View metadata, citation and similar papers at core.ac.uk

brought to you by CORE

provided by Queen Margaret University eResearch

DECENTRALISATION IN THE POST-CONFLICT ENVIRONMENT OF GUATEMALA: A CRITICAL EXAMINATION OF THE EVALUATION PROCESS OF COMMUNITY PARTICIPATION IN A HEALTH SECTOR REFORM CONTEXT

MARIO SERGIO DE LEON ESTRADA

A thesis submitted for the partial fulfilment of the requirements for the degree of Doctor of Philosophy in the discipline of International Health Studies

QUEEN MARGARET UNIVERSITY COLLEGE

2007

Abstract

This thesis focuses on a critical and comprehensive analysis of community participation within a health sector reform process in a post-conflict environment. The aim is to examine how evaluation of such processes should be guided, how decentralising policies should be implemented, and how the assumptions of existing evaluations limit their relevance and effectiveness. The thesis argues that comprehensive analysis demonstrates the need for a much deeper and more extensive understanding of the multiple complexities present in post-conflict environments than is often achieved. It is necessary to carry out a historical, comparative and analytical evaluative exercise, beyond mainstream structural-functionalist evaluations, because the latter generally do not address relevant external and internal variables affecting the conditions of the community. Utilising this proposed approach fieldwork in the communities of San Juan Chamelco and San Miguel Tucurú (in the northern department of Alta Verapaz) examined examples of the limitations of and potentials for the incorporation of traditional medicine into the institutional healthcare system. This fieldwork is used to inform development of a comprehensive framework for evaluation with wide potential as a technical-conceptual tool. The Guatemalan case is presented as an illustrative example of how this tool can be developed and elaborated within a specific historical, political, social and cultural context. Building on the findings of a sectoral evaluation carried out under the auspices of the Ministry of Health the comprehensive evaluation presented identifies key problems that prevented health decentralisation policies from having a significant and positive impact at the local level. In this complex post-conflict environment, local organisation and community participation are shown to be still in their infancy having been obliterated by the counter-insurgency policies during the course of prolonged conflict.

Acknowledgements

I am grateful to the people of San Juan Chamelco and San Miguel Tucurú who shared with me the experiences of their lives, their views of health reform and participation, and some of their practices of traditional medicine, which date back centuries and generations.

I also acknowledge the exchange of views and opinions with the representatives, professionals, experts and officials who participated in the focus groups. The discussions I had with them were vibrant, insightful and informative.

I thank the Ministry of Public Health and Social Welfare for the opportunity and space they provided so that I could participate in the evaluation of the SIAS system, which was integral to the development of this thesis.

I acknowledge the support and close working relationship with FUNMMAYAN, the Foundation of Mayan Women of the North, which provided me with the access to carry out the fieldwork in the communities selected. Through them, I was able to establish a level of confidence with the communities and successfully carry out my research.

I acknowledge the work and experience of the Latin American Faculty for Social Sciences (FLACSO - Guatemala) especially the generosity, time and support from Dr. Victor Gálvez, Director of the institution.

I am grateful for the institutional support of Queen Margaret University College. I acknowledge and am forever grateful for the advice, debate and constructive criticism from my supervisory team at the Centre for International Health and Development Studies. I thank Professor Alastair Ager (who is now at Columbia University) and Oonagh O'Brien. I also thank Dr Ken Cole from the University of East Anglia who served as my external supervisor. I also acknowledge the support and direction given to me by Dr Ian Yaxley, who served as my first supervisor.

To my mother Francisca Estrada Barrios and my aunt Rachel Estrada Barrios, to whom I dedicate great part of this effort in return for their love.

I thank with all my heart Baljit Banga for her unconditional support and love, words of advice, and an abundance of patience, which encouraged and motivated me to finish this thesis.

Abbreviations

ACICVAP*	Peace Agreement on the Timetable for the Implementation, Completion and Verification of the Peace Agreements
AGAI*	Guatemalan Association of Mayors
AIDPI*	Peace Agreement on Identity and Rights of Indigenous Populations
AIDS	Acquired Immunodeficiency Syndrome
ANAM*	National Association of Municipalities
ARI	Acute Respiratory Infection
ASESA*	Peace Agreement on Socio-economic Aspects and the Agrarian Situation
ASP*	Country Situation Assessment
BCA	Bilateral Cooperation Agency
BCG	Bilateral Cooperation Group
BID*	Inter-American Development Bank
CACAP*	Commission for the Implementation of the Peace Agreements
CAII	Creative Associates International Incorporated
CBO	Community-Based Organisation
CC*	Community Centre
CCA	Critical Comparative Analysis
CDA	Critical Discourse Analysis
CDUR*	Urban and Rural Development Council
CEA	Critical Ethnographic Analysis
CEF	Comprehensive Evaluation Framework
CEH*	Commission for Historical Clarification
CHA	Critical Historical Analysis
CIEN*	Centre for National Economic Research
CLD*	Local Development Council
COOPI***	Italian International Cooperation
CPD*	Population and Development Council
CRG*	Guatemalan Congress
CS*	Health Committees
CT*	Traditional Birth Assistants
CUM*	Metropolitan University Centre
DPA	Democratic Participative Process Approach
DPD	Diarrhoea and Parasitic Disease
DPT3	Diphtheria and Chicken Pox and Tetanus Vaccine Triple Doses
EAP	Economically Active Population
EAT	External Advisory Team
EBS*	Basic Health Team
ECAP*	Community Studies and Psychological Action Team
EPS*	Professional Medical Supervision
EU	European Union
FAO	Food and Agriculture Organisation
FC*	Community Facilitator
FDR*	Rural Development Fund
FI*	Institutional Facilitator
FIS*	Social Investment Fund
FLACSO*	Latin American Faculty of Social Sciences
FODIGUA*	Indigenous Development Fund
FOGUAVI*	Public Housing Fund
FONAGRO*	National Agricultural Fund

FONAPAZ*	National Peace Fund
FONATIERRA*	National Land Credit Fund
FRG*	Guatemalan Republican Front
FS*	Social Fund
FSDC*	Social Fund for Community Development
FUNCEDE*	Central American Foundation for Development
FUNMMAYAN	Foundation of Mayan Women from the North of Guatemala
GDP	Gross Domestic Product
GO	Government Organisation
GS*	Social Cabinet
GTZ**	Deutsche Gesellschaft fur Technische Zusammenarbeit German Cooperation for Technical Development
HC	Health Code
HD	Health Districts
HDR	Human Development Report
HepB3	Hepatitis B Vaccine Triple Doses
HIJOS	Daughters and Sons Pro Identity and Justice Organisation against
Guatemala*	Forgetting and Silence
HIV	Human Immunodeficiency Virus
HRCA	Human Rights Council of Australia
HS A	Health Service Administrator
HSP	Health Service Provider
IICA	Inter-American Institute for Cooperation on Agriculture
IDB	Inter-American Development Bank
IFI	International Financial Institution
IGSS*	Guatemalan Social Security Institute
IMF	International Monetary Fund
INCAP	Institute of Nutrition for Central America and Panama
INE*	National Statistics Institute
INFOM*	Institute of Municipal Fomentation
IRCT	International Rehabilitation Council for Torture Victims
IUSI*	Unified Property Tax
KAPs	Knowledges, Attitudes and Practices
LAC	Latin American and Caribbean Countries
LMIC	Lower Middle Income Countries
LSHTM	London School of Hygiene and Tropical Medicine
MA*	Mobile Physician
MCA	Multi-lateral Cooperation Agency
MEA	Macro Economic Agenda
MEDES*	Barefoot Doctors
MENMAGUA*	Mayan Table for Negotiations
MFP*	Ministry of Public Finance
MINUGUA*	United Nations Mission to Guatemala
MMA	Market Mechanism Approach
MSPAS*	Ministry of Public Health and Social Welfare
NGO	Non-Government Organisation
NI	Naturalistic Inquiry
ODHAG*	Guatemalan Archbishop's Office for Human Rights
OMS*	World Health Organisation
OPS*	Pan-American Health Organisation
PA	Peace Agreement
PAC	Civil Defence Patrol
PADAM*	Support Programme for Municipal Administrative Development

PAHO	Pan American Health Organisation
PAN*	Party for National Advancement
PCIA	Peace and Conflict Impact Assessment
PCS*	Community Health Participation
PMSS*	Programme for the Improvement of Health Services
PNPD*	National Plan for Peace and Development
PNS*	National Health Plan
PNUD*	United Nations Development Programme
POC*	Support to Peace and National Conciliation Project
Pol3	Polio Vaccine Triple doses
PRONADE*	National Programme for Education
PRONICE*	Boys and Girls Project in Central America
PRSP	Poverty Reduction Strategy Paper
PTSD	Post-Traumatic Stress Disorder
PVA	Policy Value Analysis
RED BARNA	Save the Children Norway Headquarters
REHMI*	Project for the Recovery of Historical Memory
ROI*	Internal Organic Regulations
RSCS*	Social Health Community Networks
RSP*	Public Sector Reform
RSS*	Health Sector Reform
SAP	Structural Adjustment Policy
SBS*	Basic Health Services
SCPCD*	Culture of Peace and Democracy Consolidation Seminar
SCT	Social Constructionism Theory
SEGEPLAN*	General Secretariat of Planning
SEPAZ*	Secretariat for Peace
SI*	International Solidarity
SIAS*	Integrated Primary Healthcare System
SIGSA*	Health Information Management System
SNIP*	National System of Public Investment
SNU	United Nations System
SWAP	Sector-Wide Approach
TBA	Traditional Birth Assistant
TBSA	Techno-Bureaucratic System Approach
UGA	University of Georgia
UME*	Monitoring and Evaluation Unit
UN	United Nations
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	United Nations Children's Fund
UNS	United Nations System
URL*	Rafael Landivar University
URNG*	National Revolutionary Unit of Guatemala
USAC*	University of San Carlos of Guatemala
USAID	United States Agency for International Development
UVG*	Valley University of Guatemala
VS*	Health Monitors
WB	World Bank
WHO	World Health Organisation

* Some of terms were translated from the original Spanish to English however, abbreviations were kept in Spanish to avoid the creation of acronyms with little contextual relevancy.
** As above, acronym in German
*** As above, acronym in Italian

Table of Contents

Chapter I **1**
Introduction
1.1. Reflection as an Individual and as a Researcher 1
1.2. Developing the Thesis Topic: My Role as a Researcher 5
1.3. Aim and Objectives of the Thesis 8
1.4. Contributions to the Field of Study 10
1.5. Development of Analytical Questions 12
1.6. Structure of the Thesis 19

Chapter II **27**
Epistemological and Conceptual Framework
2.1. Introduction to the Framework 27
2.2. Epistemological Framework: Social Constructionism Theory (SCT) 29
2.3. Critical Historical Analysis (CHA) 33
2.4. Critical Comparative Analysis (CCA) 35
2.5. Critical Ethnographic Analysis (CEA) as a Part of Naturalistic Inquiry (NI) 40
2.6. Peace and Conflict Impact Assessment (PCIA) 46
2.7. Summary of the Epistemological and Conceptual Approach towards the Development of an Alternative Evaluation Framework 48

Chapter III **51**
Review of Generic Issues Pertinent to Decentralisation, Evaluation and Health Sector Reform
3.1. The Basis for the Critical Review of Literature 51
3.2. Important Characteristics of Post-Conflict Environments 54
3.3. Health Impacts in Post-Conflict Environments 58
3.3.1. The Impact of the Civil War in Guatemala: The Problem of Health Indicators and General Health Profile 62
3.4. Definitions and Models of Decentralisation 70
3.4.1. Decentralisation as a Market Mechanism Approach 73
3.4.2. Decentralisation as a Techno-Bureaucratic System Approach 75
3.4.3. Decentralisation as Democratic Participative Process Approach 77
3.5. Evaluation of Macro-economic Problems 78
3.6. Evaluation and Poverty Assessment 81
3.7. Evaluation of Efficiency 85
3.8. Evaluation of Equity 85
3.9. An Alternative Evaluation Framework as a Way to Measure Health Sector Reform under a Decentralisation Framework in Post-Conflict Environment 90

Chapter IV **93**
The Political History of Guatemala and the Context of this Thesis
4.1. A Brief Overview of the State and Decentralisation in Guatemala 93
4.2. The Political History of Decentralisation in Guatemala towards the Identification of Variables under a Critical Historical Analysis 95
4.2.1. Exclusion, Inequality and Racism 95
4.2.2. Community and Democracy 96
4.2.3. Human and Citizens Rights 98
4.2.4 Multi-sectoral and Sectoral Reform 100

4.3.	The Nature of the Post-Conflict Environment in Guatemala	103
4.4.	Decentralisation in the Era of Peace	107
4.5.	The Guatemalan Health Status under the Peace Agreements	111
4.6.	The Need for an Alternative Evaluation Framework based on the Historical Dimension and Linked to the Particularities of the Post-Conflict Environment	115
Chapter V		**118**
Current Approaches to Sectoral Decentralisation in Guatemala		
5.1.	Defining the Key Issues on the Outcomes of Decentralisation	118
5.2.	The Challenges of Decentralisation as a Market Mechanism Approach	119
5.3.	The Challenges of Decentralisation as a Techno-Bureaucratic System Approach	120
5.4.	The Challenges of Decentralisation as a Democratic Participative Process Approach	122
5.5.	Peace Building Process and Limitations of Health Sector Reform (RSS)	123
5.6.	Limitations with Regard to Institutional Restructuring and Financing	128
5.7.	Limitations with Regard to the Reorientation and Implementation of the RSS Resources	130
5.8.	The Impact of the Lack of Community Participation in Health Sector Reform and the Need to Prioritise Evaluation Activity	132
Chapter VI		**136**
Phase 1 - Evaluation of Community Participation and Health Sector Reform		
6.1.	Epistemological Role of the Evaluation	136
6.2.	My Contribution to the Evaluation – Participant Observation	137
6.3.	The Evaluation of Health Sector Reform According to the WB/IDB/MSPAS Specifications	140
6.4.	Perceived Limitations of the Mainstream Evaluation	142
6.5.	Primary Research Objective of the Evaluation - Community Participation within the SIAS	146
6.6.	Sample of Rural Communities Selected by the MSPAS Evaluation Research	151
6.7.	Analysis of Results by Component: Component I – The Stages of Health Service Management and Community Participation	155
6.8.	Analysis of Results by Component: Component II - Evaluating the Level of Community Participation	159
6.9.	Analysis of Results by Component: Component III - Analysis of the Participation of Actors in the Technical Administrative Process	160
6.10	Critical Observations - Questions Raised and Gaps Identified Towards an Alternative Evaluation Framework	161
Chapter VII		**169**
Phase 2 - Fieldwork Findings on Community Participation and Health Sector Reform under a Model of Decentralisation		
7.1.	Observations from Phase 1 and the Epistemological Approach towards an Alternative Evaluation Framework	169
7.2.	Phase 2 – Research Methodology	171
7.3.	Fieldwork Component 1 - Lines of Response from Group One -	175

High Rank Officials within Different Government Bodies Involved in the Sectoral Reform Policies
7.4. Fieldwork Component 1 - Lines of Response from Group Two - Advisers and Consultants Involved in Health Sector Reform and the Decentralisation Process either Working Inside or Outside of the Government Sector 178
7.5. Fieldwork Component 1 - Lines of Response from Group Three – High Rank Officials from International Cooperation Agencies Supporting/Working under the Framework of Health Sector Reform and/or Decentralisation Policies 183
7.6. Fieldwork Component 1 - Lines of Response from Group Four - High Rank Officials or Representatives from the Civil and Academic Sectors 185
7.7. Fieldwork Component 2 – Focus Groups with Institutional and Traditional Health Providers, and Users of Both Medical Systems in two Chosen Rural Municipalities. 187
7.8. Fieldwork Component 2 - Lines of Response on the Theme of 'Process of Health Sector Reform' 193
7.9. Fieldwork Component 2 - Lines of Response on the Theme of 'Levels of Knowledge and Understanding of Structures of Provision' 197
7.10. Fieldwork Component 2 - Lines of Response on the Theme of 'Decentralisation of Resources and Functions and Responsibilities' 198
7.11. Fieldwork Component 2 - Lines of Response on the Theme of 'Community Participation' 201
7.12. Fieldwork Component 2 - Lines of Response on the Theme of 'Incorporation of Traditional Medicine to Institutional Medicine' 203
7.13. Fieldwork Component 2 - Lines of Response from Traditional Birth Attendants 207
7.14. Fieldwork Component 2 - Lines of Response from Healers and Herbalists 213
7.15. Fieldwork Component 2 - Lines of Response from Health Monitors and/or Health Promoters 217
7.16. Fieldwork Component 2 - Lines of Response from Mobile Physicians 219
7.17. Fieldwork Component 2 - Lines of Response from Graduate Nurses and Doctors of the Health Centres 222
7.18. Fieldwork Component 2 - Lines of Response from Users of Both Types of Medicine 226

Chapter VIII 229
Analysis of Phase Two towards the Development of a Framework for Comprehensive Evaluation
8.1. Consideration of the Parameters for Analysis 229
8.2. Analysis of Component 1 on Decentralisation, Health Sector Reform, Community Participation and Ideas towards an Alternative Evaluation Framework 230
8.3. Analysis of Component 2 on Health, Decentralisation, Community Participation and Traditional Medicine 236
8.4. Fieldwork Consideration of the Particularities of Health in a Post-Conflict Environment 243
8.5. Selection and Analysis of Variables from Phase 2 245

8.6. Component 1 – Selection and Analysis of Variables 245
8.7. Component 2 – Selection and Analysis of Variables 248

Chapter IX 253
Conclusions
9.1. The Context for Conclusions 253
9.2. Approaches Towards Decentralisation in Health Sector Reform 253
9.3. Community Participation within Health Sector Reform in a Post Conflict Environment 257
9.4. Application of Variables in a Post-Conflict Environment to Analyse Community Participation 267
9.5. Achieving the Aim of an Alternative and Comprehensive Evaluation Framework 274

Bibliography 277
APPENDIX 1: Diagram of the Theory and Its Methodologies 300
APPENDIX 2: The Ideological and Conceptual Approaches and Content Relationships with the Definitions of Decentralisation Approaches 301
APPENDIX 3: Statistics and Maps on Human Rights, Acts of Violence, and Massacres 326
APPENDIX 4: General Health Profile - Summary of Analysis and Trends 329
APPENDIX 5: Health Code Regulatory Contents for the Public and Private Sectors 336
APPENDIX 6: Set of Analytical Questions for Interview Guides and Interview Guides 339
APPENDIX 7: A Comprehensive Evaluation Framework: Examples of the Systematisation of Qualitative/Descriptive Indicators per Variable 355

Chapter I
Introduction

1.1. Reflection as an Individual and as a Researcher

I have thought about the problems of my country for many years, both as a student and a professional, attempting to understand the conflict that afflicted it and how a situation of prolonged repression and violence shaped its institutional, organisational and social development. As a citizen growing up in a country during the civil war (1960 to 1996), I witnessed, first hand, the devastation caused by the violence and repression on individuals, families and communities. I interpreted reality from an ideological perspective and participated in the movements which influenced the country's direction. My role as observer of events and participant in reconstruction efforts led me to continue to seek knowledge. I did so as a researcher perhaps because it provided me with a discipline within which to think about the problems of society.

The Central American countries, along with the wider international community, supported the signing of the Esquipulas Agreement in Guatemala, which was the first step towards the creation of a negotiation framework for the Guatemalan Peace Agreements (PAs), in 1987. My concern was not about recording history as it happened but more about interpreting its effect on individuals and communities in the shaping of a country. In the post-conflict environment following the signing of the Peace Agreements, there were many development opportunities however, I was aware that some of these opportunities would fail to materialise because of the political, social, economic, and cultural conditions prevailing in the country. Transformation, given the severity and gravity of these conditions, was not possible. The knowledge I had accumulated made me aware that there had been an erosion of the social, political and cultural fabric of the country, which was not easily addressed in the post-conflict environment. I gained ample experience in evaluating and analysing the variables that served as measures of success (and failure) of development projects. I was involved in assessing whether there had been gains for a community or whether obstacles had persisted, or emerged, to adversely affect its process of development. However, the more I was involved in this kind of work, the more I realised that I was not adequately equipped with the tools to analyse our society. Society in the post-

conflict era was unfolding in complex ways, which would require generations to re-build.

My involvement in mainstream evaluations led to questions about the limitations of such evaluations in understanding how society functioned, how events were interpreted and how development processes took place. I realised, that there was little or no consideration of the reality in which people lived their lives, how they viewed their world, the relationships they established between the material and spiritual worlds, and how they absorbed the consequences of repression as a community and responded to it.

It appeared to me that evaluation frameworks were imposed from above, designed around a set of criteria which were external to the community, based on the needs of international and national aid agencies and lending organisations, and solidified in national agreements. There were major gaps in explaining how the reality of an individual and community was measured: from what perspectives, with what values and intentions, and with what judgements and tools. The question was what variables constituted the evaluation framework, or a genuine study of a community, and how involved was the community in relation to the measurement of such variables? I wanted to know how an individual and community defined such processes and systems. I felt that this had rarely been addressed in mainstream evaluation. The general understanding was that those participating in processes of development would work in partnership with the policies and practices that were imposed on them. From this perspective, it was assumed that communities had little knowledge to understand and manage their own needs and problems. An alternative view, perhaps one which expressed development from within, through the community's expression of itself surviving in a post-conflict environment, was mostly not considered, or was rejected.

Another aspect from my years of experience in the field also emerged in my thought process. The community held important a concept of history and identity, which influenced the actions it took to address development problems. Mainstream evaluations had little scope for this perspective to be included in analysis because mainstream evaluations were interested in particular problems of development but not the complex inter-relationships that caused and affected such problems. The

post-conflict environment was different because the problems in re-constructing a society from civil war signalled the need for a deeper and a more profound understanding about how that society (and its values) functioned previously and how it currently functions.

For instance, I visited the municipality of San Juan Chamelco in 1987 for first time, to begin work on my Bachelor's thesis. At that time, the entire municipality was under heavy military and paramilitary surveillance. Civil Defence Patrols (PACs) were created in many parts of the department of Alta Verapaz, including in various communities of San Juan Chamelco. All civil authorities and institutional representatives had to answer primarily to the local army garrisons established in the area. The garrisons had to answer to the military base located in the main department capital Cobán, and the base had to answer to the G2 and D5 Sections (military counter-insurgency and civil affair control units respectively) of the Ministry of Defence in the capital city. No decision with regard to any local matter in any realm of the community's' life could be taken without prior knowledge and approval by the chain of command or the central authority. Otherwise, any local plan, initiative, or action would be 'terminated' (using military jargon). This was the way decentralisation was conceived, as a centralised, authoritarian and counter insurgency model, emerging under the conception of development poles. This historical problem with regard to power, authority, freedom, inclusion, participation, control and other key sociological categories of analysis were completely ignored in most of the literature I reviewed at that time. Even now it is still difficult to identify literature for evaluation or assessment profiles in local areas in development.

