niger's health sector: (1) the Niger Health Sector Support Grant (NHSSG), a program/project to support policy and institutional reforms (1986-96); and (2) the Niger Family Health and Demography Project (NFHDP), to expand family planning (FP)

programs and demographic research (6/88-96).

Results were mixed. The NHSSG, especially the portion funded with nonproject assistance, was slow to develop due to expectations which were both unrealistic and poorly understood. A mid-course reduction and clarification of policy reform objectives resulted in some successes, including development of a national health information system and nascent systems for cost recovery and cost containment in hospitals, other health facilities, and drug distribution. The NHSSG furthered the debate on a national population policy and supported the decentralization of health services management.

**The NFHDP also contributed to decentralization by testing service delivery models and strategies,** promoting social marketing and other modest private sector initiatives, and enhancing operations research. Nonetheless, national service standards remain far from acceptable in quality and coverage. Information, education, and communication (IEC) efforts have been largely ineffectual, and poor communications at all levels have limited the sharing of effective interventions.

Unpredictable events, ranging from labor strikes to currency devaluation to a meningitis epidemic, were significant hindrances to both projects. Equally damaging was the lack of effective coordination between the NHSSG and the NFHDP. Efforts on all sides notwithstanding, operating two complex projects concurrently was overly taxing on available systems and personnel in Niger, and effective synergy between the two was not fully realized.

Nonetheless, the two projects have helped to bring Niger to the beginning of a new stage in the development of its national health systems and infrastructure. While still fragile, the elements of a decentralized health management system are in place. Valuable lessons have been learned from trials of service and management models, which could, with improved communications, be used nationwide. While not deep, the pool of technical talent is of good quality, providing a sound base for expansion. Finally, motivation among decision makers is high, especially when they feel confident that funders are committed to true partnerships and building Nigerien capacity.

The evaluation recommends continued nurturing, with TA and targeted budgetary support, of initiatives that are critical to the development and maintenance of a decentralized health system, i.e., of a national health information system, cost recovery at all levels, national population policy dialogue, demographic analysis, and operations research. Efforts should be redoubled in areas critical to expanding access to and quality of services. This means increased attention to the skills, attitudes, and supervision of service providers; reorientation of IEC to support national capacity building and community orientation; continued improvement in contraceptive logistics; and expansion of social marketing, along with its integration into the public health system. Efforts to mobilize private sector participation in health services should be vigorously expanded.

Future use of nonproject assistance as a funding mechanism should be weighed carefully; it should probably be used only to support implementation of policy reforms already adopted, until the government's capacity to deal with more complex schemes is enhanced. In any case, all USAID support to Niger in the health and population sector should be offered under a single umbrella funding mechanism.

Finally, careful and focused attention must be given to donor coordination. USAID can set an important example by establishing rigorous interagency coordination mechanisms and standards for those organizations that use its funds and by ensuring close and continuous communications with the government. By clarifying its own programmatic priorities, USAID has positioned itself to play a lead role in developing an effective, forward-looking partnership between the international donor community and the Government of Niger. No effort should be spared in moving this partnership forward. Niger is at a point of great opportunity for strengthening its health systems; the country must have success in the near term or a still fragile opportunity could evaporate. Failure to build vigorously on the steps taken under earlier projects would have serious consequences in terms of dwindling external support and further eroding the health care available to the people of Niger. (Author abstract, modified)

## **8. Mexico - Second Basic Health Project**

**Document Type: Implementation Completion Report**

World Bank, 12/30/2002

<http://www->

[wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2003/02/07/000094946\\_03012804015773/Rendered/PDF/multi0page.pdf](http://wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2003/02/07/000094946_03012804015773/Rendered/PDF/multi0page.pdf)

The outcome of the Second Basic Health Project for Mexico was highly satisfactory, the sustainability was highly likely, the institutional development impact was high, and the Bank and borrower performance were both highly satisfactory. The lessons learned indicated that the objectives were set by the country and the Bank ' s flexible approach allowed timely achievement of development objectives. The Bank agreed on a financial package but not on a five-year blueprint detailing how to spend the money. The country was politically committed to raising the health status of the poorest, to decentralizing health services delivery, and to modernizing its operations for serving the uninsured population better. It was also recognized that reaching the poor in highly dispersed geographical locations require substantial amount of resources. While the project strengthened the supply of basic health services, the Education, Health and Nutrition Program (PROGRESA) combined a traditional cash transfer program with financial incentives for families to invest in human capital of children. The Government ' s full commitment to decentralization of health services, and to redefining and improving the Federal Secretariat of Health policy-making, and stewardship roles within a decentralized context were fundamental for the Government ' s ability to provide successfully basic health care services in dispersed rural areas. **Keywords:** Health services; Health care reform; Decentralization in management; Policy planning; Strategic planning

## **9. A decade of health sector reform in developing countries : what have we learned?**

Peter A. Berman, Ph.D.

Thomas J. Bossert, Ph.D.

March 15, 2000

[http://www.dec.org/pdf\\_docs/PNACJ344.pdf](http://www.dec.org/pdf_docs/PNACJ344.pdf)

This report reviews the progress made in the last decade on health care reform in developing countries, including both "big R" or strategic reform and "small R" or incremental reform. While more time is needed for an overall assessment of the reform experience, several specific lessons have been learned.

(1) "Big R" reform has been rare, requiring several conditions difficult to achieve, especially in the lower income countries: a major political opportunity for change, sound leadership, stability

in government over an extended period of time, and significant capacities in human skills, information, and organizations. (2) "Big R" reforms require major efforts in capacity-building -- new recruitment patterns, new skills in the workforce, and more adaptive organizational cultures in many different institutions such as public hospitals, insurance plans, local governments, ministries of health, and other central government agencies. Much more emphasis should be placed on organizational development and training in reform implementation. (3) "Small R" reforms, while seemingly less demanding, have also had a mixed record, sometimes due to the lack of the same conditions needed for "big R" reforms, sometimes because the reforms have been inappropriately chosen or designed. "Small R" reform does not eliminate the need for sound systems analysis and attention to how other changes in the system may be conditions for effective implementation. (4) While there are no clear and simple models of "the right" way to do health reform, important lessons have been learned about specific approaches: restricted intergovernmental transfers and equity funds can assure more equity in a decentralized health system; caution is advised when using fee-for-service payment mechanisms; per capita payment is more appropriate for some levels of care; under some conditions, community participation can be more effective in implementing an exemption policy for the poor in user fee programs.

(5) Health sector reform, whether big or small, cannot be developed from a single global or even regional policy formula. Attention must be paid to national history, values, and culture. It is also important to invest in developing the information and analytical tools needed to define and solve the most pressing problems. (6) Governments should focus on "steering" the health care system - - regulating a mixed public and private market -- rather than on the direct delivery of services. (7) Reformers have paid too little attention to the technicalities of design and implementation in financing, delivery, and management and not enough on the outcomes -- improvements in health, equity, financial protection, and patient satisfaction -- that reform is supposed to accomplish. (8) More effort on evaluation of reform, including impact evaluation, is needed.

Three important cross-cutting issues that are amenable to progress are identified in conclusion: development of sustainable financing strategies for priority services in the lower income countries, especially Africa; strengthening government approaches to non- government health care providers at the primary level; and improving governance in health ministries, local health departments, and health care provider organizations.