The problems of Chamelco and other municipalities have been the result of complex situations, imbedded in the historical development of the country, which continue to shape the post-conflict environment in which it presently exists. The collective memory was shaped not by a single, grand-scale event but by inter-related events such as the confiscation of land and the indentureship of labour, the movement towards mass production and ethnic segregation, and official discrimination of large numbers of inhabitants within such communities. Within mainstream evaluation, such factors were unimportant in how conclusions were drawn about the successes and failures of development policies and programmes.

However, within a post-conflict environment there are many complex variables, which are not always quantifiable.

I returned to San Juan Chamelco in 1997, as part of an evaluation team commissioned by the Inter-American Development Bank (IDB) and the Ministry of Public Health and Social Welfare (MSPAS), Programme for the Improvement of Health Services (PMSS) and the Monitoring and Evaluation Unit (UME), to discuss the implementation of the Integrated Primary Healthcare System (SIAS) and the use of traditional medicine in primary healthcare with some of the communities. The municipality of Chamelco was one of the pilot areas for the programme. I experienced difficulties because people did not openly express views about the quality of healthcare they received and the progress of SIAS in their communities or the use of traditional medicine within the health system. Further, I had to separate the different groups participating in the implementation process (the institutional groups within the MSPAS from the civil groups becoming organised by themselves, and the government or the international aid that flowed in after the signing of the PAs). There were so many political, social and cultural clashes and polarisation amongst these groups (subordination, mistrust, passive resistance, negative criticism, sectarianism, and clientelism, to name few of the outcomes of the conflict years and now dominant in the post-conflict environment). I was a direct participant in mainstream evaluations and I was beginning to feel that many variables were missing from the analysis. The opportunity in Chamelco was a vivid experience of the key problem. Often I had gathered information from my fieldwork, which I did not use in my analysis and report writing because there was no framework for the consideration of such information.

Through this journey I discovered that there was a need to apply complementary quantitative and qualitative variables and indicators in the analysis of the historical, political, social, economic and cultural characteristics of a post-conflict environment in order to better understand the process of change through a comprehensive evaluation framework. The PAs were signed at a time when civilian governments, which had replaced military dictatorships, were implementing policies of decentralisation. Health sector reform was one of the major development sectors, receiving national and international investment and donations agreed with national government. In deciding my thesis topic I considered own experience and identified

that my aim was to examine how evaluations of community participation in post-conflict environments and decentralising policies should be done and how assumptions of existing evaluations limited their relevance and effectiveness. I developed my thesis topic with this in mind and elaborated two distinct and inter-related phases to the study. In the first phase, I question assumptions about existing mainstream evaluations by using the participant observation method to involve myself in a mainstream evaluation. In the second phase, I test assumptions about comprehensive evaluation frameworks in order to more profoundly understand society. I undertake primary fieldwork in the second phase and ask questions about values, beliefs, definitions and understandings of health sector reform. Through this process, I hope to bring new knowledge to the journeys I had previously taken and now take as a researcher, student, and participant in movements of change.

1.2. Developing the Thesis Topic: My Role as a Researcher

Guatemala is in a critical period in its development. It is not the first time that the country has been on the verge of dynamic change and revolution. However it is a crucial time coming after a long history of war, repression and exclusion, which was inflicted on the majority of the population. The PAs signed between 1987 and 1996 brought Guatemala to this historical juncture. However, since the 'era of peace' in the post-conflict environment, the lack of governance, the crisis of the state, the continuous violation of human rights, the level of impunity and insecurity, and a prevailing culture of violence continue to destabilise the country. In 1996, the main health problems of the country were persistent and high levels of infant mortality, continued high levels of maternal mortality, persistence of infectious diseases and increase of chronic degenerative illnesses and violence, resurgence of epidemics such as cholera, malaria and dengue, increase in the number of cases of AIDS/HIV, deterioration of the health services networks, poor quality and quantity of the provision of health services, poor access to health services particularly in the rural areas, a focus on hospital attention, no availability of medicines and basic health inputs, centralised, bureaucratised and inefficient organisation, lack of social participation, insufficient budgets, inadequate implementation and lack of financial management, inadequate provision of human resources, insufficient quality of human resources and insufficient establishment of health teams and resources to satisfy immediate demand (Sánchez, 2000).

The background context of the post-conflict environment are: weak institutional development, authoritarian decision-making structures, underdevelopment of the tiers of government, over-reliance on central government as the main authority in the country, distorted alliances between the elite classes and the military to achieve economic benefits, widespread use of terror tactics and violence as a means to control the population, severe economic disadvantage reflected in the civil sectors and institutional structures, social exclusion, and lack of participation by the majority of the population in the economy, education, health and other sectors. The post-conflict environment is thus shaped by the collective memory of violence and repression, which continues to affect how sectors within civil society react and respond to processes of change.

When I considered a topic for the thesis I was confronted with the history of the country which had shaped my thinking for most of my life. I often viewed it as a duality between the indentured political and social reality and a prospect for the future, which held hope for a better kind of society. I drew very close links between the present problems and the roots of these problems in history. The vision of the reality of the future, which was promised with the signing of the PAs, had yet to materialise. I was a member of the Commission for the Implementation of the Peace Agreements (CACAP) as part of my work for the United Nations System in Guatemala (UNS). During my work with the Commission I began to ask myself a series of questions about the legitimacy of the PAs, the Commission, its accountability and its political development. The questions I asked at the time would later influence the kinds of questions I wanted to answer in this thesis. During my work in the Commission, I asked myself why such a small group of people had become responsible for negotiating the whole of the peace process. Why were there so few voices debating a process which should involve many more people or their representatives at various levels of the society? With the signing of the PAs there were expectations about active participation by the general population although the process itself was void of such participation. However history weighed heavily on these opportunities and doubt was raised in my mind as to whether such potentialities would materialise. Given this context and my involvement in the Commission, I began to think about the possibility of change in Guatemala. However I realised, as others who have analysed the Guatemalan situation, that there was a

very severe polarisation cutting across ethnic groups, race, class and gender. These were historical in nature.

The biggest impact on health is Health Sector Reform (RSS) under an agenda for decentralisation. In 1996, the government's response to these problems could be summarised as (1) re-organisation of structures and institutions (re-organisation at the central level, strengthening capacity and management, developing and strengthening human resources and implementing the National Health Council), (2) introducing and/or tightening regulation (implementing the legal framework for the health sector, elaborating and implementing plans and programmes with the MSPAS, Guatemalan Social Security Institute (IGSS), Institute of Municipal Fomentation (INFOM) and other institutions of the sector and out with the sector, and designing the model of healthcare and accompanying programmes), (3) monitoring (development of and strengthening information systems, analysis of the current situation and epidemiological monitoring) and, (4) service provision (definition and implementation of the heath attention model, re-organisation of health services, modernisation and decentralisation of management and administration of resources, co-ordination of inter- and intra-sectoral contracts for the provision of services, implementation of training programmes and human resource development initiatives in relation to the health model and implementation of decentralisation programmes with regard to administrative management of human resources (Sánchez, 2000).

My role in this process has been that of researcher. As a researcher I was responsible for the evaluation of health systems developed under a model of decentralisation. The history of tradition, the role of shamans and other healers and the function of medicinal herbs were missing variables in evaluation and analysis of the effectiveness of healthcare models at the local level. Without this level of understanding, there could be no realisation of the importance of the 'cosmovision' on the development and progress of the community and its social fabric. Another important aspect of RSS was the idea of community participation in healthcare. There was potential, through community participation, to create the conditions for the mutual co-existence of two types of healthcare or medicine. However, the post-conflict environment affected the level and degree of community participation.

During the conflict, a culture of fear had perpetuated and had been used by the military as a tool of coercion and control (discussed in Chapter IV).

I brought a number of ideas together and understood that there was a clear need for communities to have a voice in how they are developed. In 1996, the government articulated its vision for community participation as (1) the definition of policies, plans and programmes which facilitate social and community participation in the planning, fiscalisation and financing of health services and improvement and protection of the environment; (2) the promotion of social participation through social, public and private communication mechanisms and the development of the mechanisms which facilitate the exchange of ideas on the reform and development of the heath sector; (3) the participation of the organised community in the planning, fiscalisation and financing of the provision of health services at the local level; and, (4) support strategies to strengthen the development of municipalities through the integration of health services in the prevention of illnesses, improvement and protection of the environment through social and community participation (Sánchez, 2000).

While community participation through RSS was central to this development, I began to view the potentiality of community participation in a post-conflict environment as a way to understand the effectiveness of any policy or practice at the grassroots level. The cultures that affect people have to be appropriately contextualised and variables developed to identify, within a framework of analysis, how people relate to change and development. I thought about evaluations differently given this experience, which led me to my thesis topic.

1.3. Aim and Objectives of the Thesis

The thesis focuses on a critical and comprehensive analysis of the process of community participation within a health sector reform process. in a post-conflict environment The aim is to examine how evaluations of community participation in post-conflict environments should be done, how decentralising policies should be implemented and how the assumptions of existing evaluations limit their relevance and effectiveness. I argue that comprehensive analysis demonstrates the need for a much deeper and more extensive understanding of the multiple complexities present

in post-conflict environments than is often achieved. Therefore it is necessary to carry out a historical, comparative and analytical exercise beyond mainstream structural-functionalist evaluations. The case of Guatemala is presented as an example of those complexities and will be used to analyse progress towards or stagnation of decentralisation, democratisation and participation.

The objectives of the thesis are:

(a) To examine and compare the philosophical-ideological approaches towards decentralisation policies (as mechanisms, systems and processes) underlying health sector reform policies and actions, conceptual planning concepts and procedures, and implementation guidelines and practices at the international and national levels as presented in the Guatemalan case.

(b) To define and analyse the achievements and limitations of community participation within health sector reform programmes linked to the approaches towards decentralisation and pluralistic democratisation practices within post-conflict environments - at the national, sub-national and local levels - using examples of the institutional attempts to integrate traditional medicine into the primary healthcare level in two municipalities in the countryside of Guatemala.

(c) To determine and apply complementary variables over the historical, political, social, economic and cultural characteristics of a post-conflict environment, - macro and micro in scope - (mainly qualitative variables and macro in scope), in order to analyse community participation within a health sector reform process and decentralisation policies aimed at the primary healthcare level, through a comprehensive evaluation framework.

The thesis is not about health sector reform *per se*. The thesis examines community participation in a post-conflict environment and within a health sector reform process, which is being shaped by decentralisation policies. The thesis is about the evaluation of such practice and policy undertaken in order to identify the limitations of a mainstream evaluation framework and to propose an alternative and comprehensive evaluation framework. For communities, health is not just related to clinical biological aspects of the state of the body, but also to the context in which the body of the individual engages with development or the lack of it. Thus, I look at the impact of an array of variables that form a part of those development policies affecting the lives of the majority of the population - economically, politically, socially

and culturally. It is within this context that health is understood and used in this study.

1.4. Contributions to the Field of Study

The main contribution of the thesis to the field of study is the development of the epistemological and conceptual framework. This framework shows the importance of developing the foundations for critique of mainstream evaluation methodologies. A brief introduction to the framework is provided below because it is important to understand some of its elements, in order to understand the design of the analytical questions that are used to structure the analysis. The main discussion of the framework is provided in Chapter 2 (and Appendix 1). The framework applies the epistemological conceptualisations of Social Constructionism Theory (SCT). I used this epistemological conceptualisation to understand the differences between institutional (international and national) visions and sub-national or local visions. I wanted to know why and how these meanings occur (are constructed) and what learning can be identified from the following concepts as categories of analysis: decentralisation, democratisation, participation and post-conflict.

The framework is designed around four methodologies, which are critical to its development. The methodologies are brought together to help understand the complexities of post-conflict environments, how policies and practices are interpreted in such environments, and how processes such as community participation are developed or remain underdeveloped. These four methodologies are fully discussed in Chapter 2, but a brief overview is provided here to assist in the development of the analytical questions. The first methodology - Critical Historical Analysis (CHA) - was applied through the construction of a retrospective, comparative and prospective review of (1) the philosophical-ideological, political and legal framework of decentralisation policies over a specific period of history, (2) the trends in conceptual decentralisation planning and implementation practices over a specific period of history and, (3) the level of central political authorities' willingness or unwillingness to support organisational procedures and community-building capabilities over a specific period of history.

The second methodology - Critical Comparative Analysis (CCA) - was applied through the construction of categories of content and critical comparison, which include: (1) the ideas and definitions of decentralisation policies from the World Bank (WB) and other sources, (2) the construction and meaning of the three ideological and conceptual approaches towards decentralisation (as a Market Mechanism Approach - MMA, as Techno-Bureaucratic System Approach – TBSA, and as a Democratic Participative Process Approach - DPA) using Critical Discourse Analysis (CDA) as a part of CCA, (3) the impact of multisectoral and sectoral policy issues, (4) the features of health sector reform and, (5) the features and trends observed in the recent post-conflict and 'peace-building' process of the country. These categories were assessed according to their descriptive and analytical conceptualisations on the following themes: (1) the features or characteristics of organisational structures of leadership, authority and management, (2) the trends in the promotion or prevention of social participation or any other form of participation, and, (3) the elements of the institutional or non-institutional approaches to promoting and building democratisation.

The third methodology - Critical Ethnographic Analysis (CEA) as a part of Naturalistic Inquiry (NI) - provided an analytical description of social and cultural situations. The methodology was used to build analytical categories, variables and indicators in the following way: (1) Content analysis of the socio-cultural differences between institutional management, organisational and traditional structures based on the system of beliefs and practices between central, sub-national and local levels. (2) Content analysis from observations of attitudes and practices (ideological, professional and cultural) which conflict with, or are indifferent to parts of or the entire decentralisation process. (3) An appraisal of participative monitoring and evaluation at the community level. (4) Critical analysis of the socio-political, socio-economic, and socio-cultural trends, effects, outcomes and impacts of decentralisation related to the Guatemalan post-conflict environment (presenting polarisation and differences in the points of view, interests and agendas). While the first two methodologies (CHA and CCA) are concerned with how ideas, concepts and systems emerge, the latter methodology (CEA) is concerned primarily with the collection of primary data for this research to arrive at a deeper and more profound understanding of the meaning of concepts given the evolution of processes within the society.

The fourth methodology - Peace and Conflict Impact Assessment (PCIA) - is a means for evaluating (*ex post facto*) and anticipating (*ex ante* as far as possible and according to particular circumstances and cases), the impacts of proposed and/or completed programmes, projects or initiatives in conflict-prone, conflict and post-conflict environments. Five areas are of potential peace advancement and conflict impact are stressed under PCIA which could be applicable for a comprehensive evaluation of the Guatemalan case, with regard to sectoral decentralisation, and the post-conflict environment and its complex variables: (1) Institutional Capacity to Manage/Resolve Violent Conflict and to Promote Tolerance and Build Peace, (2) Military and Human Security, (3) Political Structures and Processes, (4) Economic Structures and Processes and, (5) Social Reconstruction and Empowerment.

Through the integration of the four methodologies and the development of the epistemological and conceptual framework it is possible to understand complex realities and to use them to examine evaluation frameworks. It is possible to identify what can be learnt from them and how they can be developed further. From this epistemological and conceptual framework, key questions are devised to be addressed in the thesis.

1.5. Development of Analytical Questions

Based on the planned contribution of this thesis, a set of questions was designed to structure development of the study. These are the main theoretical questions and should be viewed as the foundation and focus of the thesis (indicating why the thesis is being done). These questions address the thesis aim - to examine how evaluations of community participation in post-conflict environments should be done, how decentralising policies should be implemented and how the assumptions of existing evaluations limit their relevance and effectiveness. The questions were designed and elaborated from five sources. The first source was the framework papers from the World Bank (discussed in Chapter 3) with regard to decentralisation. The second source came from the analysis of 15 additional definitions of decentralisation from further sources and documents (presented in the bibliography). Through a Critical Discourse Analysis as part of the Critical Comparative Analysis and other authors' ideas on decentralisation the three

approaches towards decentralisation (MMA, TBSA and DPA) were constructed. The analysis is based on the discourse of meaning, content, aims and objectives, comparative advantages and disadvantages, and limitations and potentialities of decentralisation when used and implemented as part of a development policy framework in developed and developing countries. The third source came from the revision of sources on the political history of Guatemala in relation to the main categories of analysis of this thesis - democratisation, participation, decentralisation, and conflict and post-conflict environments - using Critical Historical Analysis. The fourth source came from the review of the technical documents and papers from multilateral and bilateral international agencies and institutions of development and national ministries and bodies in relation to the process of multisectoral (Public Sector Reform –RSP-) and sectoral (Health Sector Reform –RSS-) decentralisation and development in Guatemala (presented in the bibliography). The fifth source came from a thorough analysis of the gaps and limitations of the mainstream evaluation performed by the MSPAS and its Monitoring and Evaluation Unit (UME). This can be found in Chapter 6. A series of analytical questions were elaborated under each methodology as epistemological tools to complete the aim and the objectives of this research. Some questions were linked to more than one of the four methodologies due to their contents. The questions are detailed below:

Critical Historical Analysis (CHA) The construction of retrospective, comparative and prospective review of: The philosophical-ideological, political and legal framework of decentralisation policies over a specific period of history The trends of conceptual decentralisation planning and implementation practices over a specific period of history The level of central political authorities' willingness or unwillingness to support organisational procedures and community-building capabilities over a specific period in history	**Research Objective A:** To examine and compare the philosophical-ideological approaches towards decentralisation policies (as mechanisms, systems and processes) underlying health sector reform policies and actions, conceptual planning concepts and procedures, and implementation guidelines and practices at the international and national levels as presented in the Guatemalan case. **Analytical Questions under Critical Historical Analysis (CHA) Related to Objective A:** What visions, definitions and practices have been employed through different constructions of the decentralisation models at the international level by the IFIs in Guatemala throughout time? What kind of ideological and conceptual approaches towards decentralisation have been developed through its different constructions at the international level by the IFIs in Guatemala throughout time? What kind of political, economic and cultural positions have the social sectors held in Guatemala at the national, sub-national, and local levels on the process of decentralisation throughout time? What are the characteristics of evolution and stagnation of the socio-political and socio-economic model in terms of power (authority and decision-making), and the provision of social services throughout time? **Analytical Questions Linking Critical Historical Analysis (CHA) and Critical Comparative Analysis (CCA) Related to Objective A:** How has the social construction of discourse, conceived as definitions, ideological representations, visions of decentralisation, democratisation and participation, been translated into institutional and normative policies in Guatemala by central authorities and sub-national and community authorities and representatives? How have the visions and conceptualisations of the three approaches towards decentralisation: the MMA, TBSA and DPA been socially and culturally conceptualised, interpreted and practiced by the different social sectors involved in such processes in the Guatemalan post-conflict-environment at the national, sub-national and local levels? How could a more democratic and participative approach towards decentralisation based upon international and national concepts of delegation, devolution and appropriation be adapted and applied to a post-conflict environment like Guatemala? Under what kind of political, economic, social and cultural framework have decentralisation policies been implemented (including international and regional agreements, peace agreements and inter-sectoral and sectoral development programmes)? What leads to the hegemony of these discourses on decentralisation at the national and sub-national levels?

Critical Comparative Analysis (CCA) The construction of categories of content and critical comparison include: The ideas and definitions of decentralisation policies from the WB and other sources; The construction and meaning of the three ideological and conceptual approaches towards decentralisation: the MMA, TBSA and DPA using Critical Discourse Analysis (CDA) as part of the CCA; The impact of multisectoral and sectoral policy issues; The features of health sector reform; The features and trends observed in the recent post-conflict and/or 'peace-building' process of the country. Assess the above categories according to their descriptive and analytical conceptualisations on the following themes: The features or characteristics of organisational structures of leadership, authority and management; The trends in the promotion or prevention of social participation or any other forms; The elements of the institutional or non-institutional ways of promoting and building democratisation.	**Research Objective B:** To define and analyse the achievements and limitations of community participation within health sector reform programmes linked to the approaches towards decentralisation and pluralistic democratisation practices within post-conflict environments -at the national, sub-national and local levels- using examples from institutional attempts to integrate traditional medicine into the primary healthcare level in two municipalities in the countryside of Guatemala. **Analytical Questions under a Critical Comparative Analysis Related to Objective B:** What is the current nature of the restructuring relationship between public, private and civil sectors, managers and policy makers, service providers and consumers according to the decentralisation model(s) and approaches implemented? How has the social construction of discourse, conceived as definitions, ideological representations, visions of decentralisation, democratisation and participation, been translated into institutional and normative policies in Guatemala by central authorities and sub-national and community authorities and representatives? How have the visions and conceptualisations of the three approaches towards decentralisation: the MMA, TBSA and DPA been socially and culturally conceptualised, interpreted and practiced by the different social sectors involved in such processes in the Guatemala post-conflict-environment at the national, sub-national and local levels? How could a more democratic and participative approach towards decentralisation based upon international and national concepts of delegation, devolution and appropriation be adapted and applied to a post-conflict environment like Guatemala? (This question can also be applied under CEA) Under what kind of political, economic, social and cultural framework have decentralisation policies been implemented (including international and regional agreements, peace agreements and inter-sectoral and sectoral development programmes)? What kind of conceptualisations could be useful to evaluate this process within the framework of the three approaches towards decentralisation addressed throughout this study? **Analytical Questions Linking Critical Comparative Analysis (CCA), Critical Ethnographic Analysis (CEA) and Peace and Conflict Impact Assessment (PCIA) Related to Objective B:** What kind of categories of analysis could be useful to evaluate this process within the framework of the three approaches towards decentralisation addressed throughout this study? What can be identified, assessed and learnt from the three approaches towards decentralisation? What kind of opinions and perceptions exist between authorities, population, NGOs, traditional and institutional health practitioners working in the sector at the central and international, national and local levels and how do they affect the implementation process with regard to decentralisation at the local level? What is the nature of the constraints to health decentralisation? Is it the lack of resources and managerial skills? Is it the lack of legitimacy in the political and social context of the country? Is it the lack of more democratic forms of decision-making, organisation and participation? Whose decentralisation model and approach is it, and whose vision is it? Who is heard and who goes unheard? What general implications is the process producing at the local level and is this real participation?

	How could a more democratic and participative approach towards decentralisation based upon international and national concepts of delegation, devolution and appropriation be adapted and applied to a post-conflict environment like Guatemala? How have social, economic and cultural factors affected some ethnic groups more directly than others experiencing the exclusion model? Did/will the programme, project or initiative (decentralisation) affect organisational capacity of individuals or collective organisations (institutions, social groups, public and private sector) and is this impact positive or negative? Did/will the programme, project or initiative (decentralisation) identify and respond to peace and conflict challenges and current and future opportunities? If so, which groups and to what degree? How and why? How did/will the programme, project or initiative (decentralisation in this case) affect the understanding, composition and distribution of political resources within and between state and civil society? Did/will the programme, project or initiative (decentralisation in this case) contribute to the development or consolidation of equity and justice or the means of providing basic needs? Did/will the project include members from the various communities affected by the conflict? What are the criteria for effectiveness within the members of those communities on any development initiative? Did/will the programme, project or initiative (decentralisation in this case) provide/generate the skills, tools, capacity for individuals and communities to define issues/problems to be addressed and formulate solutions to those problems or resolve those self-defined problems? To what extent did/will the programme, project and initiative (decentralisation in this case) incorporate/prioritise the views and interests of affected indigenous populations?
Critical Ethnographic Analysis (CEA) as part of the Naturalistic Inquiry (NI) The construction of analytical ethnographic categories amongst different social groups based on: Content analysis of the ideas and opinions and socio-cultural differences between institutional management, organisational and traditional structures based on the system of beliefs and practices between central, sub-national and local levels. Content analysis from observations of attitudes and practices (ideological professional, and cultural), which conflict with, support, or are indifferent to parts or the entire decentralisation process. An appraisal of participative monitoring and evaluation at the community level. Critical analysis of the socio-political, socio-economic, and socio-cultural, trends, effects, outcomes and	**Research Objective C:** To determine and apply complementary variables over the historical, political, social, economic and cultural characteristics of a post-conflict environment, -macro and micro in scope- (mainly qualitative variables and macro in scope), in order to analyse community participation within a health sector reform process and decentralisation policies aimed at the primary healthcare level, through a comprehensive evaluation framework. **Analytical Questions under the Critical Ethnographic Analysis (as part of Naturalistic Inquiry) Related to Objective C:** What can be identified, assessed and learnt from the three approaches towards decentralisation? What kind of opinions and perceptions exist between authorities, population, NGOs, traditional and institutional health practitioners working in the sector at the central and international, national and local levels and how do they affect the implementation process with regard to decentralisation at the local level? What kind of evaluation procedures exist? Are these robust, comprehensive and interconnected in terms of the collection of data according to the representation of groups in order to achieve decentralisation, democratisation, and participation in health services? What opinions and perceptions exist on decentralisation, participation and democratisation between authorities, the population, NGOs, traditional and institutional health practitioners working in the sector at the central, sub-national and local levels? What is the nature of the constraints to health decentralisation? Is it the lack of resources and managerial skills? Is it the lack of legitimacy in the political and social context of the country? Is it the lack of more democratic forms of decision-making, organisation and participation? What further democratic and participative planning, implementation, and monitoring and evaluation procedures need to be constructed with regard to the primary healthcare system between the different stakeholders at the community level?

impacts of decentralisation related to the Guatemalan post-conflict environment, presenting polarisation and differences in the points of view, interests and agendas.	What additional evaluation components could be established through the construction of participative and democratic categories related to authority, responsibility, decision-making, organisational skills and practices, and health conceptualisations and treatments? Whose decentralisation model and approach is it, and whose vision is it? Who is heard and who goes unheard? What leads to the hegemony of these discourses on decentralisation? What general implications is the process producing at the local level and is this real participation? What are the roots and manifestations of the exclusion model? How is exclusion referred to, conceptualised and practiced in Guatemala? How have social, economic and cultural factors affected some ethnic groups more directly than others experiencing the exclusion model? **Analytical Questions Linking Critical Ethnographic Analysis (CEA) as part of Naturalistic Inquiry and Critical Comparative Analysis (CCA) Related to Objective C:** What kind of political, economic and cultural positions have the social sectors held in Guatemala at the national, sub-national, and local levels on the process of decentralisation throughout time? What are the characteristics of evolution and stagnation (advances and setbacks) of the socio-political and socio-economic model in terms of power (authority and decision-making), and the provision of social services throughout time? What are the roots and manifestations of the exclusion model - it is necessary to analyse critically the current external ideological domination of neo-colonialism values and beliefs? How is exclusion referred to, conceptualised and practiced in Guatemala? What were/might be the main obstacles to a positive peace building impact in the middle and long terms (in relation to democratisation, participation and decentralisation)? Did/will the project (decentralisation in this case), affect the military/paramilitary/criminal environment (post-conflict) indirectly or directly, positively or negatively? If so how? To what extent did/will the programme, project or initiative (decentralisation in this case), contribute to the demilitarisation of minds (as part of a reconciliation process) Did/will the programme, project or initiative (decentralisation in this case) help or hinder the consolidation of constructive political relationships within and between the state and civil society? Did/will the programme, project or initiative (decentralisation in this case) help diffuse inter-group tensions? If so how? What was/will be the impact of the programme, project or initiative (decentralisation in this case) on human, citizen and legal rights in the country or/and region (awareness, legislation, and levels of abuse/respect? Did/will the programme, project or initiative (decentralisation in this case) take into consideration the history/legacy of conflict in its design? (For example, does it consider the specific impact on children, women and other vulnerable groups such as displaced populations and the politically, socially and economically marginalised)?
Peace and Conflict Impact Assessment (PCIA) The construction and application of a comprehensive evaluation	**Research Objective C:** To determine and apply complementary variables over the historical, political, social, economic and cultural characteristics of a post-conflict environment, -macro and micro in scope- (mainly qualitative variables and macro in scope), in order to analyse community participation within a health sector reform process and decentralisation

framework in the Guatemalan case, with regard to the post-conflict, environment and its complex variables related to: Institutional Capacity to Manage/Resolve Violent Conflict and to Promote Tolerance and Build Peace Military and Human Security; Political Structures and Processes; Economic Structures and Processes; Social Reconstruction and Empowerment.	policies aimed at the primary healthcare level, through a comprehensive evaluation framework. **Analytical Questions under Peace and Conflict Impact Assessment (divided into four areas of potential peace advancement and conflict impact) Related to Objective C:** *With regard to Institutional Capacity to Manage/Resolve Violent Conflict and to Promote Tolerance and Build Peace, the questions are:* Did/will the programme, project or initiative (decentralisation) affect organisational capacity of individuals or collective organisations (institutions, social groups, public and private sector) and is this impact positively or negatively? Did/will the programme, project or initiative (decentralisation) identify and respond to peace and conflict challenges and current and future opportunities? If so, which groups and to what degree? How and why? What were/might be the main obstacles to a positive peace-building impact in the middle and long terms (with relation to democratisation, participation and decentralisation)? *With Regard to Military and Human Security, the questions are:* Did/will the project (decentralisation) affect the military/paramilitary/criminal environment indirectly or directly, positively or negatively? If so how? To what extent did/will the programme, project or initiative (decentralisation) contribute to the demilitarisation of minds? *With Regard to Political Structures and Processes, the questions are:* Did/will the programme, project or initiative (decentralisation) help or hinder the consolidation of constructive political relationships within and between the state and civil society? How did/will the programme, project or initiative (decentralisation) affect the understanding, composition and distribution of political resources within and between state and civil society? Did/will the programme, project or initiative (decentralisation) help diffuse inter-group tensions? If so how? What was/will be the impact of the programme, project or initiative (decentralisation) on human, citizen and legal rights in the country or/and region (awareness, legislation, and levels of abuse/respect)? *With Regard to Social Reconstruction and Empowerment, the questions are:* Did/will the programme, project or initiative (decentralisation) contribute to the development or consolidation of equity and justice or the means of providing basic needs? Did/will the project include members from the various communities affected by the conflict? What are the criteria for effectiveness? Did/will the programme, project or initiative (decentralisation) provide/generate the skills, tools, capacity for individuals and communities to define issues/problems to be addressed and formulate solutions to those problems or resolve those self-defined problems? Did/will the programme, project or initiative (decentralisation) take into consideration the history/legacy of conflict in its design? (For example, does it consider the specific impact on children, women and other vulnerable groups such as displaced populations and the politically, socially and economically marginalised?) To what extent did/will the programme, project and initiative (decentralisation) incorporate/prioritise the views and interests of affected indigenous populations? **Analytical Questions Linking Peace and Conflict Impact Assessment (divided into four areas of potential peace advancement and conflict impact), Critical Historical Analysis (CHA), Critical Comparative Analysis (CCA) and Critical Ethnographic Analysis (CEA) Related to Objective C:** What kind of political, economic and cultural positions have the social sectors held in Guatemala at the national, sub-national, and local levels on the process of

	decentralisation throughout time? What are the characteristics of evolution and stagnation (advances and setbacks) of the socio-political and socio-economic model in terms of power (authority and decision-making), and the provision of social services throughout time? What kind of evaluation procedures exists? Are these robust, comprehensive and interconnected in terms of the collection of data according to the representation of groups in order to achieve decentralisation, democratisation, and participation in health services? What further democratic and participative planning, implementation, and monitoring and evaluation procedures need to be constructed regarding the primary healthcare system between the different stakeholders at the community level? What additional evaluation components could be established through the construction of participative and democratic categories related to authority, responsibility, decision-making, organisational skills and practices, and health conceptualisations and treatments? What are the roots and manifestations of the exclusion model - it is necessary to analyse critically the current external ideological domination of neo-colonialism values and beliefs? How is exclusion referred to, conceptualised and practiced in Guatemala? What were/might be the main obstacles to a positive peace-building impact in the middle and long terms (with relation to democratisation, participation and decentralisation)?

1.6. Structure of the Thesis

In this chapter I discussed the evolution of my own thoughts in developing the topic for this thesis. I related this 'evolution' to the history of Guatemala and linked the historical observations to the current post-conflict reality. By re-visiting my earlier experiences as a student, researcher and participant in processes of change and development, I identified the need for further study about the methods and frameworks applied to understanding complex realities. I identified that the aim of my thesis would be to examine how evaluations of community participation in post-conflict environments should be done demonstrating the need for a deeper understanding of the complexities present in post-conflict environments. Through a re-examination of my earlier experiences, I arrive at the need to develop an alternative epistemological and conceptual framework to understand society. This is discussed as the main contribution of the thesis.

Chapter two details the epistemological and conceptual framework that is used in this thesis. This framework is the main conceptual contribution of the thesis to the field of study. The chapter outlines Social Constructionism Theory (SCT) which, is used to understand how individuals interpret their reality. Within the context

of this thesis, SCT lends itself to understanding the interpretations and application of the concepts of democracy and participation from the perspective of individuals belonging to communities and the state and how such understandings affect community participation in health sector reform under a model of decentralisation. The discussion of the theory is followed by a discussion on the four methodologies elaborated to understand the reality of Guatemala and to work towards the design of a comprehensive evaluation framework. This chapter develops the epistemological and heuristic elements of Critical Historical Analysis (CHA), Critical Comparative Analysis (CCA), Critical Ethnographic Analysis (CEA) as a part of Naturalistic Inquiry (NI), and, Peace and Conflict Impact Assessment (PCIA) addressed in the sections of this chapter called contributions to the Field of Study.

Chapter three presents a review of literature focusing on the generic issues relating to decentralisation, evaluation and health sector reform. The contribution of Chapter 3 towards the aim of the thesis is to review relevant literature on decentralisation in the health sector in Guatemala with a particular emphasis on community participation. This is done to help identify limitations of existing evaluation frameworks and understand the issues that shape an alternative evaluation framework. Community participation is emphasised because for a decentralisation framework to succeed, reform and change must be embedded within a process of democratisation. This focuses upon (a) a review of the different views of decentralisation related to the post-conflict environment and limitations of policies and theories within this context; and (b) an examination of the theory and policies of the decentralisation models posed by the World Bank and other International Financial Institutions (IFIs) to understand the intention behind policy implementation, how they are conceived and what impacts they have. The review provides the ideological framework for the consideration of decentralisation policies in post-conflict environments. Before I begin the review of literature I provide an analysis of the characteristics of post-conflict environments in general and then discuss the health particularities in post-conflict environments specifically. I do this to provide context in order to consider the generic issues pertinent to decentralisation and to highlight the problems that face such countries.

First, the literature review examines the political framework within which such policies are implemented. The chapter provides a description of the three

approaches towards decentralisation elaborated in this research and briefly contextualises the descriptors with respect to the post-conflict environment in Guatemala. For instance, a decentralisation process driven through private sector modernisation (the Market Mechanism Approach) within the context of Guatemala reinforces the role of the traditional oligarchy, and distracts from broader social, economic and political reform. A decentralisation process driven by developing technical capacity and expertise (the Techno-Bureaucratic Systems Approach) and by strengthening institutions in a post-conflict environment addresses some of the problems caused by structural and institutional inefficiencies, but ignores the articulation of local needs within the framework of implementation and evaluation. A decentralisation process driven through local participation (the Democratic Participative Approach) is limited in terms of the outcomes where the technical, administrative and institutional capacities are not adequately developed.

Chapter four is elaborated using the methodological approaches of Critical Historical Analysis and Critical Comparative Analysis. This section provides an analysis of the nature of the Guatemalan state. This is considered important to discussions on decentralisation in Guatemala, in order to understand how political institutions were developed and the impact of these institutions on the process of democratisation (or lack thereof). In this chapter, the history of the state in Guatemala is defined as authoritarian, despotic and oligarchic. These are recognised as the main features of the state under the Peace Agreements signed in 1997. The discussion of decentralisation focuses on ideas about delegation of authority, deconcentration of state institutions to local levels and the importance of participation within the process overall. However, without a thorough understanding about the need for decentralisation in terms of structural change and the need to promote the credibility of the state as a positive consequence of its own transformation, the goals of development and peace, which are identified under the Peace Agreements as aspirations towards decentralisation, cannot be achieved. By underpinning the recent history of the state in Guatemala, a more profound understanding can be obtained about the nature of political institutions and structures and how these have controlled the population. The discussion identifies the need for a conceptual framework not only to understand the impact of the history of the state on current initiatives such as health sector reform, but also to take account of knowledge and experience within the context of the post-conflict

environment. Underlying any discussion on the history of Guatemala is analysis of human rights and gross violations. I have provided an overview of the post-conflict environment in Guatemala by drawing attention to the roots of the conflict from an individual perspective. I use statistics on human rights violations not only to support the assertions I have made, but to elaborate the point that from such devastation, a new, post-conflict society must emerge.

In Chapter five the literature review is continued and addresses the process of decentralisation, as implemented under public sector reform within the peace and development agenda of Guatemala. The chapter develops the literature further from the two previous chapters by applying the generic literature and the historical overview to the present situation in Guatemala. Decentralisation is first described as a failure under the MMA, because it relies on achieving macro-economic balance through privatisation and the implementation of user fees at the local levels. It does not consider the devastating impacts of the war, violence and poverty on the population, which has been historically excluded and disadvantaged. The former approach is modified under TBSA, emphasising delegation in an attempt to slow down the pace of economic liberalisation and transformation impacting the local areas with regard to local health provision and other public social services. The non-government organisations (national and international) are identified as the drivers of RSS at the local level. The key to the implementation of this approach is the transition from a benefactor state and clientelism to local provision of services through specialised skills and knowledge under the integrated primary healthcare system. However the main obstacle is structural and institutional incapacity to sustain, motivate and develop managerial and organisational systems through which reform could be administered. Nonetheless a health infrastructure is created under this approach through the implementation of the Basic Health Teams (EBS). The nature of the health system and reform in the post-conflict environment are discussed in the previous chapter.

Chapter five also examines the DPA. This approach is discussed at the theoretical level and viewed as a vision for the future because it incorporates the critical element of participation in health sector reform. The DPA is also viewed as having far reaching impacts in terms of the objectives for peace and development especially in addressing poverty, exclusion and discrimination experienced by

indigenous groups, promoting the revitalisation of these groups and supporting local decision-making and political power structures. The vision is clear for the development of the country in the critical post-conflict environment, under the framework of the PAs and especially in relation to RSS. Nevertheless, it is not developed into policy and implemented through programmes. This chapter provides an overview of the limitations, both institutional and financial, inhibiting the orientation and implementation of the resources to the health sector and to the extension of health sector reform.

Chapter six describes the first phase of the fieldwork conducted for this thesis. This chapter examines the evaluation conducted by the Ministry of Public Health and Social Welfare in sixteen communities where health sector reform was piloted. This chapter represents Phase 1 of the primary research where I took part in the evaluation as a participant observer. I was a part of the external evaluation team and my participation in the evaluation was agreed on the basis that it would be used as the primary phase of fieldwork for this research. At the beginning of the chapter, I discuss the fieldwork methodology used to conduct this part of the primary research. I decided to discuss the fieldwork methodology at the start of this chapter rather than providing a separate chapter for this discussion to take place. The reasons were three-fold: first, the statement of the fieldwork methodology at the start of the chapter provides the context within which to consider how the fieldwork was done. Second, the discussion also allows for the discussion of critical issues with regard to the fieldwork itself to be identified. And third, given the complexity of the epistemological and conceptual framework that I developed, I believe that the discussion at the start of the chapter adds clarity and relevance.

The chapter provides an overview of the main findings of the evaluation in sixteen communities. The objective of the evaluation was to assess the level and degree of participation of local communities in health sector reform carried out under a model of decentralisation. The chapter provides a discussion and critical analysis of the conventional evaluation framework used by the MSPAS to undertake the evaluation on community participation, and sets the scene for the need to elaborate a non-conventional evaluation framework based on the historical-political development of the country and the characteristics of its post-conflict environment. It is revealed through the analysis that there were fundamental gaps, limitations and

mistakes in the consideration and interpretation of data and in the scope of the evaluation framework implemented. There was very little scope within the evaluation for critical historical and critical comparative analysis. Such factors affect the conceptual framework of the evaluation, behaviours and attitudes, and analytical frameworks, which limit understanding and knowledge. The evaluation and the critical analysis of its findings are used as a point of departure to arrive at a deeper and a more profound understanding of variables relevant to an evaluation of health sector reform promoting a model of decentralisation in a post-conflict environment.

In Chapter seven, the second phase of the primary research is presented. Again, I present the fieldwork methodology at the start of this chapter for the reasons stated above. The second phase is comprised of two components. Component one of the fieldwork involved focus groups with high rank officials within the health sector and other government bodies directly or indirectly involved in health sector reform and decentralisation policies, advisers and consultants involved in health sector reform and the decentralisation process either working within or outside of the government sector, representatives from the civil and academic sectors, and officials from international cooperation agencies supporting/working under the framework of health sector reform and/or decentralisation policies.

Component two of the fieldwork involved focus groups carried out in San Juan Chamelco and San Miguel Tucurú. The objectives of the focus groups were to evaluate the nature of community participation, the level of development of the healthcare model, the factors which affect community participation, and the systematisation and incorporation of traditional medicine within primary health care. Focus groups involved personnel from the institutional medical system including nurses assigned to the Health Centres and members of the Basic Health Teams including Mobile Physicians, Health Monitors, Traditional Birth Assistants, personnel from the traditional medical system, and community members including users of both traditional and institutional medicine. These focus groups were important to the research because through the discussion of the incorporation of traditional medicine and institutional medicine issues around health sector reform, cultural values, the inclusion of the indigenous population, and participation could be explored comprehensively. The variables of equity and equality are important in the discussion as stated in the Peace Agreements, especially around the incorporation

of local knowledge and experience. By taking account of the value of traditional medicine within the framework of health sector reform questions around the nature of the reform, who was included in the reform process and who was not included, and whose cultural visions and beliefs were reflected within a process of decentralisation were addressed.

Chapter eight presents the analysis of results from Phase 2 within three main sections. The first section examines the results for Component 1, which represents the macro level of analysis and the results for Component 2, which represents the micro level of analysis. The micro level of analysis is broken down into two parts– analysis by thematic area and analysis by sub-group of respondents (by thematic area and by respondent group). The responses are compared within each component and limited comparison is drawn across components. The purpose is to establish how variables are interpreted and understood and to consider interpretations and visions within an alternative evaluation framework. The second section identifies variables from Phase 2 fieldwork. The third section brings together research from Phases 1 and 2 and analysis from the literature review to consider how an alternative evaluation framework might be constructed. The variables and key words are identified. The themes covered are inter-related and complex and multiple links can be drawn between the variables, how they are derived, defined, interpreted and understood within the context of the thesis. Indicators are suggested about how the variables can be measured within an evaluation framework and some of the issues with regard to verification are also stated.

Conclusions are presented in chapter nine. I consider that there is a fundamental gap in knowledge and knowledge generation in and about post-conflict environments. The epistemological and conceptual framework was designed to address this gap. A more comprehensive set of variables and indicators should be developed which challenge existing evaluative models that are functional, a-temporal, not contextualised amongst the communities studied, and unable to identify the role of the actors. Evaluations could include and inter-relate the key issues with the critical and analytical aspects of the methodological inquiry such as the kinds of factors (variables) intervening in preventing organisational and managerial skills from developing in the community and therefore, directly or indirectly affecting the implementation of SIAS, the meaning of power,

decentralisation, democracy, participation, inclusion, equality and empowerment among other conceptual categories related to community organisation, the degree to which the community's skills are disrupted, diminished or destroyed during the Civil War, and the potentials of community resurgence. The problems of polarisation, economic, ethnic and gender issues developed throughout the country's history were pervasive in character. Unless there are attempts to transform the health sector reform process through participation, the negative and pervasive socio-economic structure will remain indefinitely, causing further disenchantment, apathy, frustration, violence and another cycle of internal generalised unrest and another attempt of revolution.

Chapter II
Epistemological and Conceptual Framework

2.1. Introduction to the Framework

In Chapter 1, I discussed the development of a conceptual and epistemological framework to address the research aim - to examine how evaluations of community participation in post-conflict environments should be done, how decentralising policies should be implemented and how the assumptions of existing evaluations limit their relevance and effectiveness. The development of this framework is viewed as the main contribution of the thesis to the field of study because the framework allows for the study of complex realities by understanding the historical context of realities and how they shape present environments. The framework also allows for a comprehensive study of post-conflict environments with conditions similar to Guatemala where it is difficult to sustain experiences of participation and democratisation. The brief discussion of the framework in Chapter 1 provided insight to an approach to addressing the research aim, the idea of which was generated through the experience of the post-conflict environment. This was done to demonstrate the complexity of the environment and the layers of study and knowledge that are necessary to examine the research aim and, subsequently, to develop the rationale for a more comprehensive evaluation framework. Following on from the brief discussion of the contribution of the conceptual and epistemological framework and how it is critical to this study, a series of analytical questions were identified for consideration in the research.

The purpose of this chapter is to describe the epistemological and conceptual considerations of the research in depth and under a framework as it is applied to the research. The framework influences understanding in the way ideas and concepts emerge around the central themes of the research from a historical and political perspective and how they are elaborated and contextualised within an evaluative framework considering social, political, economic and cultural aspects of community participation in health sector reform. The chapter details the use of a qualitative analysis approach as the point of departure to challenge the inherent assumptions and procedures of conventional evaluation approaches applied to a decentralisation process. The epistemological and conceptual framework of this research is based on Social Constructionism Theory (SCT). The conceptual

construction process of the categories of analysis is developed through the following methods - Critical Historical Analysis (CHA), Critical Comparative Analysis (CCA), Critical Ethnographic Analysis (CEA) as a part of Naturalistic Inquiry (NI) and Peace and Conflict Impact Assessment (PCIA), all further discussed in this chapter. Through the framework it will be possible to identify how an evaluation model evolves using a more comprehensive construction of the analytical categories relating to the decentralisation process in Guatemala. This will be done through a multi-dimensional approach (inter-relating socio-political, socio-economic and socio-cultural variables and factors) and will consider community participation as integral to the analysis. The variables and factors are examined at the macro, meso and micro levels of Guatemalan reality, with an emphasis on the first level in order to construct the background of the country's situation.

The research examines the evaluation approach initially through the construction process of its components, variables and indicators obtained from a series of analytical questions (Chapter 1). These analytical questions emerge from an examination of the historical-political context of the post-conflict environment of Guatemala and through an assessment of the theories of community participation and decentralisation, and their application. Through these questions, themes are identified in order to structure the subsequent discussion on evaluation of community participation in health sector reform under a decentralisation process in post-conflict environments. The analytical questions are then used to construct the primary research phase and identify the analytical categories within this research. The variables and their associated indicators are systematically considered using the four methodologies: CHA, CCA, and CEA as a part of NI, and PCIA, and their respective levels of analysis. The proposed evaluation approach is focused on the past, current and possible difficulties of the post-conflict environment, its impact on democratisation and participation processes and, political, social and institutional power and responsibilities in Guatemala related to health sector reform.

The scope and objectives of the research are justified with respect to the need for multidimensional strategic knowledge of the particular outcomes of sectoral decentralisation. Traditionally, technical evaluations are constrained in understanding and in depicting complex socio-political situations and development processes within a post-conflict environment. Therefore, this chapter provides an

initial critical review of how the situations and processes could be addressed in order to expand the scope of the evaluation. In the case of Guatemala this includes an understanding of the diverse variables facilitating and inhibiting community participation with regard to democratisation such as equity, inclusion and empowerment based on the Peace Agreements agenda. The framework was developed specifically to take account of the context of study that is the post-conflict environment of Guatemala and the significance of the conditions and factors of this kind of environment in terms of human development. In other words, it is a study of a process in a society traumatised by war and living through a very difficult post-conflict period. The uniqueness of this experience is relevant to the whole of the study and the analysis that emerges leads to an understanding of the possibilities, limitations and potentialities of community participation and decentralisation as a development process. In this sense, the study also addresses the kinds of situations and conditions of Guatemalan society within the post-conflict environment at all levels and the challenge faced by a sectoral reform process implementing a new Integrated Primary Healthcare System (SIAS) in the rural areas deeply affected by the Civil War.

2.2. Epistemological Framework: Social Constructionism Theory (SCT)

This section reviews some of the epistemological concepts of Social Constructionism Theory (SCT) in order to understand the nature of the differences between institutional and local visions and concepts of decentralisation, democratisation and participation, how these meanings occur and what learning can be identified from them. Under SCT the importance of both 'knowledge' and 'reality' as contingent in social relations is conceptualised. The analysis of the structure of the common-sense world of everyday life (daily experience) is an important epistemological influence within this framework. SCT takes epistemological concepts from a variety of philosophical sources, but the three main ones are:

1. The concept of Hermeneutics, based on Wittgenstein's ideas addressing the inter-subjectivity of meaning between language and thought. 'To interpret' a hermeneutike (techne) is the 'art of interpretation' (Laks and Neschke, 1990). A text is interpreted from two points of view: 'grammatical', in relation to the language in which it is written, and 'psychological', in relation to the mentality and development

of the author (Laks and Neschke, 1990). We cannot gain complete understanding of either of these aspects since we cannot have complete knowledge of a language or a person. We 'move back and forth between the grammatical and the psychological sides and no rules can stipulate exactly how to do this' (Laks and Neschke, 1990). We cannot fully understand a language, a person or a text; unless we understand its parts, but we cannot fully understand the parts unless we understand the whole (Mueller-Vollmer, 1986 and Palmer, 1969). Thus, at each level we are involved in a hermeneutical circle, a continual reciprocity between whole and parts (Mueller-Vollmer, 1986; and Palmer, 1969). For Ricoeur (1981) a significant text can never be understood right away, every reading puts the reader in a better position to understand since it increases his/her knowledge.

2. The concept of Praxis based on Marxist and post-Marxist ideas about the contingency of knowledge and politics upon production and socio-economic relations and their ideological representations and justifications (Lobkowicz, 1967). Praxis is “the Greek word for 'action', it enters the philosophical literature as a quasi-technical term with Aristotle, meaning 'doing' rather than 'making’ something' (Lobkowicz, 1967). It was developed by some of the ‘left’ Hegelians, and is now primarily associated with Marx and Marxism (Lobkowicz, 1967). In the 1960s and 1970s the term characterised the approach of East European (especially Yugoslav) Marxists (known as the Praxis Group), whose central concern was to study and influence the role of free creative activity in changing and shaping ethical, social, political, and economic life along humanistic socialist lines (Lobkowicz, 1967).

3. The concept of Phenomenology based on Husserl’s ideas about human practices and interactions based on continuous habits, beliefs and adaptations to environments, which shape individual and collective consciousness. According to Husserl, “the knowledge of things divides into direct knowledge and knowledge through aspects. Under this approach ‘essences’ (universal properties) are known directly, but perceptual objects are only known through their aspects. However, in addition to perceptual things, there are also mental things; these aspects are known through consciousness” (Spiegelberg, 1982; and Husserl translated by Gibson, 1931).

According to Bergen and Luckman (1966), “…Social constructionists do not believe in the possibility of value-free foundations or sources of knowledge, nor do they conceptualise a clear objective-subjective distinction, or a clear distinction

between 'knowledge' and 'reality'. The position, therefore, has profound implications for the practice and philosophy of science and for political philosophy…”(Bergen and Luckman, 1966: 35-36).

Sismondo (1993) suggested that the term ‘social construction’ does not necessarily have similar meanings from one person or group to another. The term may be used to draw attention to several different applications of how phenomena are understood, from different perspectives and counterparts (Sismondo, 1993). This has also occurred amongst researchers trying to construct the categories of meaning or content in a determined study (Sismondo, 1993). However, the commonality of constructionist theories and analyses is a concern with how people assign meaning to their world (Sismondo, 1993). As suggested by Burr (1995) and Gergen (1994), constructionists ‘generally’ accept the following conditions:

1. That all ways of understanding are products of culture, politics and history, and dependant upon the particular social and economic arrangements prevailing in a culture at a particular time;
2. That currently accepted ways of understanding the world are products not of the objective observation of the world, but of the social processes and interactions in which people are constantly engaged with each other; and,
3. That these ‘negotiated’ understandings can take a variety of different forms, and therefore it is possible to talk of numerous possible ‘social constructions’ of the world (Burr, 1995 and Gergen, 1994).

Each construction can invite a different kind of action from human beings, thus some constructions of the world can help to maintain some patterns of social action and exclude others (Burgess, 1992). The same author suggested that this could be viewed as a form of cultural politics, ()…"different groups representing sectional interests are locked in struggles over the meanings and values of plants, animals and landscapes threatened by development"…() (Burgess, 1992:236). The crucial issue inferred from this statement is that any group involved in a development process has been differentially empowered on the management of resources, maintenance of livelihoods and structures of organisation for their survival and well being (Burgess, 1992). Sismondo (1993) suggested that a “social constructionist approach accepts that ‘distinctly social’ processes are involved in the construction of institutions, knowledges and subjective realities and draws attention

to these social processes." (Burr 1995, cited by Larkin, 2003) identifies four basic assumptions of the social constructionist position:

1. A critical stance towards taken-for-granted knowledge - the world does not present itself objectively to the observer, but is known through human experience which is largely influenced by language.
2. Historical and cultural specificity - the categories in language used to classify things emerge from the social interaction within a group of people at a particular time and in a particular place. Categories of understanding, then, are situational.
3. Knowledge is sustained by social process - how reality is understood at a given moment is determined by the conventions of communication in force at that time. The stability/instability of social life determines how concrete our knowledge seems to be.
4. Knowledge and social action go together - reality is socially constructed by interconnected patterns of communication-behaviour. Within a social group or culture, reality is defined not so much by individual acts, but by complex and organised patterns of ongoing actions.

Within the above approach to social phenomena, SCT provides an epistemological and conceptual framework applied to the assessment of post-conflict environments like Guatemala. For instance, it is possible to assess the dynamic of the political power behind the implementation of the decentralisation process in the country and its degree of sectoral impact (adoption or rejection, advancement or reversal) in the health service provision model at the local level. Furthermore, SCT assists in the understanding of the complexities of the post-conflict environment embedded in such processes, their incidence in the degree of positive and negative impact, and outcomes at the national, regional but more specifically, at the local levels. For this research, the SCT framework is mostly oriented to the epistemological categories of knowledge, reality and experience at the local level. These three epistemological categories and their interwoven relationships are related to the Guatemalan case in the following way: first, the asymmetrical characteristics of the social economic, political, and cultural relationships especially in developing countries with the kind of political history like Guatemala; second, the ideological conceptualisations of the three approaches towards decentralisation in the implementation policies of the IFIs in developing countries, and their adaptation in a country with the socio-political, socio-economic

and socio-cultural characteristics of Guatemala; and, third, the political, economic, social and cultural complexities of post-conflict environments experiencing high and contrasting differences in the concepts and understanding of equity, justice, and political unrest in developing countries like Guatemala.

The SCT framework (in this thesis it is referred to as the epistemological and conceptual framework) is discussed below in relation to the methodological applications of Critical Historical Analysis, Critical Comparative Analysis, Critical Ethnographic Analysis as a part of Naturalistic Inquiry, and Peace and Conflict Impact Assessment. The four methodologies are inter-related by each level of analysis and the questions raised are answered throughout the thesis. The main objective of this process is to shape and design the conceptual categories of a comprehensive and alternative qualitative evaluation framework. This framework is established by contrasting and cross-examining the meanings of decentralisation, democratisation and participation within the scope of health sector reform and the complexities of the post-conflict environment in Guatemala.

2.3. Critical Historical Analysis (CHA)

Critical Historical Analysis (CHA) is part of numerous methodological approaches related epistemologically to the term 'critical perspective', which is used in various disciplines of the social sciences and is becoming an umbrella concept (Mercado-Martínez, 2002). Under this umbrella concept different theoretical positions have used CHA in conventional and unconventional ways (Marxist and neo-Marxist thought, conflict theory, social critical theory, postmodernism, and post-structuralism) (Mercado-Martínez, 2002). In other words, the 'critical perspective' denotes a group of epistemological approaches, which through CHA emphasise the questioning of the status quo and thus, these approaches attempt to confront injustice in a particular society or in public life within society. (Mercado-Martínez, 2002).

Critical Historical Analysis is either comparative or historical or both in micro or macro scope (Goldstone, 1997). It encompasses the logic and technique of how to make comparisons among cases, beginning with some critical analysis

embedded in the logic for macro-comparison throughout different time frames (Goldstone, 1997). Issues to be explored include formulating a research problem, use of theories and concepts, the logic of comparison and contrast, types of data, deployment of evidence, strategies of explanation, and modes of historical discourse (Goldstone, 1997). CHA examines evidence relating to a controversial historical or contemporary issue, where the researcher identifies the arguments advanced by various sides, differentiates between evidence and opinion, determines the values and motivations of the people involved, attempts to determine the credibility of source information by understanding the authors' values and motivations, and writes a narrative description (historical account) of the issue (Goldstone, 1997).

The CHA method is distinctively appropriate for developing explanations of macro-historical phenomena of which there are inherently only a few cases (Skocpol, 1984). This is in contrast to more plentiful and manipulable kinds of phenomena suitable for experimental investigations (Skocpol, 1984). In contrast to other phenomena where there are large number of cases required for statistical analysis, comparative historical analysis is the mode of multivariate analysis to which one resorts when there are too many variables and not enough cases (Skocpol, 1984).

CHA epistemological categories represent the first level of analysis of the comprehensive evaluation framework (CEF). This section presents the methodological framework for CHA and discusses the use of epistemological categories (retrospective, comparative and prospective) to evaluate the political and historical trends of the decentralisation policies in Guatemala. These trends are considered over a period of time and defined retrospectively, comparatively and prospectively (for example, its evolution in a given historical period, its current situation and its future perspectives based on the historical evidence). Thus, through this framework the research encompasses three main analytical-historical components for the construction of a CEF:

1. A retrospective, comparative and prospective review of the philosophical-ideological, political and legal framework of decentralisation policies over a specific period of history, including the current situation and future perspectives.

2. A retrospective, comparative and prospective review of the trends of conceptual decentralisation planning and implementation practices over a specific period of history, including the current situation and future perspectives.
3. A retrospective, comparative and prospective review of the level of the central political authorities' willingness or unwillingness to support organisational procedures and community-building capacities over a specific period of history, including the current situation and future perspectives.

The research inter-weaves the above retrospective analysis with historical trends and characteristics related to the current process of decentralisation in Guatemala and their future perspectives at the national, sub-national and community levels. These comprise another set of general qualitative indicators and as such a set of questions are raised to construct the qualitative variables and indicators. From this assessment a matrix was developed containing qualitative variables and indicators to represent the first level of analysis. The evaluation under the CHA includes the following parts: first, the structure of contents; second, the application of the methodological categories; third, the types of analysis undertaken; fourth, the findings anticipated; and fifth, the relationships between each set of variables, categories and indicators to be shaped and designed.

2.4 Critical Comparative Analysis (CCA)

According to Frendeis (1983), Critical Comparative Analysis (CCA) is a diverse and flexible methodology and only takes on a specific form when applied to the study of a particular phenomenon. Nonetheless the approach has several essential elements, and the intention is to summarise them in order to arrive at a deeper understanding of the perspective, and its consequences for validity (Frendeis, 1983). Wainwright (1997) suggests that at the core of CCA lies the application of dialectical logic. Essentially, the methodological approach addresses the relationship between objects and events in the material world and their subjective representation in human consciousness (Wainwright, 1997). The epistemology underlying this methodological approach views human beings not as purely physical entities, but as social ones full of socially constructed information on how they understand and act in the world, for example, language, concepts and categories (Wainwright, 1997). The problem for Füredi, (1990) resides in the gap between

socially constructed phenomena, as they exist in the real world and the equally socially constructed representations of those phenomena in the consciousness of the individuals. The key to this problem is the continuing process of change over time. The application of dialectical logic enables the researcher to recognise the historical specificity and social construction of prevailing phenomenal forms, in order to consciously transform them, and better satisfy our needs and wants (Füredi, 1990).

To summarise, although CCA is diverse and constantly developing, the following characteristics are essential to the approach: the application of dialectical logic; the critique or deconstruction of existing phenomenal forms and analytical categories that delves beneath the superficial appearances available to unaided common sense to reveal the network of social, political and economic relations that are the essential conditions of existence for comparative assessment of a current phenomenon; the exposure of previously hidden oppressive structures; and, a praxiological orientation in which knowledge is considered to be inseparable from conscious practical activity (Füredi, 1990).

Qualitative researchers using CCA tend to look at whole cases and they compare them with each other. Cases can be analysed in variables, or seen as configurations (as a combination of characteristics) (Ragin, 1989). Their interpretation accounts for historical outcomes or sets of comparable outcomes for study because of their significance for current institutional arrangements or for social life in general (Ragin, 1989). CCA seeks to make sense out of different cases by piecing evidence together in a manner sensitive to chronology and by offering limited historical generalisations that are both objectively possible and cognizant of enabling conditions and limiting means of context (Ragin, 1989). CCA is used to identify the similarities and differences amongst social units and cross-societal similarities and differences that constitute the most significant feature of the social landscape (Ragin, 1989).

Comparison extends beyond cataloguing and the similarities and differences described above by interpreting specific experiences and trajectories of countries (for instance, comparing and contrasting cultures, continuity and change over time

and cause-and-effect relationships) (Lieberson, 1991). CCA is applied to comprehend, from the cases themselves, rather than just between variables characterising broad categories of cases (Lieberson, 1991). This methodological applicability reinforces the tendency to use macrosocial attributes in explanatory statements (Lieberson, 1991).

CCA epistemological categories represent the second level of analysis of the comprehensive evaluation framework (CEF). This section explains the methodological development of Critical Comparative Analysis through the use of some of the SCT epistemological categories (comparative assessment of tendencies and trends indicating likeness and unlikeness, convergence and divergence, and positive and negative patterns). The epistemological categories analyse the structure of contents of electronic, bibliographic and documentary sources with regard to decentralisation policies, their multisectoral and sectoral impact on democratisation and participation issues in the country, and with particular attention to the health sector reform variable and the country's post-conflict or peace process as another variable.

The methodology for the evaluation's second level of analysis utilises an initial cross-examination process of specialised written sources focused on their rhetorical content statements and narrative categorisations and conceptualisations. The categories of content for the comparative analysis were constructed out of the following sources: international and national decentralisation policies, decentralisation laws, national development plans, the government's inter-sectoral and sectoral plans and programmes, the Peace Agreements, documents and statements by the Non-Government Organisations (NGOs), Community-based Organisations (CBOs) and other organised civil groups, critical international academic studies, and newspaper articles offering critique. The written sources represent different interests and agendas around the following categories of content: (a) the decentralisation policies; (b) the impact of multisectoral and sectoral policy issues; (c) in relation to the above, the features of health sector reform; and, (d) the features and trends observed in the post-conflict or 'peace-building process' in the country.

The comparative analysis addresses the relationships mentioned above at the macro, meso and micro levels, namely, international, national, sub-national and local levels. The evaluation also assesses the above categories according to their descriptive and analytical conceptualisations on the following themes: first, the features or characteristics of organisational structures of leadership, authority and management; second, the trends in the promotion or prevention of social participation or any other form of participation and involvement by the civil sectors; and third, the elements of the institutional or non-institutional methods of promoting and building democratisation. The analytical conceptualisations described above are integrated with the main ideas and definitions of the three ideological and conceptual approaches towards decentralisation: the MMA, TBSA and DPA (discussed in Chapters 3). Thus, their content profiles can be elaborated defining the most important features, elements and trends related to the categories of content and their developed themes. From this analysis, other conceptual categories or sub-categories are analysed and then interpreted as variables and indicators.

To carry out the relational process, the analytical questions focus on the behavioural elements intervening in the institutional and human resource conversion process through decentralisation at the national, sub-national and local levels. There are other important variables/factors that are addressed by the evaluation approach related to policy values in Guatemala and the complexity of the country's historical development throughout time as a post-conflict society. The analytical questions focus on the composition of planning and managerial attitudes and behaviours with regard to the political decision–making processes to carry out the implementation and follow-up procedures of international and national policies by the national institutions and organisations (including structural adjustment programmes, decentralisation processes, and institutional, physical and human resource conversion).

Thus, under the comprehensive evaluation approach, the decentralisation policy values are made explicit and understandable in their design, implementation and outcomes. By addressing existing values (professional, cultural and ideological), a clearer picture of the different manifestations of conflicts can be obtained and their solutions provided in the middle and long terms. For example, in the case of

Guatemala, recent decentralisation policy values have focused on individual responsibility and privatisation whilst public sector policy values have emphasised corporate responsibilities and promote collective responses to health needs. Therefore there has been institutional resistance from the public sector against decentralisation with regard to the new healthcare model. The questions address the kinds of decentralisation trends that exist and whether they lead to the conditions of national and local priority setting.

The comprehensive evaluation framework in this sense addresses some of the variables of the local political environment affecting development. Local governments are 'theoretically' willing to embrace, display and embody the virtues of transparency, accountability, participation and the effective use of resources, however such performance should be assisted, required and monitored by an informed citizenry (Luckham et. al. 2000). Civic society must successfully demand 'democratic governance or guarantees of an inclusive governability' and communities also have to participate and generate such a process from within (Luckham et. al. 2000). The community has to empower itself about local issues (such as budgets, legislative decisions, and treaties affecting basic rights) (Luckham et. al. 2000). The analytical questions address community involvement, organisation and control processes at the local level.

The evaluation approach addresses the key questions above, which require assessment in terms of both theoretical and fieldwork analysis for comparative validation. The evaluation would simultaneously develop and provide a systematic evaluation and monitoring system necessary for continued improvement and adjustment to changing circumstances. Consequently, the research has long-ranging policy and practice implications for the country. According to Demeritt (1998) "the comprehensive conceptual epistemology and the application of the methodology provide the insight to comparatively analyse social power and legitimacy of a particular discourse" (Demeritt, 1998). Hence, the discourses of some of the groups of stakeholders could be examined and contrasted as part of the social phenomenon of a post-conflict and highly polarised environment such as Guatemala.

2.5. Critical Ethnographic Analysis (CEA) as a Part of Naturalistic Inquiry (NI)

The epistemological categories under Critical Ethnographic Analysis (CEA) as a part of Naturalistic Inquiry (NI) represent the third level of analysis of the comprehensive evaluation framework (CEF). This section reviews some of the methodological categories of CEA as a part of NI. These are viewed as strategic steps to carry out research fieldwork as part of the comprehensive evaluation approach. Therefore, most of the information obtained and analysed comes from social interactions with different individuals and collective interviews. The scope of the methodological categories is oriented towards the Guatemalan reality. Thus, most of the multi-dimensional qualitative evaluation framework (categories, themes, variables and indicators) is constructed upon the country's experience with a particular emphasis on the micro level of analysis and the local socio-political, socio-economic and socio-cultural environment. CEA as a part of NI is a methodological approach related primarily to phenomenological experience. CEA as a part of NI is related to Grounded Theory as a qualitative research methodology (Crotty, 1998). Grounded Theory uses conversational activity, in which participants coordinate the presentation and acceptance of their utterances to establish, maintain and confirm mutual understanding (Clark, 1996; Cohen and Levesque, 1994; and Grosz and Sidner, 1990). The process by which they do this has been called 'grounding' (Clark and Brennan, 1991; Clark and Wilkes-Gibbs, 1990; and Clark and Schaefer, 1987 and 1989). Refraining from grounding results may be costly both in terms of time and effort (Paek and Horvitz, 1999; Traum and Dillenbourg, 1996; Brennan and Hulteen, 1995; and DiMarco et al., 1995).

NI is used as an ethnographic approach (CEA) to carry out socio-anthropological research and attempts to prevent 'control procedures' during research to distort the inquiry process (Clark, 1996; Cohen and Levesque 1994 and Grosz and Sidner, 1990). It places special attention on studying people in the situations where they usually interact and behave as they customarily do when engaged in their everyday activities and it approaches social groups without 'interfering' in what they say or do (Clark 1996; Cohen and Levesque, 1994 and Grosz and Sidner, 1990). Common assumptions guiding CEA as a part of NI are the following:

1. Naturalism - the belief that phenomena should be studied in its natural context (Lincoln and Guba, 1985 and 1986);
2. Phenomenology - the belief that the 'object-subject of interest' should be examined without preconceived notions or a priori expectations setting aside what might be expected in order to more fully understand the data collected (Foley, 2002); and,
3. Interpretive Nature - the belief that the researcher, while trying to see the situation from the point of view of those who are being studied, cannot escape from providing a personal interpretation of the situation (Cortazzi, 2001).

With regard to the application of the methodological category of 'Contextualisation' under the CEA as a part of NI, the individuals participating in the research should be viewed in their broad cultural and social settings as well as in their immediate scenarios at the local level (Pearce, 1989). Therefore, institutional categories based on formal knowledge could differ from those assessed by the research at the beginning of the methodological development (Pearce, 1989). Nonetheless, these differences may allow many possible construction frameworks of conceptual reality at the three levels of institutional and geographical context assessed by the comprehensive evaluation approach - the national, sub-national and the local levels (Pearce, 1989). Thus, the research should be carried out using an open approach in order not to reject or support a specific theory or assumption a priori in respect to the themes addressed (Pearce, 1989). The research should try to maintain accuracy through careful listening, limited talking, and immediate recording of the information obtained and feedback in order to achieve and maintain balance (Pearce, 1989).

With regard to the application of the methodological category of 'Trustworthiness' under the CEA as a part of NI, the researcher evaluator needs to show values of honesty and perseverance carefully and slowly reaching out and contacting different stakeholders and counterparts (Lincoln and Guba, 1985 and 1986). This will allow the researcher evaluator to simultaneously build up 'Credibility and Validity' (Rodwell, 1987). These other methodological categories under the CEA as a part of NI could be reinforced through subsequent communication through telephone, fax and internet exchange before, during and after the fieldwork process

is carried out with the different counterparts. In relation to the utilisation of the methodological category of 'Credibility', this could also be achieved by developing the following agenda:

1. Visits to high rank officials working with international and national institutions, agencies and organisations involved in the decentralisation process.
2. Visits to sectoral government authorities including sub-national and local authorities in the health districts and municipalities where the research is focused.
3. Visits to the personnel of NGOs to establish contacts with some of the members of the focus groups who participate in various collective sessions as part of the research development.

The aim of these visits and contacts should be to present the objectives of the research and to encourage the group to engage in active participation (Rodwell, 1987). In exchange, a consensual agreement should be reached in order to devolve and discuss the results. Upon completion of this initial and strategic approach, follow-up visits would allow for a more depth understanding of the context by creating rapport and empathy with the research participants (Rodwell, 1987). The use of lengthy in-depth interviews using guided conversation should help to build a relationship with the respondents based on trust and affinity (Rodwell, 1987). However the participants should also be allowed to prepare questions to be generated within the interview in order to extensively discuss the focus of the study if they wish to do so (Rodwell, 1987).

To ensure 'Dependability' as it is comprised under the CEA as a part of NI, it is important for the researcher evaluator to maintain the level of quality and reliability of the information obtained and the sources contacted (Smith, 1984). Therefore, information exchange should be carried-out through subsequent telecommunications and internet exchanges and other hyperlink communication tools as well (Smith, 1984). Chronological journal entries about observations, interviews, and anecdotes should be kept during the fieldwork and analysis developed from review and reflection of data written in the field journal (Smith, 1984). This is important in the case of Guatemala where views and opinions change rapidly because of the complexities of the political environment. The notes should be synchronised and synthesised as well as the sets of answers, lines of inquiry,

and participative observations, which should be constructed at various times with the different groups for further labelling and content categorisations (Smith, 1984).

With regard to the methodological category of 'Triangulation' under the CEA as a part of NI, this should be achieved through comparing data collection from the different groups interviewed and with the data sources gathered as part of the methodological procedures, and the researcher's point of view in the field (Fiadeiro and Mainbaum, 1993). In this case, comparing between the first and second levels of analysis, through the CHA, CCA methodologies, and the own ideas of the researcher. 'Validation' is another methodological category under the CEA as a part of NI involving the testing of ideas and theory and grounding them against different social settings (Schofield, 1993; Pitman and Maxwell, 1992; Wolcott, 1990 and Lincoln and Guba 1985). The above information would serve as an important means for Validation of the 'in situ information' directly handled by the researcher's evaluation fieldwork.

The evaluation process in Guatemala should apply a Critical Ethnographic Analysis (CEA) as part of the NI research experience in order to design a more comprehensive method of evaluating the decentralisation process in a post-conflict environment at the local level. Amongst the different approaches used by NI, the CEA as an epistemological approach is an analytical description of social and cultural situations, which are sought in order to 'give voice to mistreated people and those struggling for social change in local settings' (Foley, 2002). The CEA would assure that the findings are useful, of high quality, true to the respondents and reliable to develop the analysis with the data obtained (Lincoln and Guba, 1985).

Thus, the methodology for the third level of analysis should be based on the analytical categories, variables and indicators through the CEA in the following way: first, content analysis of the socio-cultural differences between the institutional management, organisational and traditional structures based on the system of beliefs and practices between central, sub-national and local levels. An examination of physical and conceptual planning to build, extend and re-adequate the infra-structural and human resource inputs and outputs. Also, the characteristics of organisational, human and physical structures and networks planned and

implemented as part of sectoral reform at the national and sub-national levels. Second, the content analysis from observations of ideological, professional, and cultural attitudes and practices which conflict with, support, or are indifferent to parts of, or the entire decentralisation process. An appraisal of social accountability mechanisms established to follow-up such procedures such as institutional auditing, normative bureaucratic liability and social participation. Third, critical analysis of the socio-political, socio-economic, and socio-cultural, trends, effects, outcomes and impacts of decentralisation related to the Guatemalan post-conflict environment (presenting the polarisation and differences in the points of view, the interests and agendas). This is a situational comparative analysis of the inter-relationships between the decentralisation process and the profile and trends emphasising the local settings about:

1. Vulnerability, understood as the constraints of organisation, spaces, skills and resources;
2. Poverty, understood as the lack of access to economic assets and means;
3. Inequity, understood as powerlessness and exclusion based on social, political, economic, cultural and gender position and status; and,
4. Sustainability, understood as the concrete possibilities of evolution and development in the middle and long terms.

The three analytical categories are used to shape the analytical questions under NI and hence, will be referred to as the NI categories in the text below. In developing some of the questions, all three NI categories will be used together while in other instances only one or two will be used.

Using Gergen's ideas (1994) based on Wittgenstein's notions of terms acquiring meaning; the above variables and indicators for the Guatemalan case should be shaped and obtained from three inter-connected and complementary sources. I did this by first, gathering and examining different bibliographic, electronic and documentary sources. The most recent information included: reports, documents issued by the MSPAS Health Area and District, the local reports and studies of municipalities, NGOs, and CBOs working as administrators and providers of the SIAS, and other community organisations collaborating with the process. Second, I gathered and reviewed the statements of various key sources representing different institutional and social sectors involved in the Guatemalan decentralisation process through a series of focus groups. These focus groups were

conducted with the actors directly involved in the Guatemalan decentralisation process including international financial institutions (IFIs), the United Nations System Guatemala Office, MSPAS, the Guatemalan High Commissioner for Decentralisation, the Secretariat for Peace (SEPAZ), international and national NGOs, Mayan organisations, Inter-Ethnic Co-ordinators, CBOs and communities. Third, I gathered and reviewed individual and collective statements applying methods such as focus groups and participative observation. The groups were approached in their own environments at the international, national and sub-national levels. The focus of the initial interviews with these groups was on how discursive practices are embedded in social relations of power and ideology, and how some power relationships will give authority to certain discourses whilst subverting others, revealing the possible implications of this for future policy and practice. (Bauman and Briggs, 2003; Goebel, 1998 and Smith, 1984). Through this, the research can initially explore the level of awareness about power and ideology by asking some retrospective questions (Glazer and Moynihan, 1975) in relation to the first and second categories of CEA as a part of NI as mentioned above.

The culture of violence has increased in a post-conflict society and affects most activities related to organisation, mutual co-operation and co-working between different groups amongst other socio-cultural variables inter-related to the socialisation process. Thus, the comprehensive evaluation in Guatemala should extend the depth and understanding of cognitive social and cultural knowledge. The question here is what concepts and attitudes towards organisational change and development in a post-conflict reconstruction environment exist (for example, passive resistance with alienation and/or accentuated mistrust and paranoia, which affect the level of community participation attained). An understanding of the relationships and meanings of societal change where the many years of civil war have impacted traditional social structures while certain cultural values and practices derived from them remain strong should be elaborated.

Due to the difficult task of restructuring relationships in a post-conflict environment the fieldwork concentrated more on the ideas, concepts and representations of democratic participation and the incorporation of traditional medicine into the SIAS. With this purpose medical, paramedical and community members working and residing in the selected rural municipalities were interviewed.

The focus was on institutional decision-makers (local administrators and elected officials), traditional decision-makers (chiefs and religious leaders) and groups that traditionally had not been represented in the decision-making process.

2.6. The Peace and Conflict Impact Assessment (PCIA)

The Peace and Conflict Impact Assessment (PCIA) epistemological categories represent the fourth level of analysis of the comprehensive evaluation framework (CEF). This section discusses PCIA as addressed by Bush (1998). It is used as the basis for the development of the elements and characteristics of the post-conflict environment. PCIA determines some of the key evaluation categories, variables and indicators in terms of the current and future complexities of the country's post-conflict environment. 'PCIA is a means for evaluating (ex post facto) and anticipating (ex ante as far as possible and according to a particular set of circumstances and cases), the impacts of proposed and/or completed programmes, projects or initiatives in conflict-prone, conflict and post-conflict environments' (Bush, 1998:2). PCIA looks at those structures and processes that strengthen prospects for peaceful co-existence, decrease the likelihood of violence, and continuation or recurrence of conflict-relationships (Hoffman, 2004 and Bush, 1998). Thus, PCIA attempts to address such problems or causalities in their different manifestations (political, social, economic, ethnic and cultural) (Hoffman, 2004 and Bush, 1998). Further, PCIA considers those structures and processes that may increase the likelihood that conflict will be dealt with through violent means (Bush, 1998).

PCIA was thought of initially as the kind of assessment, which would be useful for the design of a programme, project or initiative in order to ensure sustainability and comprehensiveness in the long term (Bush, 1998). PCIA would also be useful for complex appraisals (multi-level, inter-sectoral and extensive evaluations), reviewing critically the relationships of complex situations such as the ones underlying a post-conflict environment like Guatemala. Hence, PCIA is a methodological framework that differs from conventional evaluations because its scope extends far beyond the stated conventional and mainstream outputs, outcomes, goals, and objectives commonly evaluated in development (Hoffman, 2004 and Bush, 1998). It attempts to discern a programme, project or initiative's

impact on a peace, conflict-prone or post-conflict environment by constructing a conceptual and dialectic evaluative tool (Bush, 1998). PCIA should be applied when assessing processes and situations such as development activities in conflict-prone and post-conflict environments and contextualising the most important political variables intervening in such settings. However, this methodological approach as a valuable tool places attention on evaluating the outcomes of peace-building and social reconstruction processes (its achievements or failures) and the dialectical relationship between them in broader terms and according to the context (Bush 1998). For instance, a programme, project or initiative may fail according to limited development criteria (such as improvement in healthcare delivery) but succeed according to a peace-keeping and peace building criteria and vice versa (Bush, 1998).

According to Hoffman (2004) and Bush (1998) analyses, the PCIA stressed five areas of potential peace advancement and conflict impact, which should be applicable for a comprehensive evaluation of the Guatemalan case, with regard to sectoral decentralisation, post-conflict environments and its complex variables:

1. Institutional Capacity to Manage/Resolve Violent Conflict and to Promote Tolerance and Build Peace - Impact on the capacity to identify and respond to peace and conflict challenges and opportunities, organisational responsiveness, bureaucratic flexibility, efficiency and effectiveness, ability to modify institutional roles and expectations to suit changing environments, needs, and financial management situations.
2. Military and Human Security - Direct and indirect impact on the level, intensity, dynamics of violence, violent behaviour, insecurity, defence/security policy, repatriation, demobilisation and reintegration, reform and retraining of police and security forces/structures, disarmament, banditry, and organised crime.
3. Political Structures and Processes - Impact on formal and informal political structures and processes such as municipality, policy content and efficacy, decentralisation/concentration of power, political ethnicisation, representation, transparency, accountability, democratic culture, dialogue, conflict mediation and reconciliation, strengthening/weakening civil society actors, political mobilisation, impact on the rule of law, independence/politicisation of legal systems, human rights conditions, and labour standards.

4. Economic Structures and Processes - The level of impact on strengthening or weakening equitable socio-economic structures/processes, distortion/conversion of war economies, the impact on economic infrastructure (supply of basic goods, availability of investment capital, and banking systems), employment impacts (productivity, training, income generation, production of commercial product or service and food in/security), and impacts on the exploitation, generation, or distribution of resources, especially non-renewable resources and the material basis of economic sustenance or food security.
5. Social Reconstruction and Empowerment - Impact on the quality of life, constructive social communication (such as those promoting tolerance, inclusiveness and participatory principles), displaced people, in/adequacy of health care and social services, in/compatibility of interests, distrust, inter-group hostility/dialogue, communications, transport, resettlement/displacement, housing, education, and nurturing a culture of peace.

2.7. Summary of the Epistemological and Conceptual Approach towards the Development of an Alternative Evaluation Framework

SCT applied in this research has been oriented towards the epistemological categories of knowledge, reality and experience at the local level. These three epistemological categories and their interwoven relationships have been related to the Guatemalan case in the following way: in understanding the asymmetrical characteristics of relationships; in understanding the ideological conceptualisations of the three approaches towards decentralisation; and, in understanding the complexities of post-conflict environments experiencing differences in interpretation of the ideas of democratisation, decentralisation, participation and post-conflict in developing countries like Guatemala. Through SCT, the thesis is able to examine the visions for decentralisation, their interpretation and context at the micro, meso and macro levels. Related to SCT, the frameworks for CHA and CCA are used to identify and understand variables and indicators considering a retrospective, comparative and prospective review of the emergence and evolution of concepts, issues, trends and categorisations in their current application. CHA and CCA provide the thesis with the historical-political framework of understanding decentralisation in the health sector and the related variables and indicators. The CEA as part of the NI is applied in order to design a more comprehensive way of

evaluating the health decentralisation process in a post-conflict environment at the local level in Guatemala. Because of the nature of the historical socio-political and socio-cultural relationships, CEA is utilised as an epistemological approach, which is an analytic description of social and cultural circumstances, situations and interactions between groups.

The PCIA is a part of every aspect of this thesis because it reflects the nature and emergence of ideas in situations of conflict, post-conflict and peace. The importance of PCIA is that it addresses the gaps in the analysis of post-conflict situations, which are inherent to a system in transition by looking at the complexities of the conflict and the nature of political, economic, social and cultural inequities. PCIA helps to address the extent to which such a situation can be measured. PCIA is not presented as a level of analysis but rather as a condition of the evaluation in which the factors identified should be contextualised to arrive at a deeper understanding of the society which is being studied, an understanding based on the society's terms of development.

A more critical and cognitive analysis addressing socio-cultural differences between the institutional management and organisational and traditional structures are necessary. The analysis should reflect the system of beliefs and practices, mainly at the sub-national and local levels. It is necessary to systematise this kind of analysis for further evaluation exercises within the Guatemalan context and compare it with other experiences in other post-conflict environments in developing countries. Moreover, it is strategically necessary to evaluate how communities have perceived and understood the local decentralisation process and its impact. In the Guatemalan case, it is necessary to build-up a process of participative democracy linking the utilisation of resources with prioritisation of local needs through local organisation. Thus, community participation in post-conflict environments is a key variable.

The contribution of Chapter 3 towards that aim of the thesis is to review relevant literature on decentralisation in the health sector in Guatemala with a particular emphasis on community participation. The latter is emphasised because for a decentralisation framework to succeed reform and change should be imbedded

within a process of democratisation. In a post-conflict environment, this is viewed as essential for reconstruction at all levels of societies. At the local level, this is articulated through community participation. The knowledge obtained from the review of the generic literature demonstrates that decentralisation policies are imposed rather than negotiated in developing countries. The literature on post-conflict environments and change and reform processes remains weak, and not enough is known about the local experience from historical and transformational perspectives. There is a clearly identified need to bring together knowledge and experience, to measure the impact of a given process of change in a societal context. This thesis aims to do that by examining an alternative evaluation framework, which takes this into account. This chapter identifies the generic issues, which contribute to the design of the evaluation framework.

The literature review covers the health impacts in post-conflict environments, which enable an understanding of how health is perceived at the local community level and how this perception may differ from the institutional approaches to addressing health problems. This is done to define the context of health issues and thus justifying the kinds of variables that need to be identified in the development of a more comprehensive evaluation framework. This leads into a review of literature on the particularities of post-conflict environments in order to understand what influences such societies to develop or remain underdeveloped, how economic, social, political and cultural factors interact at diverse levels and what kind of society emerges after a conflict, what processes it embraces, what processes it disregards and what it is not prepared to embrace. Mainly, it is important to understand what has happened to that society during conflict, which defines it in the post-conflict period.

Chapter III
Review of Generic Issues Pertinent to Decentralisation, Evaluation and Health Sector Reform

3.1. The Basis for the Critical Review of Literature

In Chapter 2, I described the epistemological and conceptual considerations of the research under a theoretical framework. The framework has influence the way ideas and concepts emerge around the central themes of the research both from historical and political perspectives and how such ideas are elaborated and contextualised within an evaluative framework considering social, political, economic and cultural aspects of community participation in health sector reform. Chapter 2 detailed the use of a qualitative analysis approach as a point of departure to challenge the inherent assumptions of conventional (mainstream) evaluation approaches applied to a decentralisation process. Through the framework it is possible to identify how an evaluation model evolves using a more comprehensive construction of the analytical categories describing the decentralisation process in Guatemala. This is done through a multi-dimensional approach inter-relating socio-political, socio-economic and socio-cultural variables and factors by using the questions presented in Chapter 1. The categories of analysis are examined at the macro, meso and micro levels of Guatemalan reality, with an emphasis on the first level (macro) in order to construct the background of the country's situation.

In this chapter I will discuss the originality of the contribution of the thesis to the literature. According to Bush (1998) research represents qualitative comparative building blocks for an epistemological synthesis capable of identifying the strengths and weaknesses of socio-political and socio-cultural experiences and where they may be replicated or even, where they may fail to be replicated. Comparative results have come from an assessment of concrete policy impacts, implications and the lessons learned about decentralisation processes developed in such scenarios (Bush, 1998). However under a recovery and peace-building process, decentralisation is rarely addressed by current research (Bush, 1998). According to the same author, there have not been many studies on health community planning, monitoring and evaluation, and organisational behaviour (in this case community participation) in complex post-conflict environments. The importance of this thesis is to provide a studied experience of decentralisation policies in a post-conflict

environment at the local level. While there are many policy and programme documents, knowledge around decentralisation processes and how they work in the post-conflict environment is still weak. This research contributes to a further understanding of decentralisation through the identification and construction of variables based on institutional and general knowledge and the experience of the population.

The contribution of this chapter to the thesis is to provide an initial critical review of how the situations and processes could be addressed in order to expand the scope of the evaluation. It is a study of a process in a society traumatised by war and living through a difficult post-conflict period. The uniqueness of this experience is relevant to the whole of the study and the analysis that emerges leads to an understanding of the possibilities, limitations and potentialities of community participation and decentralisation as a development process.

By exploring the definitions and models of decentralisation the following is acquired towards the aim of this thesis: (a) a comprehensive review of the definitions and approaches to decentralisation in developing countries according to the WB and IMF criteria as the main IFIs behind the implementation policies of such processes; (b) an analysis of the context (of some of the main characteristics) of decentralisation in a post- conflict environment; (c) the identification of the need for an alternative evaluation framework which can be used to better understand the realities of a post- conflict environment and where further knowledge might be needed. The review of literature starts with an examination of some important characteristics of post-conflict environments. Other countries are not mentioned in detail in this analysis. The analysis is an examination of a particular country experience. The intention is to use the Guatemalan case as an example from which further comparisons could be done in future, as a comparative critical theory between countries with similar characteristics within their post-conflict environments. The purpose is to compare between conceptual ideas, institutional procedures and evaluation frameworks that have been used to assess particular complex situations and the middle and long-term impacts and effects of a civil war.

This thesis provides a qualitative comprehensive evaluation exercise-focused on decentralisation, where it is carried out in undemocratic, non-participative and polarised political, social and economic environments like the Guatemalan one. Thus, I as a researcher, provide a particular example of the Guatemalan experience because I have lived through conflict and post-conflict, and I am interested in exploring such an experience in-depth. This is an analysis of the health impacts of post-conflict environments to identify the breadth and depth of problems that could be addressed by health sector reform under a decentralisation framework. The definitions and models of decentralisation are then discussed in relation to both the WB definitions and the particularities of the post-conflict environment. This establishes how existing definitions and approaches are applied and considered under a conventional evaluation framework and how they should be considered under an alternative and more comprehensive evaluation framework relevant to the post-conflict environment. The WB documents 'Rationale for Decentralisation' and the 'Definitions of Decentralisation' (WB, ED1, 2004 and 2001)[1], are used to provide the general conceptual framework and to assess the lessons learned in relation to initial experiences of decentralisation from the evaluations that have taken place in developing countries.

The evaluation policies focus on four key development issues: macro-economic stability, poverty assessment, efficiency and equity (WB, ED1, 2004 and 2001). These issues have become the main parameters to initiate evaluation procedures with regard to decentralisation. This section also addresses the political dynamics, contradictions, constraints and possibilities of these evaluation policies with regard to decentralisation in developing countries. This section provides the thesis with an overview of the aims and objectives of evaluation based on the variables and indicators identified by the WB and the IFIs. Much of the literature review below will focus on the WB's own documents with regard to evaluation. This is done primarily because of the lack of literature around the thematic area, but also because these documents lay the foundation for the elaboration of evaluation policies and practice.

[1] They are cited as WB, ED1, 2004 and 2001 throughout the thesis. The WB website pages have lately been changed; see bibliographic reference in p.294 for more information.

3.2. Important Characteristics of Post-Conflict Environments

Decentralisation policies have often been implemented in conflict and post-conflict environments in developing countries with varying degrees of success. As Shepherd (1999) suggests, some similarities and particularities will always exist in any comparison of country experiences however, in post-conflict environments, the political, economic, social and cultural divisions in relation to international cooperation initiatives are manifested both overtly and subtly. Thus, it has been strategically important to understand the conflicting inter-relationships that exist in complex environments. The objective of decentralisation as the devolution of political power to the local levels has been to increase people's participation in managing development interventions over their own local affairs (Alegrett, 1997). However, in post-conflict environments such as Guatemala, this objective has hardly been achieved (FAO, 1997).

According to Slater (1989), there has been the 'delegation' of powers under new decentralisation policies however this has also been mismanaged and has resulted in experiences of co-optation, coercion, and corruption. Torres-Rivas (2000) suggests that the main reason for this has been the impact of the existing inequalities especially of power and resources from the state and the dominant elites. Thus, decentralisation measures in post-conflict developing countries have been 'seized and held' by national and local elites, preserving their political and economic status quo (Conyers, 1986). Lenihan and Iliffe (2001) suggest that the outcomes of decentralisation policies have been varied and are complex in nature because they are related to policy values and socio-political and socio-cultural conditions of the country. Traditional community institutions and organisations have been ignored, diminished in importance, or destroyed. According to Rosada (1987) some representatives who have been part of such community systems have already been incorporated into local formal or state government structures.

In post-conflict societies developing under a decentralisation framework such as Guatemala, decisions have been influenced either by polemic local politics or unexpected local situations (PRONICE/RED BARNA, 1998). Thus, the role of organisations working in conflict regions and the types of relationships that have developed within the social and cultural fabric of the society is important to analyse.

These have been seriously affected by the outcomes of war, violence and cycles of distress and trauma that the situation produces (PRONICE/RED BARNA, 1998). A number of sources have suggested that an analysis of these phenomena would provide an integrational perspective of inter-sectoral co-ordination, conflict-resolution strategies and negotiation amongst the local groups analysed through participative and inclusive consensual methodologies (Ahmed and Rafi, 1999; Dasgupta, 1999; Baer et. al., 1997). According to the same sources, this kind of analytical approach may provide the opportunity to better understand the nature of the relationships of the different institutions involved in decentralisation to community based organisations. The analysis should also consider how these sectors have related to power structures and the different perspectives, interests and agendas each 'actor' has held (Ahmed and Rafi, 1999; Dasgupta, 1999; Baer et. al., 1997).

Recurrent problems in post-conflict environments such as Guatemala include: (a) an underdeveloped centralised and militarised managerial and administrative system; (b) an over-concentration of political and institutional power under coercive voluntarism and authoritarianism; (c) a 'centralised decision-making power' causing a drain on resources including financial, human, information systems, and facilities, debilitating regions and communities; and, (d) an overwhelming number of unfulfilled functions accumulated in rapidly changing and unstable socio-political and socio-cultural scenarios (Stover and Rosenthal, 1997). Under the approaches towards decentralisation encouraged by the International Financial Institutions (IFIs), the idea of 'nation-wide uniformity' has been over-emphasised (based on the pre-eminence of macro-economic factors and variables) (PAHO/WHO, 1998; and Nsibambi, 1997). However the diversity of socio-political and socio-cultural perceptions, values and practices as well as the complexities of local post-conflict conditions have been ignored (PAHO/WHO, 1998; and Nsibambi, 1997).

In the case of developing countries like Guatemala, political, social and cultural differentiations are important characteristics in order to understand development or lack thereof, at the national, sub-national and local levels. According to Darquea (1999) and Kolodko (1999), any effort to implement decentralisation measures in situations which are highly complex and where a number of different variables need to be taken into account should include provisions for local

sustainability, equity and inclusion among its objectives. In this sense, it is crucial to determine the context of application and the relevant circumstances to be taken into account and to establish clear definitions of purpose, if any kind of decentralisation programme is going to be implemented at the local level which has been affected by conflict (Darquea, 1999 and Kolodko, 1999).

A few sources suggest that in post-conflict local environments such as Guatemala, decentralisation initiatives have not been carefully examined from different perspectives or in relation to the level of willingness of communities in terms of their social formation and capacity to participate in developing local programmes (Gutman, 1999 and Jackson, 1988). The local population has hardly participated in decentralisation initiatives due to previous experiences of feeling manipulated by central authority and negative experiences with development institutions (international co-operation, government agencies, non-government organisations (NGOs) and, churches amongst others) (Gutman, 1999 and Jackson, 1988). Therefore it is strategically important to create local collective consensus through negotiation in order to gain local support and confidence rather than responding through passive or active resistance from the local population sectors (Bryant, 1997 and Ortiz et. al. 1991).

According to Messer et. al. (1998) constraints have been imposed by conditions of multilateral or bilateral donors such as the IFIs, United Nations (UN), and European Union (EU) based on their particular visions of decentralisation. However functional and effective authority and power have been more difficult to develop in post-conflict environments such as Guatemala, in which local political and social power has been obliterated by a long lasting civil war and violence (Messer et. al. 1998). Community relationships, which have not been based on trust, have prevailed after the implementation of repressive policies of surveillance and control imposed in almost every realm of daily life (Messer et. al. 1998). Given this situation, the existing authority and the functions it carries out require attention so that there may be opportunities to develop leadership and organisational structures at the local levels (Messer et. al. 1998). The emergent leadership may be conceived as ‘customary (traditional structures of political power within the community), consensual (recognition of political authority through an internal community agreement) or promoted (recognition of political authority by internal community

agreement through a development initiative, objective or purpose) by internal and external forces (Messer et. al. 1998).

In post-conflict environments such as Guatemala, many complex factors, which can be considered as variables within an evaluative framework, impact on the orientation of sub-national and local governments. Thomas (1998) suggests three: first, the extent to which sub-national and local public authorities have represented the interests of their constituents within the political climate, which either, facilitates or restricts free popular expression, functional responsibilities and financial resources; second, the extent to which sub-national and local representatives are able to make decisions relating to the planning and implementation of human development projects and programmes; and third, sub-national and local governments often have had significant expenditure responsibilities in the areas of basic social services, but their concerns have tended to vary between localities, particularly between rural and urban areas. This problem is exacerbated in post-conflict environments because in many cases counter-insurgency strategies continue to impact on decision-making. Political intentions are also strategically motivated especially around the allocation of expenditure, development support and socio-economic aid (O'Donnell, 1998 and Thomas, 1998). Thomas (1999) suggests that -

> "…Without further change to local level priorities as determined by communities, any further decentralisation of responsibility for primary education, health, water supply and other basic services to the local level cannot be contemplated as a local development initiative either…"(Thomas, 1999:15).

In post-conflict environments, some problems associated with decentralisation have included the development and implementation of projects and policies which cannot be adapted to local realities, delays in support aid, and under-utilisation and sustainability of local resources (WB ED1, 2004 and 2001). The comparative priorities of different levels of government suggest that local governments, where devolution of decision-making power has taken place are likely to make expenditure decisions which satisfy the basic priorities of local human development (UNDP/HDR, 1993). Not only do local governments tend to focus on more basic (and cheaper) levels of provision, the evidence suggests that their

expenditure patterns as a whole are more oriented towards education, community amenities and healthcare (UNDP/HDR, 1993).

Thus, one of the main objectives of decentralisation at the grassroots level would be the promotion of political participation in public decisions in order to transform the nature of expenditure policies and revenue decisions affecting human development in rural areas (UNDP/HDR, 1993). However, this has been difficult to achieve in post-conflict rural areas of countries like Guatemala. The study of alternative forms of local development to analyse the concrete potentialities and constraints in the construction of a more participative and democratic decentralisation approach in developing countries is a key issue (Osner, 2004; Lustig and Legovini, 1999; and Sartorius, 1998).

The epistemological and conceptual framework discussed in Chapter 2 specifically addresses this scenario. Through the discussion of mainstream evaluation systems, an alternative approach is suggested based on the particular situations of a given post-conflict environment. The main contribution of this thesis is achieved by understanding these particularities and how they must be used to shape conceptual thinking about the problems and approaches of development. The alternative evaluation framework fills a gap in the literature by allowing the documentation and recording of specific experiences of post-conflict environments and through evaluation, shape policy and practice.

3.3. Health Impacts in Post-Conflict Environments

There have been more than 160 wars and armed conflicts since 1945 and most of these have taken place in developing countries. Currently, there are more than 50 wars and conflict situations and more than 90% of these are internal rather than between sovereign states (Summerfield, 1997). Since 1970, there has been a six-fold increase in the number of war refugees worldwide. They now number 1% of the global population and 90% of all casualties are civilians (Summerfield, 1997). Despite the growing number of armed conflicts and wars throughout the world, not enough attention has been paid to the local patterns of distress and the long-term health impacts and psychosocial consequences of the various forms of political violence against individuals, communities, or specific ethnic groups (Zwi, Fustukian

and Sethi, 2002 and Summerfield, 1997) The short or long-term impact assessments of complex-political emergencies (internal civil conflicts, cross-border and inter-state civil wars and transitional post-conflict environments) on civilian populations of poor countries have been scarce. Studies focussing on experiences of collective suffering and trauma-related disorders among survivors (mainly children and refugees) began to emerge more frequently in the scientific literature just in the last decade (Loughry and Eyber, 2003 and Summerfield, 1997). The medicalisation of collective suffering and trauma reflects a partial understanding of the relationships among critically important social determinants and the range of possible health outcomes of political violence in the middle and long run.

Effects on biomedical health during civil wars have been well known. These include short-term research such as a year-long study on the impact of infectious disease and health system breakdowns associated with refugees established by Toole, in 1997 (cited by Ghobarah et. al. 2003). Also, Gustafson et. al. (2001) documented war-related deaths from tuberculosis during the war in Guinea-Bissau. Roberts et al. (2001) reported war-derived disease deaths in the Congo during the war as 6 times greater than those from direct violence. However, longer-term impacts and the complex effects beyond the war period have been less clear. An important step forward has been the data analysis collected on a global basis by the World Health Organisation (WHO) during the 1990s (Murray and López, 1996). This institution estimated disease-specific disability rates for all countries (dividing the world geographically and epidemiologically into 14 regions). The WHO has used the disability rates to adjust available data on death rates at different age levels and life expectancy for each country (Mathers, et. al. 2000). Recently Ghobarah, et. al. (2004), using the WHO data analysis model described above, has further elaborated a general theoretical and evidence-based framework from cases from Eastern Europe, Africa and Asia. The model assesses the impacts and effects of civil wars and some elements of the post-conflict environment.

First, civil wars substantially increase the exposure of the civilian population to conditions that increase risks of disease, injury, and death. Prolonged and bloody civil wars are likely to displace large populations, either internally or as refugees. Bad food, water, sanitation, and housing make these camps into new vectors for infectious disease—measles, acute respiratory infections (ARIs), and acute

diarrhoeal and parasitic diseases (DPDs)—while malnutrition and stress compromise people's immune systems. Children may be especially vulnerable to infections (Ghobarah et. al. 2004).

Second, civil wars can threaten non-displaced populations putting them at greater risk. Diseases that become rampant in refugee camps may easily spread to other regions (Ghobarah et. al. 2004). Prevention and treatment programmes, already weakened by the destruction of healthcare infrastructure during wars become overwhelmed, especially when new strains of infectious disease increase. Violence is also likely to increase in the aftermath of long and severe civil wars (Pedersen, 2002 and Bracken and Petty, 1998 cited by Ghobarah et. al. 2003). Homicide and other crime rates rise within countries during international wars, tending to peak in the first year after the war (Stein, et. al. 1980 and Archer and Gartner, 1976 cited by Ghobarah et. al. 2003). There are psychosocial changes with the widespread availability of weapons and a general tendency for a culture of violence across all social sectors.

Third, civil wars constrain the level of resources allocated to the public health care system in their aftermath. Post-war governments face multiple competing demands for public expenditure. Also, according to Ghobarah et. al. (2004), long and destructive civil wars lead to problems such as: (a) reconstruction and environmental repair, (b) reform and rebuilding of the army and police forces, judicial systems, and administrative capacity, and (c) military and security expenditure increases. Pressure for military capability raises the classic question about trade-offs between military spending and non-defense needs such as public health (and DeRouen, 2000 and Mintz, 1989 cited by Ghobarah et. al. 2003; Adeola, 1996 and Ball, 1988). Thus, the direct effects of violence are the erosion of innovative health policies in favour of increased military expenditure, corruption, depredation, nepotism and clientelism (Zwi, 1991 and Zwi and Ugalde, 1989). Despite needs for better healthcare, the demands of post-war peace building and recovery make resource trade-offs involving healthcare spending hard to avoid (Collier, 1999 and Stewart, 1993 cited by Ghobarah et. al. 2003).

Fourth, civil wars reduce resource efficiency, which are allocated to public health, and those reductions in efficiency extend into the post-civil war period.

Destruction of health infrastructure that supported surveillance and control programmes for diseases produce long-term health problems (Ghobarah, et. al. 2004). Civil wars also deplete or drain the human and fixed capital (infrastructure and human resources) from the health care system. Rebuilding this kind of infrastructure is unlikely to be completed quickly in the post-war period (Ghobarah, et. al. 2004).

Nevertheless, there is still a lack of more comprehensive assessment frameworks on the negative health impacts in post-conflict environments (Pedersen, 2002; Bush, 1998 and Macrae, Zwi and Forsythe, 1995). There have hardly been any sectoral assessments designed to critically analyse the inter-relationships between decentralisation, democratisation, participation and post-conflict processes and who are involved in such processes and what agendas and interests they represent (Middleton and O'Keefe, 1998 and Putoto, 1997).

Some research around multimodal approaches has begun to surface, for instance, the ones carried out by Nelson, Simic, Beste, Vukovic, Bjegovic, and Van Rooyen, on Serbia in 2003; Giacaman, Abdul-Rahim, and Wick in Palestine in 2003; Mosquera, Zapata, Lee, Arango, and Varela on Colombia in 2001 and, Lanjouw, Macrae and Zwi on Cambodia in 1999. However, their work has mainly been focused on rehabilitation of institutional health systems and post-conflict settings, with some references to decentralisation, democratisation, participation and post-conflict. Their research includes documented impacts of different forms of violence on health and analysis of social and political factors, according to the particularities of the political, economic, social and cultural contexts. Although their analysis provide useful insights about what the main problems are in each context but the epistemological frameworks are still fragmented, because the scope of the analyses do not include comprehensive epistemological categories (socio-historical, socio-political and socio-cultural) in order to obtain a deeper critical analysis (Marmot and Wilkinson, 1999).

3.3.1. The Impact of the Civil War in Guatemala: The Problem of Health Indicators and General Health Profile

Fieldwork experience, analysis and reflection have been documented on the devastating impacts of the armed conflict in Guatemala. Such work includes socio-political, socio-economic and socio-anthropological research conducted by ODHAG/REMHI in 1996 from the Catholic Church, and CEH in 1999 by the UN as part of the recommendations under the Peace Agreement. Nevertheless, the work has been mainly focused on the traumatic effects of the civil war and not the post-conflict environment of Guatemala. These works also focused on the former conflict areas (departments with the most massacres). They have mostly applied qualitative psychosocial methodologies, with a collective (solidarity, women and children groups) rather than individual application. The work has mostly used psychoanalysis, critical psychology and transactional psychology as applied methodologies for the treatment of Post-Traumatic Stress Disorder (PTSD), and other forms of anxiety and depression (de León and González, 2001b).

These institutions represent different social sectors: grassroots and indigenous organisations, non-governmental organisations, civil society, human rights organisations, religious groups, multilateral and bilateral development agencies, specialised/professional agencies and groups, governmental organisations and secretaries, universities, and private organisations (examples include USAID, CAII, SEPAZ, COOPI, PNUD, UNICEF, UNESCO, Mental Hygiene League of Guatemala, Alliance Against Impunity, Save the Children, UVG, USAC, URL, PRONICE, HIJOS Guatemala and many more); (de León and González, 2001b). There have also been various meetings, seminars and publications with national and international scope, comparing and exchanging views about these themes (for example, Zepeda, et. al., 2004; ECAP/CUM-USAC/POC-GTZ, 2003; ECAP/ODHAG/IRCT, 2001; SCPCD, 2001 and ECAP, 2001). However, there has not been any comprehensive framework pulling together biomedical, psychosocial, socio-economic and socio-political evaluative research using quantitative and/or qualitative methodologies for the Guatemalan case. There has not been a comprehensive framework that could assess the long-term impacts and effects of the civil war (conflict and post-conflict traumas) even though the majority of the Mayan and rural population has presented with serious health problems.

This thesis presents an example of the difficulties and limitations to provide some basic information on the health impact in Guatemala during the conflict and the post-conflict periods. Three tables are presented containing the most important comparative statistical (quantitative) indicators on the health status of the population in Guatemala during the peak of the civil war and in the post-conflict environment. The tables are based on the database model developed by the WHO in the 1990s and updated by the WB in 2002, which also include some of the initial indicators elaborated by Ghobarah et. al. in 2003.

These tables are difficult to analyse for two reasons: first, substantial data is missing from them (no updated data was possible to obtain from the WB and WHO even though I approached them directly at their headquarters in Washington and Geneva). Second, the lack of reliable data makes it difficult to compare the country's situation throughout time (from year to year). Data in some instances is presented from the Ministry of Health and Social Welfare and from the National Statistical Survey (Appendix 4 provides the General Health Profile of the country from which some of the data is extracted as well). This data is presented to establish a profile of the country's health rather than to identify the specific particularities of health in a post-conflict environment. The latter is not possible to establish because data is identified from different years and not all years are directly comparable. While some data is collected in detail, other data is lacking or collected inconsistently. Therefore a general profile cannot be attributed specifically to the health particularities of a post-conflict environment. Further, there is no framework for directly comparing a general health profile to a post-conflict environment. The analysis of variables relevant to the post-conflict environment is lacking. The data below attempts to pull together different sources of information however the gaps are persistent and do not enable a consistent picture to emerge of health in a post-conflict environment.

Reviewing Table 1 from the WB, there is no data for the decades 1980 and 1990 with regard to financial indicators for investment in the health sector. This problem correlates with the peak of the civil war. There was no complete and reliable information for that time (including from the MSPAS and IGSS). Also, PAHO/WHO, the highest international technical body, did not have any indicators for that period. The little information that existed was in military hands and was considered confidential for national security reasons and never disclosed. Social

investment (in health and education) was moved from the civil sector to finance military counter-insurgency needs. Comparing the investment in the health sector for Guatemala and the average for the rest of Latin American and Caribbean countries and lower middle-income countries, Guatemala had the lowest level of health expenditure per GDP. However, health expenditure increased in Guatemala in 2002, due to increased public investment through the RSS and the implementation of the SIAS as part of the PAs.

Table 1 – Country Health Finance Indicators

Indicator	Guatemala				Latin American and Caribbean Countries (LAC)		Lower Middle Income Countries (LMIC)	
	1980	1990	1995	2002	1980	2002	1980	2002
Total health expenditure (% of GDP)	--	--	3.8	4.8	--	7	--	5.6
Public health expenditure (% of GDP)	--	--	1.4	2.3	--	3.3	--	2.6
Private health expenditure (% of GDP)	--	--	2.4	2.5	--	3.6	--	3
Public health expenditure (% of total health expenditure)	--	--	37.2	48.3	--	47.9	--	46.1
Private health expenditure (% of total health expenditure)	--	--	62.8	51.7	--	52.1	--	53.9
Per capita health expenditure (US$)	--	--	64	86	--	255.6	--	79.4

Source: WB - World Bank, Country Health Profile, 2002.

Reviewing Table 2 from the WB, the country health indicators for life expectancy for Guatemala for 1980 and 1990 are lower than those of the Latin American and Caribbean countries (LAC). They are also lower than those of the Lower Middle-Income countries (LMIC) for the different cohorts of the Guatemalan population. At the same time, mortality rate indicators for Guatemala are high for the same years in comparison with LAC and LMIC. In the case of Guatemala there is some data for 1995, which shows slight improvement in both life expectancy and mortality rate indicators when compared with 1980 and 1990. This could be associated to the peak of the civil war and its effect on the population mainly at the rural level, the lack of investment in the health sector described in Table 1, and the initial increase in social investment from the two transitional civilian governments after 1990, until the signing of the PAs in 1996. However, there is an absence of

information for the child and female cohorts for the same years. These cohorts were the most affected by the violence of the civil war in the case of Guatemala (for instance, they were most likely to be massacred in the conflict areas). There is no information for the other categories of countries therefore comparisons are not possible. While reasons for the missing data are not clear, a likely assumption is that the data is unreliable in most countries for those cohorts. Also, data is lacking for the cohort for the elderly, which could be due to the lack of reliable information and research. In contrast, in 2002, there is data available for Guatemala in most columns. This could be attributed to a baseline elaborated by the government in preparation for the PAs Follow-Up Technical Meeting in Washington DC in 2002 and data collected to assess the impact and the recovery process from Hurricane Mitch which struck the country. In November 1998, Hurricane Mitch caused heavy damage in 14 of the country's 22 departments, causing 106,000 people to be evacuated and taking the lives of 268.

Table 2 – Country Health Indicators

Indicator	Guatemala				Latin American and Caribbean Countries (LAC)		Lower Middle Income Countries (LMIC)	
	1980	1990	1995	2002	1980	2002	1980	2002
Total life expectancy at birth (years)	57	61	64	65	65	71	65	69
Life expectancy at birth – male (years)	55	59	61	63	62	68	63	67
Life expectancy at birth – female (years)	59	64	67	69	67	74	67	71
Total rate of infant mortality (per 1,000 live births)	97	60	49	36	61	28	61	32
Rate of mortality for children under age 5 (per 1,000)	139	82	64	49	82	34	84	40
Rate of child mortality – male (per 1,000)	--	--	--	--	--	--	--	--
Rate of child mortality – female (per 1,000)	--	--	--	--	--	--	--	--
Total rate of adult mortality	--	--	206	--	--	--	--	--
Rate of adult mortality – male (per 1,000)	336	311	--	286	228	222	234	214
Rate of adult mortality – female (per 1,000)	266	224	--	182	154	125	168	135
Rate of survival to age 65 – male (as % of cohort)	--	--	--	58	--	--	--	--
Rate of survival to age 65 – female (as % of cohort)	--	--	--	72	--	--	--	--

Source: WB - World Bank. Country Health Profile, 2002.

As mentioned, the general health profile is drawn from data from two sources – the MSPAS' Health Information Management System (SIGSA) and the National Statistical Institute (INE). According to SIGSA, a total of 53,486 deaths were registered in 1999, for a mortality rate of 4.8 per 1,000 inhabitants. For both sexes, the leading causes of mortality were pneumonia and diarrhoea, which in 1999 represented 22.3% and 6.0% of all deaths, respectively. Data from INE analysed in 1997 indicated that the major causes of mortality were communicable diseases (13%), external causes (13%), diseases of the circulatory system (12%), certain conditions originating in the perinatal period (8%), tumors (7%), and, all other causes (47%). Physicians certified 59.8% of all deaths. Under-registration was around 56%. Life expectancy was 67.2 years (64.7 years for men and 69.8 years for women). With regard to the situation of children between 0-4 years, in 1997 and 1999, the infant mortality rate was 37.7 per 1,000 live births, and 40.5 per 1,000 live births respectively. The rates for neonatal and post-natal mortality were 15.4 and 22.3 per 1,000 live births respectively. The infant mortality rate was 45 per 1,000 live births. In 1999, acute respiratory infections accounted for 40% of all deaths in children under the age of one, acute disease claimed 12% of children, and perinatal causes claimed 11%. The mortality rate in children between 1-4 years old was 14 per 1,000 overall (broken down as 9 per 1,000 in the cities and 20 per 1,000 in rural areas). With regard to the situation for schoolchildren between 5-9 years, in 1999, a total of 1,027 deaths were registered in this age group, for a rate of 0.6 per 1,000. There is no analysis to link this data to the health profile in the post-conflict environment.

Reviewing information in Table 3 from the WB, the first sub-category of indicators for Guatemala with regard to medical resources and usage, the ratios of medical personnel and bed availability per inhabitants are very low and the data is scarce. This reflects the lack of coverage, resources, infrastructure and overall efficiency of public health services. Another inference is that again there is no information for the years 1980 and 1990 when there was a lack of investment in and/or destruction of resources and infrastructure during the peak of the civil war.

Table 3 – Health Services Indicators

Indicator	Guatemala				Latin American and Caribbean Countries (LAC)		Lower Middle Income Countries (LMIC)	
	1980	1990	1995	2002	1980	2002	1980	2002
MEDICAL RESOURCES AND USAGE								
Physicians (per 1,000 people)	--	0.8	1.1	--	--	--	1.2	--
Hospital beds (per 1,000 people)	--	1.1	1	--	--	--	2.9	--
Inpatient admission rate (per 1,000 people)	--	--	--	--	--	--	--	--
Average length of stay (days)	--	--	--	--	--	--	--	--
Per capita outpatient visit	--	--	--	--	--	--	--	--
IMMUNISATION COVERAGE								
Rate of child immunisation - measles (% of children age between 12-23 months)	23	68	83	92	43	91	--	78
Rate of child immunisation – DPT3 (% of children age between 12-23 months)	43	66	77	84	37	88	--	84
Rate of child immunisation - BCG (% of children age between 12-23 months)	36	62	79	96	--	--	--	--
Rate of child immunisation – Pol3 (% of children age between 12-23 months)	43	74	80	84	--	--	--	--
Rate of child immunisation – HepB3 (% of children age between 12-23 months)	--	--	--	--	--	--	--	--
DISEASE PREVALENCE, TREATMENTS AND IMPACTS								
Reported cases of malaria	77375	41711	24178	--	--	--	--	--
Malaria treatment (% of population under 5 with fever being treated with anti-malarial drugs)	--	--	--	--	--	--	--	--
Tuberculosis prevalence (per 100,000 people)	--	--	--	49	--	--	--	--
Tuberculosis incidence (per 100,000 people)	--	--	--	77	--	67	--	128
Tuberculosis death rate (per 100,000 people)	--	--	--	12	--	--	--	--
DOTS detection rate (% of estimated cases)	--	--	44	45	--	--	--	--
Tuberculosis treatment success rate (% of registered cases)	--	--	--	85	--	--	--	--

Number of estimated deaths from AIDS	--	--	--	5200	--	--	--	--
Number of children orphaned by AIDS	--	--	--	32000	--	--	--	--
Prevalence of HIV – male (% of population aged 15-24 years)	--	--	--	0.85	--	0.47	--	0.98
Prevalence of HIV – female (% of population aged 15-24 years)	--	--	--	0.91	--	0.68	--	0.69
Total prevalence of HIV – (% of population aged 15-49 years)	--	--	--	1	--	0.67	--	0.7

Source: WB - World Bank. Country Health Profile, 2002.

In relation to immunization coverage for Guatemala, there is a good level of information. This is due to a fact that civil war immunization coverage was important in the countryside where it was used by the army as a part of the propaganda campaign and during the counter-insurgency strategy against the population in the rural communities. There is a noticeable and increasing difference in the figures between 1980 and 1990, and even more in 2002, where the country's averages are similar or a little better than those averages for the LAC and LMIC. The monitoring reports on vaccinations were kept and published by the state institutions. Data from SIGSA generally confirms this assertion. Diseases preventable by immunisation were also prevalent. The last case of poliomyelitis was reported in 1991. Epidemiological monitoring for the occurrence of acute flaccid paralysis continued during 1996-2000, when the system reported 49, 77, 51, 56, and 87 cases in those five years; none of them was confirmed to be polio. In 2000, the overall rate of acute flaccid paralysis was 1.7 per 100,000 in the population under 15 years. In 1996, there were no reported cases of measles; one isolated case occurred in 1997, but since then there have been no further cases. In the five years 1996-2000 there were reports of 128, 303, 171, 291, and 904 cases, respectively of unconfirmed measles. The numbers of reported cases of neonatal tetanus in the four years 1996-1999 were 17, 7, 5, and 2, respectively. In 2000, there were 6 cases and 3 deaths. Cases of pertussis increased during the period 1996-1999: 40 in 1996, 131 in 1997, 441 in 1998, 268 in 1999, and the age group most affected was between 6-9-year-olds. The 194 reported cases in 2000 represented 28% fewer cases than the year before. The last case of diphtheria was recorded in 1997. In 2000, there were five reported cases of tuberculous meningitis, one more than in 1999, with four deaths.

With regard to the prevalence, treatment and impact of diseases, again the information is scarce and it is not provided for most of the years indicated in the table. However, it is noticeable for Guatemala that, the cases of malaria was high for all the years (1980, 1990, and 1995), although they decreased by 50% during the period. Endemic diseases were high during the peak of the civil war. Again most of the information available in the columns of the table is presented for the case of Guatemala in 2002, which coincides with the establishment of the baseline by the government before the PAs Follow-Up Technical Meeting in Washington D.C. and the recovery process from Hurricane Mitch. The figures for the LAC and LMI countries are incomplete. Data from SIGSA confirms the above. Vector-borne diseases afflicted large segments of the population. In 1999, a total of 101,326 cases of malaria were reported and the annual parasite index was 12.2 per 1,000 of the population. Of the confirmed cases, 92% were attributed to Plasmodium vivax, 3.2% to P. falciparum, and 5.3% to 12 associated cases. In 2000, there were 109,874 reported cases of malaria (95.9%) compared to low incidence of P. vivax (4%) and P. falciparum (0.1%). In 1999, a total of 3,617 cases of dengue were reported (931.7 per 100,000 of the inhabitants, two cases of hemorrhagic dengue and one death). In 2000, there were 10,083 reported cases, 9,006 of which were clinically diagnosed as classical dengue (1,035 of them confirmed) and 42 were hemorrhagic dengue, leading to 9 deaths (case-fatality rate was 21.4%). The HIV/AIDS epidemic has been concentrated in urban populations and groups traditionally regarded as being at high risk. As of 30 June 2001, a total of 4,197 cases had been reported officially (35.9 per 100,000 population), and under-registration is believed to be as high as 50%. Seventy-four percent of the affected individuals are males and the 15–49 years age group is most vulnerable accounting for 87% of the cases. As of 1999, there were 141 known cases of mother-to-child transmission. A total of 266 cases of AIDS were reported in 1999 and 316 in 2000.

Therefore, it is very difficult to assess the health situation in Guatemala in the last 20 years using the statistical information available in the tables elaborated by the WB. From my fieldwork detailed in Chapter 7, the general opinion was that the accurate recording of statistics was a problem. While some discussion took place with regard to data recording and monitoring systems, participants generally avoided discussion about this topic on record. Off record, participants did raise this as an issue. The low quality of the information analysed above, makes it almost

impossible to determine the Guatemalan health profile throughout that period of history. This illustrates that large portions of the population do not have adequate access to healthcare. Before and since the signing of the Peace Agreements, demand for adequate healthcare increased beyond the capacity of the health system to satisfy it. Decentralisation in the health sector was occurring at a time when the health system itself had become under resourced and over burdened.

3.4. Definitions and Models of Decentralisation

This section describes the generic issues of decentralisation related to the three inter-related approaches to decentralisation. These are based on a critical discourse analysis of the definitions of decentralisation and a critical comparative analysis of the ideological contents of the World Bank's decentralisation models, their implementation policies and their combinations (modalities) in developing countries. In the context of health sector reform, the term 'decentralisation' is used to describe a wide variety of power transfer arrangements and accountability systems (WB, ED1, 2004 and 2001). Policies range from the transfer of limited powers to lower management levels within current health management structures and financing mechanisms to extensive sectoral reform efforts, which reconfigure the provision of even the most basic services (WB, ED1, 2004 and 2001).

The World Bank (WB) has defined four types of decentralisation models: Political, Administrative, Fiscal and Economic decentralisation, which, have also been implemented by other International Financial Institutions (IFIs) in developing countries (WB, ED1, 2004 and 2001). Based on the World Bank definition, political decentralisation is often associated with pluralistic political systems and representative government, but it can also support democratisation by giving citizens or their representatives more influence in the formulation and implementation of policies (WB, ED1, 2004 and 2001).

The aim of administrative decentralisation is to redistribute authority, responsibility and financial resources for providing public services among different levels of government (WB, ED1, 2004 and 2001). The three major forms of administrative decentralisation are deconcentration, delegation, and devolution. Through deconcentration, decision making authority and financial and management

responsibilities are redistributed among different levels of the central government, shifting responsibilities from central government officials in the capital city to those working in regions, provinces or districts, or field administration and local administrative capacity under the supervision of central government ministries can be created (WB, ED1, 2004 and 2001). Through delegation central governments transfer responsibility for decision-making and administration of public functions to semi-autonomous organisations not wholly controlled by the central government, but ultimately accountable to it (WB, ED1, 2004 and 2001). Devolution refers to devolved functions - the transfer of authority for decision-making, finance, and management to quasi-autonomous units of local government with corporate status (WB, ED1, 2004 and 2001).

With fiscal decentralisation, financial responsibility is a core component of decentralisation. Fiscal decentralisation can take many forms including (a) self-financing or cost-recovery through user charges; (b) co-financing or co-production arrangements through which the users participate in providing services and infrastructure through monetary or labour contributions; (c) expansion of local revenues through property or sales taxes, or indirect charges; (d) intergovernmental transfers that shift general revenues from taxes collected by the central government to local governments for general or specific uses; and, (e) authority for municipal borrowing and the mobilisation of either national or local government resources through loan guarantees (WB, ED1, 2004 and 2001).

The most complete forms of decentralisation from a government's perspective are privatisation and deregulation (or economic decentralisation). Privatisation can include (a) allowing private enterprises to perform functions that had previously been monopolised by government; (b) contracting out the provision or management of public services or facilities to commercial enterprises (c) financing public sector programmes through the capital market allowing private organisations to participate; and, (d) transferring responsibility for providing services from the public to the private sector through the divestiture of state-owned enterprises (WB, ED1, 2004 and 2001). Through deregulation the legal constraints on private participation in service provision are reduced or competition among private suppliers for services is promoted (WB, ED1, 2004 and 2001).

This discussion provides an understanding of the political, ideological and conceptual aspects of the definitions and models of decentralisation applied in the complex environments and post-conflict environments in developing countries. Stallings (1992) identified that the ideological and conceptual tendencies of the implementation policies of the decentralisation models applied by the IFIs were the following:

(a) The policies have been mainly market oriented under the neo-liberal vision about the effectiveness of globalisation and efficiency of privatisation;

(b) The policies have been mostly bureaucratically managed under the concepts of authority based on knowledge, organisational change and service responsibility;

(c) The policies have been similarly justified under the democratic rhetoric of 'open participative pluralism, egalitarian citizenship and active social inclusion';

(d) The policies have been simultaneously complementary (in pursuing similar benefits and outcomes) and contradictory (in the ways in which they have been implemented);

(e) Where decentralisation has been implemented, the theoretical concepts of the policies have not been completely equal to the institutionalised practices and vice versa, and their objectives have not been completely in tune with the results that were intended to be achieved; and,

(f) The IFIs and the governments of the developing countries' have yet to thoroughly evaluate the structural constraints (and the possibilities) of decentralisation policies in conflict and post-conflict environments.

It is evident therefore, that the policies were based on a number of assumptions including (a) the presence of dynamic social and economic sectors within countries; (b) that such sectors participate in society on an inclusive basis; (c) that political systems are also effective as management systems; (d) that democracy is a developed and imbedded process; and, (e) that historical relationships of the diverse sectors of the population pursue similar socio-economic objectives and that there is general consensus. However, the conceptual framework does not take account of the impacts of the post-conflict environment on decentralisation policies namely exclusion and political corruption. The experience of evaluation of decentralisation in post-conflict environments, as suggested, is missing.

According to Stallings (1992) the ideological contents and conceptual meanings of the decentralisation models and their implementation policies can be conceived as three general but inter-related approaches:

1. A Market Mechanism Approach where decentralisation is a mechanism oriented to the promotion of market relations and these relations are perceived as the engines of development.

2. A Techno-Bureaucratic Approach where there is managerial control with decentralisation serving as a system of redistribution of development and well being based on expertise.

3. A Democratic Participative Approach where there is a strategy of socio-political and socio-cultural change, with decentralisation perceived as a shifting process of development and power.

The inter-relationships between the three approaches are based on (a) the objectives of implementation and the anticipated or realised results that have been brought about; (b) by the institutional and organisational sectors that have been managing the decentralisation processes; and, (c) by the kind of institutional, political, economic, social and cultural sectors that have either, favoured or disrupted the development of these policies (Stalling, 1992). With regard to the nature of the three approaches, they can be used as analytical tools in order to understand the ideas behind the trends and implications of decentralisation policies in developing countries (Stalling, 1992). This is especially significant in the development of an evaluation framework to assess the objectives, practices and outcomes of decentralisation in post-conflict environments (Stalling, 1992).

3.4.1. Decentralisation as a Market Mechanism Approach

The rationale to establish decentralisation as Market Mechanism Approach (MMA) stems from the need to have a method which allows for the achievement of market features within a given system of development (Cole, 1999). The MMA has been used to establish, enhance and/or expand a market element in the economies of developing countries (Cole, 1999). The policy of modernisation of any developing country essentially involves the promotion of private enterprise and capitalism (Cole, 1999). Progress and economic development is viewed as a consequence of the benefits of modernisation, its trickle-down effect and the competitive dynamism of

market relationships (Cole, 1999). The market has its direct and indirect means or mechanisms to recreate the nature of reproduction and exchange through structural adjustment policies, fiscal management and privatisation (Cole, 1999).

Decentralisation policies also enable market cycles to develop in random and/or sequential ways (Bennett, 1994). The ideas of post-modern utopianism (improved competitiveness to reduce the risk of an open economy and expand opportunities for material progress with an emphasis on an increasing supply of human capital and the development of social and political capacities for decentralised co-ordination) under the MMA appear to expand the scope and depth of 'concerns for equity' with a host of complementary public policies and social programmes (Ratinoff, 1999). However, free-market ideology has the effect of reducing of development and potential impact of social policies and in this framework lead to the creation of 'transitional safety nets' (Ratinoff, 1999). According to the same author class conflict is apparently replaced by pragmatic 'concerns for economic-efficiency' and 'expanded consumption potentials', which are perceived as the real and effective 'political pacifiers' and 'social compensators' of unresolved historical-structural problems in developing countries.

The three authors cited here argue that the MMA can serve to stimulate the market through private enterprise, economic modernisation and trickle-down under a free market ideology. The risk of the MMA in a post-conflict environment in increasing levels of poverty and underdevelopment is high. Under the MMA, the contents of the neo-liberal policies used by the IFIs in their Loan and Project Development Programmes have had the following impacts: (a) reshaping macro-economic features through monetary reforms and balance of payments discipline; (b) dismantling public structures through decentralisation processes; and, (c) modifying economic productivity levels through technological and labour inputs and outputs (Workman, 1997 and Barnum et. al. 1995).

The market policies under the framework of the decentralisation policies with regard to the deconcentration, delegation and privatisation of the public sector have been ideologically justified under the following measures: (a) to streamline services; (b) to make decisions faster and more relevant based on cost-benefit assumptions; and, (c) to attract and increase the number of 'customers' providing more effective

and efficient services (IMF/WB, 1998). According to the content of these policies, privatisation is used to transform social services from being 'paternalistic, duplicated, and inefficient into ones which are specialised, competitive and efficient in order to satisfy increasing demand' (IMF/WB, 1998). A number of sources suggest that the progressive transference of services, from the public to the private sector, and the opening up and expansion of markets as 'driving forces' have occurred under a tight set of regulations attached to this type of vision for decentralisation (Litvack et. al. 1998; Ranis, 1997 and Tanzi, 1995). What is decentralised here is the transfer of power from central government to the private sector. Through the critical historical analysis it is evident that in the post-conflict environment of Guatemala there is very little difference between the groups, which comprise central government and the groups associated with the private sector.

3.4.2. Decentralisation as a Techno-Bureaucratic System Approach

The rationale for establishing decentralisation as a techno-bureaucratic system approach (TBSA) in developing countries has stemmed from ideas about the role of human institutional, technical and bureaucratic networks, managing and redistributing development resources to different sectors of society. The structural transformation of society and any attempt to modernise it, is mainly characterised by both an 'improved technological capability and social justice', and both have to be managed by experts, economists and development theorists (Cole, 1999). Within this vision, organisational structures, 'specialised expertise', and bureaucratic authority (statutory powers) have been recognised as the historical subjects to carry out any decentralisation process (Cole, 1999). The approximated definition of techno-bureaucracy using the theoretical framework of sociology of organisation is related to those social and cultural descriptive characteristics, which derive from the occupation of a position of office within a hierarchical structure and from the powers that reside in the office (Cole, 1999).

According to the same author, institutional power and authority has been given to the IFIs' political and technical organisational structures by the developed countries. Further and as suggested by Cole (1999) these structures have been 'recognised and legitimised' by the rest of the international community as financial recipients through extra-coercive measures. The most common of these measures

are the global and regional bilateral and multilateral trade agreement and financial aid packages by bilateral and multilateral agencies (Furtado, 2001; Bloom, 2000; Cole, 1999 and Haggard and Kaufman, 1992). Thus, technical bureaucracies, as suggested by these authors, are in charge of the conceptual design, planning, implementation and monitoring of decentralisation policies in developing countries. The objectives of conceptual planning categories have been: increasing efficiency, cost-effectiveness and performance management (Furtado, 2001; Bloom, 2000; Cole, 1999 and Haggard and Kaufman, 1992). However, decentralisation under TBSA has been implemented at a slower pace than the MMA and has often been combined with the MMA (Furtado, 2001; Bloom, 2000; Cole, 1999 and Haggard and Kaufman, 1992). The TBSA has been mainly directed to sub-national and local governments, after the MMA has been applied at the national and central government levels as part of the whole structural adjustment process directed to transforming the public sector (Furtado, 2001; Bloom, 2000; Cole, 1999 and Haggard and Kaufman, 1992).

Some aspects of policy-making and implementation tasks have been transferred from direct central control to regional and local controls, such as programming, budgeting and evaluation among others (Grebe, 1996). According to Kolehmainen-Aitken (1999 and 1998) and Aitken (1997) under this approach and in cases where there have been positive outcomes, it has taken many years to develop the skills and the support between the central and sub-national levels before the desired outcomes are achieved. According to these authors, the IFIs have negotiated the political and technical responsibility with central governments and their institutional bureaucracies through multilateral agreements where the aim has been to carry out socio-economic structural changes. Further, these authors note that these international bureaucratic networks exert authority directly and/or indirectly according to the institutional and power-knowledge that exists within the national bureaucratic networks in the developing countries. Thus, these kinds of techno-bureaucratic relationships are institutionally verticalist, unequal and subordinated (Kolehmainen-Aitken, 1999 and 1998 and Aitken, 1997).

It can therefore be suggested that the inter-relationship between the TBSA and MMA approaches, within the context of Guatemala, has these characteristics: (a) under the TBSA the aim is to strengthen the institutions of society based on

improving skills and expertise however in the post-conflict environment the notion of the legitimacy of institutions should be addressed before institutional capacity issues are addressed; (b) under the TBSA, it is assumed that local people have forged strong relationships of exchange with institutions however such relationships are affected by a number of variables including inequality and exclusion; (c) a number of adverse impacts have been evidenced under structural adjustment policies especially in terms of how different sectors interact with one another and in the levels of financial constraints faced by local governments and these factors together can serve as inhibitors in progressing certain policies under TBSA; and, (d) a strong public sector should exist in the first instance.

3.4.3. Decentralisation as Democratic Participative Process Approach

The rationale for establishing decentralisation as a democratic participative process approach (DPA) in developing countries has stemmed from the ideas about the political and social involvement of different population sectors in planning, management and accountability processes of decentralisation (Cole, 1999). The institutions of daily life have to be transformed to operate according to democratic principles with clear lines of accountability to the community and any activity must be analysed to ensure that those in authority address the changing needs of people (Cole, 1999). According to the same author, the DPA recognises the need for practical and strategic procedures to build-up and promote political and organisational capacity based on local experience. Further, the same author notes that development policies depend upon improving communication, listening to others, conceptualising people's experiences and insights, diagnosing needs, analysing problems, and interacting and planning activities with people, teams and organisations.

According to Cole (1999) the DPA has focused on the progressive appropriation of policies, resources and processes of decentralisation by critically addressing the complexities of the relationships between macro-economic and micro-economic planning policies in developing countries. The main objectives under the DPA have been (a) to achieve a more compensatory and equalitarian community based model of decentralisation; (b) to work to lessen the adverse socio-political, socio-economic, and socio-cultural consequences caused by neo-liberal

globalisation policies or unequal structural changes; and, (c) to improve the articulation of the institutional and organisational structures of central and peripheral management and social community networks at local levels through the exertion of power (Cole, 1999).

Another ideological characteristic of DPA is that it has been used to create political consciousness around the impact of globalisation under neo-liberal policies in developing countries (Shah, 1998 and Baer et. al. 1997). The DPA is based more on the degree of inclusiveness, supporting active participation, grassroots devolution and increasing appropriation because it uses the rhetorical concepts of plurality, social wealth and human capital, and shared financial resources for community social services and political grassroots development (Evans, 1997). Nevertheless, this approach has 'failed' to address other realms of community life and according to some experiences of decentralisation in developing countries, some of the assets a community has are more collectively shared and utilised at the local level (Evans, 1997).

The three approaches are inter-related, and this is most evident in the levels of potential application (national, sub-national, local and private). However, in the post-conflict environment of Guatemala the implementation of decentralisation policies has not entirely depended on the inter-relationship between the three approaches, but how the relationship(s) between the MMA and TBSA have been articulated in policy decisions particularly at the central and national level of authority.

3.5. Evaluation of Macro-economic Problems

The WB and other IFIs have indicated that macro-economic problems have been due to the lack of adequate fiscal and development planning decisions, as well as the absence of inter-institutional co-ordination between the central and the sub-national governments (WB, ED1, 2004 and 2001). Alternatively, some experiences with regard to the 'dialectics of political power and its imbalances' between central and peripheral authorities in developing countries have shown that sub-national influence over macro-economic conditions has some times been 'desired albeit ambiguously to compensate for this problem' even though it has created further

imbalances in the overall economic structure of the countries (WB, ED1, 2004 and 2001). For instance, sub-national governments have accumulated unsustainable debts and had to be bailed out by central governments due to the lack of financial monitoring mechanisms (WB, ED1, 2004 and 2001).

However, in many cases the contrary has also been evident in that, (a) the WB and the other IFIs have stated that programme development and planning expenditure has fallen short of expected and required levels for sub-national and local governments; (b) the IFIs have done little to evaluate the impact on factors such as reducing the levels of mismanagement, corruption, nepotism and clientelism as these practices are still generalised and rampant at central government level; (c) the vicious circle of dependency of sub-national and local governments on central governments and its institutional bodies should also be evaluated; (d) local authorities have needed to breakdown the system of vested interests that is operated by central authorities; and, (e) by maintaining autonomy and manipulating decentralisation policies, central government has continued to operate for special interests (WB, ED1, 2004 and 2001). The above situations are exacerbated in post-conflict environments in which, financial resource allocations are made based on strategic political policy objectives.

Bah and Linn (1994) suggest that central governments have been rescuing or renegotiating the debt payments with international and national lenders in order to continue receiving financial support. Alternatively, the arbitrary political decisions between the IFIs and central government have created cycles of economic recession, social disenchantment and frustration for local authorities and the population in general (Bah and Linn, 1994). Central governments have attempted to resolve their fiscal imbalances by decentralising expenditure responsibilities without the matching revenues subsidising and refinancing sub-national disparities (Bah and Linn, 1994). A ‘contradictory’ macro-economic relationship has emerged where sub-national deficits have seriously jeopardised the development perspectives of those regions and communities due to the lack of accurate mechanisms for accountability and this situation has caused macro-economic hardships in terms of the financial profile of the country (da Costa Pinto Neves, 1997).

According to Schacter (2000) a more direct social accountability is needed where the population is included at a socio-political level by monitoring progress in strategic areas. However in most developing countries experience has demonstrated that the reinforcement process for establishing procedures for strict budget constraints, strong management, fiscal discipline and monitoring accountability have been difficult to achieve (Schacter, 2000). Furtado (2001) suggests that strategic information and training on how to combine legal, institutional, social and cultural frameworks to complex country environments is lacking. Through these combined frameworks, if they existed, there would be an effective and collective management system to oversee and evaluate the outcomes of fiscal and economic policies at the macro, meso and micro levels (Furtado, 2001).

The WB argues that there has not been shared and regulated responsibility or accountability between sub-national and central authorities (WB, ED1, 2004 and 2001). Vertical imbalances in favour of national governments are likely to be 'resolved' by national governments while imbalances in favour of sub-national governments lead to large national debts, and to insufficient fiscal discipline at sub-national levels (IMF/WB, 2001 Bordignon, 2000). One main structural problem is the chronic inability of central bureaucracies to disburse budget allocations and obligations to sub-national and local governments (IMF/WB, 2001 and 1999). A main political problem is the danger of corruption of political elites using the available fiscal and financial resources to their advantage and developing 'pervasive clientelism' in those regions and localities (IMF/WB, 2001 and 1999).

There has been no clear or automatic relationship between decentralisation and economic growth in developing countries (WB, ED1, 2004 and 2001). For instance, Weisbrot, (2002) and Davoodi and Zou (1998) indicated that decentralisation within the globalisation framework has a negative relationship on growth in developing countries. Even the WB has argued about several methodological problems in various studies; much more research is needed to validate the conclusions around the decentralisation and growth relationship (WB, ED1, 2004 and 2001). Nonetheless, the overall problem with the above view is that decentralisation has been considered 'the key factor' in either, producing a significant improvement in the levels of 'socio-economic efficiency linked to macro-economic growth', or 'exacerbating the deficits and instability connected to macro-

economic growth' (WB, ED1, 2004 and 2001). However it is necessary to examine whether the objectives of decentralisation become mired in 'public institutional constraints' from the perspective of technical expertise, or is it strategically necessary to include 'extra-macroeconomic variables' such as socio-historical, socio-political and socio-cultural to have a better understanding of the relationships in developing countries (WB, ED1, 2004 and 2001).

Experience has demonstrated that there have been other overwhelming political factors impeding macro-economic growth (Kullenberg, Shotton and Romero, 1997). These political factors have been linked to power, poverty and equity issues in developing countries emphasising regional and local disparities (Kullenberg, Shotton and Romero, 1997). Adequate financing and clear delineation of new financial mechanisms have been essential in defining any decentralised service model (Kullenberg, Shotton and Romero, 1997).

3.6. Evaluation and Poverty Assessment

The IFIs, the UN and other multilateral and bilateral international development agencies have also introduced policies aimed at poverty reduction. In 1999, the World Bank Group and the IMF determined that nationally owned participatory poverty reduction strategies should provide the basis of all their concessional lending and for debt relief under the enhanced Heavily Indebted Poor Countries Initiative (WB, ED1, 2004 and 2001). This approach, building on the principles of the Comprehensive Development Framework, has led to the development of Poverty Reduction Strategy Papers (PRSPs) by country authorities for submission to the Bank and Fund Boards (WB, ED1, 2004 and 2001). There is no blueprint for building a country's poverty reduction strategy however the process should reflect a country's individual circumstances and characteristics (WB, ED1, 2004 and 2001).

There are four key steps that typically characterise the development of effective poverty reduction: first, an understanding of who the poor are, where they live, and the barriers to moving out of poverty is key. Second, the multidimensional nature of poverty (low income, poor health and education, gender, insecurity, and powerlessness) needs to be carefully considered. Third, a solid understanding is needed of the nature and causes of poverty in order to prioritise macroeconomic,

structural, and social policies. And fourth, an appropriate framework for selecting and tracking measures to indicate progress for chosen poverty outcomes is needed to test the effect of policies and programmes and make adjustments as needed (WB, ED1, 2004 and 2001). Poverty Reduction Strategy Papers (PRSPs) have the following technical elements: (a) comprehensive poverty diagnosis with costed priorities for macro-economic, structural, and social development policies; (b) appropriate targets and indicators for monitoring progress; and, (c) descriptive analysis of the participatory process for obtaining poverty information from different resources (WB, ED1, 2004 and 2001).

A number of sources including the IFIs technicians (IMF/WB, 2001; Bordignon, 2000 and WB, 2000) and among other independent researchers (Furtado, 2001; Crook and Severrison, 2001 and Bossuyt and Gould, 2000) have critically reviewed recent experiences in developing countries where PRSPs comprehensive poverty diagnostics have taken place. The IFIs observed that the PRSP profiles from developing countries contain out-of-date socio-economic data and limited disaggregated household survey data (WB, ED1, 2004 and 2001). However, the above mentioned authors have identified the following reasons for these problems: (a) political and social turmoil and cycles of instability; (b) information control systems under counter-insurgency; (c) general mistrust of the population in providing information; (d) institutional and bureaucratic incapacity to generate accurate information; and, (e) intentional institutional tactics to generate misinformation and manipulate procedures in order to intervene and disrupt the management of information systems.

The above authors have also argued that it is necessary to address the political issue of 'hiding information' by different institutional and social actors responsible for providing information in the first place. Amongst the reasons for this institutional behaviour are: protection of vested political and electoral interests, demagogy, mismanagement of resources, and political corruption (WB, ED1, 2004 and 2001). However other researchers and international NGOs and the Human Development Reports by the UNDP (over the last five years) have started to support the inclusion of indicators, which have not yet been included within a broader framework for evaluation, drawing links between socio-economic development and poverty (HRCA, 2001). For instance, the human rights status, the country trends and

incidence of violations are a part of the pervasive conditions of poverty in developing countries (HRCA, 2001 and Wunsch and Olowu, 1997 and 1996).

Thus, a more political approach to socio-economic development and poverty may be based on human rights, governance, democratisation and equity issues (HRCA, 2001). Social investment (either from public or private sources), particularly in health and education has been politically oriented in favour of the middle and upper classes, instead of the urban and rural poor (HRCA, 2001). Investment in these kinds of 'formal political and legal structures' reinforces corruption and impunity, perpetuate political instability. In the worst scenarios, it can cause cycles of violence and war to continue (ASP/SNU, 2000). While it is primordial to address poverty and exclusion, promoting political investment and reinforcing justice and stability in the long-term, the IFIs evaluation procedures and policies have yet to address these perspectives (HRCA, 2001 and Conyers, 1986).

Furthermore, a comprehensive approach to assessing the historical and political causes of poverty in conflict and post-conflict environments in developing countries has become essential to achieve concrete democratic changes and development (Dodd and Hinshelwood, 2002). Following the discussion about poverty, the WB and the IFIs have confirmed the importance of descriptive analysis involving different social sectors as part of the participatory process to obtain information on poverty from different resources (WB, ED1, 2004 and 2001). They argue that descriptive analysis have considerable variance in terms of understanding the extent and quality of participatory processes undertaken by these sectors in developing countries under the PRSPs strategy implemented by the IFIs (Dodd and Hinshelwood, 2002). However, it is crucial to examine the hierarchical, institutionalised and authoritarian tendencies of political power in most developing countries because these tendencies have limited the establishment and practice of more democratic and innovative forms of participation to generate and manage critical information about poverty (Atkinson et. al. 2000). It is evident that the IFIs would have a more positive role by curbing political domination, controlling vested interests and overturning generalised social exclusion policies as part of the structural constraints managed by the state apparatuses in developing countries (Jiménez, 1999). In my fieldwork I consider the descriptive analysis in relation to key

variables in order to make significant progress towards the comprehensive evaluation framework.

Another issue to assess is the omnipresent state political power structures, which has either encouraged or discouraged any form of democratic participation and organisation by impoverished sectors of the population (Atkinson et. al. 2000). In addition, the disclosure of information on socio-economic data, from national and sub-national authorities has been a difficult and complex political problem (as addressed above). Thus, if a process of democratic participation is allowed and supported by local, regional and central authorities, the categorisations, methodologies, strategies and analytical tools may have to be simplified. They should be made more comprehensible and meaningful for use by heterogeneous sectors of the population (Shah, 1998 and Nelson et. al. 1997). Communities would be empowered about how to use such assessments for their direct benefit. Nevertheless, other alternatives and effective ways of communication between state institutions and the population at all the social levels are also necessary (Ahmed and Rafi, 1999 and Calvo and Mendoza, 1999). The tools that I have used in my fieldwork should be viewed as examples of templates that could be applied. For virtually all PRSP countries, the development of effective tracking systems has required improvements across the full range of budgetary and financial management systems (Cohen, 1999 and Dillenger et. al. 1999). However, it also requires simplification and easily deciphered and useful information for dissemination, education and participation purposes. Therefore, the integration of a fully costed poverty reduction strategy into a consistent macro-economic framework represents considerable political, social and cultural challenges in developing countries (Cohen, 1999 and Dillenger et. al. 1999).

The lessons learned by the IFIs from recent experiences in developing countries with regard to the application of poverty assessment approaches have shown that PRSPs have been prepared largely from existing development programmes. The intention of these assessment approaches has been to place poverty reduction policies across other development programmes, which have already been implemented at the national or sub-national levels (WB, ED1, 2004 and 2001). A more qualitative and positive role for the IFIs would be to provide direct horizontal support (such as through the DPA) to local initiatives involving civil society

(NGOs, CBOs and local leaders) creating special programmes for participation (both civic and active) in decisions concerning investment, business development and rebuilding the socio-economic realms at the macro-meso-micro levels in developing countries (HRCA, 2001 and da Costa Pinto Neves, 1997).

3.7. Evaluation of Efficiency

The IFIs have politically and technically targeted measurements on the impacts of efficiency (related to effectiveness of performance, quality assurance, and impact and change in organisational, infrastructural and institutional settings) of decentralisation models. Managerial norms and procedures to increase efficiency in service provision have been developed amongst central governments and within national and sub-national structures of government in developing countries (WB, ED1, 2004 and 2001 and IMF/WB, 2001). Nevertheless, within the IFIs' implementation framework sectoral decentralisation has been carried out in many cases without properly assessing the intergovernmental landscape regarding the degree of efficiency, the accountability mechanisms and the strategies for sustainability. The accountability mechanisms have hardly been established amongst central governments in developing countries (Shah, 1998 and Griffin, 1996). Moreover, only in some exceptional cases alternative accountability and follow-up mechanisms have been created at the sub-national and local levels, but with no guarantee of being politically reinforced and technically supported (Freire et. al. 1999 and Griffin, 1999).

These mechanisms are necessary for accurately evaluating and monitoring the degree of efficiency achieved under decentralisation. A political, institutional and social operational approach has not clearly been established (such as the DPA) through which, decentralisation may incorporate different organised economic and social actors for the accountability and the measurement of the impact of decentralisation policies upon efficiency (Freire et. al. 1999 and Griffin, 1999). Efficiency impacts on management and administration of the decentralised sectors have rarely been comprehensively evaluated since institutional changes occurred in most developing countries (Ahmed, and Rafi 1999 and Sartorius, 1998). Through decentralisation the variables equity, accountability, and quality require multivariate

data and clear technical and strategic tools to establish and systematise the qualitative and quantitative procedures (Ahmed, and Rafi 1999 and Sartorius, 1998).

A common vision of the IFIs, recipient governments, and other organised and institutional sectors about the goals of sectoral and inter-sectoral reform -within decentralisation related to efficiency- is that, they have to be adapted to local conditions at the sub-national and community levels of each developing country (Kolehmainen-Aitken, 1998 and Gilson, et al. 1994). However both, managerial and organisational efficiency improvements and constraints to building capacity cannot be ignored in either, central and decentralised management levels (Thorbecke, 1999). For instance, in some cases, inadequate or delayed attention has been given to awareness and staff training programmes, which are critical to prepare staff for their new roles. According to Furtado (2001) management training capacity may be insufficient to meet the rapidly expanding training needs and there have been few studies to examine the behavioural and cultural transformation (awareness) needed in order to increase efficiency at the local levels. The central-level managers also require systematic retraining and reorientation, and although this has been recognised, many countries have overlooked this need. In other cases, staff cutbacks at the Ministry of Health have been so severe that, the centre's capacity to function effectively is in question (Robinson, 1999).

According to Bossert et. al. (2000), responsiveness to local demands has been a very important benefit for any decentralisation initiative but has created problems at the socio-political and socio-cultural levels as some experiences have shown in developing countries. Diverse local groups have also been opposed to decentralisation policies because they are directly and adversely affected by them. The policies affect their own socio-economic interests and socio-cultural beliefs (Nsibambi, 1997). Finally, there has not been a clear analytical framework to isolate or generalise the efficiency factors behind 'successful and unsuccessful' decentralisation experiences in developing countries (Robinson, 1999). These have yet to be defined. For instance, CHA and CCA methodologies can be used to assess the level of efficiency of institutions and structures. However, studies on decentralisation have suggested fundamental weaknesses in taking political-historical factors into account.

3.8. Evaluation of Equity

The rationale of the IFIs is to address the problems of equity in terms of a central government tax and transfer system. This is linked to the political and technical conceptualisation of 'horizontal equity' (WB, ED1, 2004 and 2001). In theory, all citizens have to be 'treated similarly' no matter where they reside in the country or their socio-economic conditions (Collier, 2000 and Slater, 1989). Although the IFIs have also acknowledged the 'acute economic and fiscal disparities' between regions and areas in most of the developing countries, the fact that central governments have attempted to use decentralisation in order to attain equity, mainly in economic and fiscal terms, has supported this rationale (Dasgupta, 1999 and Slater, 1989). But, most citizens do not have equal access or entitlement to political, social, economic and cultural development, or even the protection of their civil rights in most of the developing countries (Dasgupta, 1999 and Slater, 1989). Also, small-scale regional or local economies cannot sustain net fiscal benefits of sub-national and local government activities and many regions, areas, and communities are impoverished and marginalised from 'national mainstream development' (Fernandez, 1999).

Access to political power has been a critical issue not clearly addressed by the IFIs under decentralisation policies. It is especially unclear with regard to the transfer of political authority and responsibilities to local levels in conflict and post-conflict environments in developing countries for a number of reasons:

(a) The IFIs have not measured the variables that would allow political participation to take place;

(b) The tendency has been that the IFIs through the central government have imposed the vested corporative interests of the developed countries;

(c) The IFIs have reinforced the 'concentrated, vertical, developmentalist and authoritarian political structures' that remain in most developing countries, in spite of the decentralisation efforts;

(d) These political characteristics have been exacerbated in the case of post-conflict environments in which, pluralist and democratic practices have yet to be constructed and practiced in the long-term; and,

(e) The IFIs have concentrated their 'concerns for equity' in tax generation and collection strategies as well as budgetary transferences between national and sub-

national governments as part of the decentralisation process in developing countries (Stewart, 2000; Figueroa, 1999 and Lustig and Legovini, 1999).

The structural socio-economic problem has led to substantial differences in the real incomes of citizens and the possibilities of collecting substantial amounts of taxation and other fiscal revenues (WB, ED1, 2004 and 2001). A number of factors contribute to this problem:

(a) The approach has accentuated the dependency on fiscal and economic resources and incentives from central governments, who are the main recipients of international co-operation;

(b) Political trends such as authoritarianism, voluntarism, and clientelism have been reinforced with these kinds of 'mainstream macro-structural changes' between central and local authorities;

(c) The problem is the transfer of resources and the 'principle of subsidisation' to propitiate trickle-down to the local levels in order to generate economic and fiscal growth;

(d) It is also politically ineffective to promote changes in relationships between the population, institutions and authorities because these changes should be embedded within institutional and social interactions between the population and sectoral institutions; and,

(e) These interactions should be in the form of political negotiations about how to plan, manage and monitor economic and fiscal resources effectively, and how to produce socio-economic transformation for the majority of the population in the middle- and long-terms (Stewart, 2000; Figueroa, 1999; Lustig and Legovini, 1999 and Suzumura, 1999).

The intention of the IFIs has been to generate economic growth opportunities, social and infrastructure investment, and sustainable production and productivity. This is a planning development rationale to 'equalise' per capita economic and fiscal capacities at the sub-national and national levels (Lustig and Legovini, 1999). Participative democratic process depends heavily on horizontal decision-making. Thus, it would be very important for the IFIs to address the degree and extension of power as practiced by political and social groups in post-conflict developing countries (Figueroa, 1999 and Suzumura, 1999). For example, DPA as an approach towards decentralisation would be (a) operationally focused on the

devolved and appropriation of powers, supporting democratic and extended social forms of local government rather than only the institutionalised ones strongly backed by the IFIs; and, (b) the DPA vision would be built up through broadening the democratisation processes outside of formal institutional organisational structures (WB, ED1, 2004 and 2001).

It is necessary to build-up a process of participative democracy linking resources to local needs. If the transfer of power is devolved effectively to local levels, central governments may have limited power and decision-making authority to subordinate those local populations (Eid and Ibern, 1999 and Nelson et. al. 1997). The IFIs decentralisation policies have been aimed at delegating rather than devolving powers. Therefore a step forward in any decentralisation effort would be to (a) empower local people and (b) evaluate how communities have perceived and understood the local decentralisation process and its impact (Eid and Ibern, 1999 and Nelson et. al. 1997). The latter point is addressed by the fieldwork. According to the WB (2001a and 2001b), an 'integral and equitable approach to evaluation' assessing the effect of local development within multisectoral participative and democratic decentralisation processes would include:

1. An appraisal of the financial planning procedures to administer and manage budgets at the national and sub-national levels and mechanisms for institutional and social accountability established to follow-up such procedures including institutional auditing, normative bureaucratic liability and social accountability.
2. A comparative situational analysis of the inter-relationships between the decentralisation process and the profile and trends on (a) vulnerability - understood as the constraints of organisations, spaces, skills and resources; (b) poverty - understood as the lack of access to economic assets and economic means; (c) inequity - understood as powerlessness and exclusion under the following categories: social, political, economic, cultural and gender; and, (d) sustainability - understood as the concrete possibilities of development in the middle- and long-terms.
3. An examination of physical and conceptual planning to build, extend and re-adequate the infra-structural and human resource inputs and outputs. Also, the characteristics of organisational human and physical structures and networks planned and implemented as part of sectoral reform at the national and sub-national levels.

4. A critical and cognitive analysis of the socio-cultural differences between institutional management and organisational and traditional structures based on the system of beliefs and practices mainly at the sub-national and local levels (WB, ED1, 2004 and 2001).

3.9. An Alternative Evaluation Framework to Measure a Multisectoral or Sectoral Reform in a Post-Conflict Environment

The overall experience of evaluation within this context is weak. Below I will specifically look at the evaluation of reform processes from the institutional perspective and analyse some of the weaknesses and inconsistencies that exist. I will use the Guatemalan example where appropriate. One of the principle obstacles to the peace-building process, which has not been achieved under MMA and TBSA has been the lack of institutional development through which, processes of participation and democracy would be consolidated. Without such a process it is difficult for a decentralisation process to contribute to transparency, accountability, representativeness and appropriateness of political structures of the state institutions and civil society as a whole.

As a part of DPA, progressive appropriation of policies, resources and procedures of decentralisation has to occur. However in the case of Guatemala it is a very difficult and complex task. DPA at the rhetorical level has addressed the impact of structural adjustment policies on sub-national and local economies. It has also been embedded and overlapped with international and national sectoral policies such as those related to social and cultural and human rights, democracy and equity through international and national agreements recognised by Guatemala. The DPA represents an opportunity for the country through which participation in health sector reform at the local level may be achieved and through the Peace Agreements framework the DPA approach would help to resolve the inequities of the country. The ideological vision under the DPA is mostly based on a non-elitist class or group representation in contrast with the former approaches (MMA and TBSA) applied in Guatemala. Whereas the other two decentralisation approaches implicitly highlight the economic differentiation of social conditions of political and economic power, individual or collective leverage, power-knowledge, and authority status, the DPA is based more on the degree of inclusion supporting active

participation through grassroots devolution and increasing appropriation by organised representatives of peasant, Mayan groups and unions.

The evaluation policies from the IFIs have focused on four key socio-political and socio-economic development issues: macro-economic stability, poverty assessment, efficiency and equity. These issues addressed by the IFIs have become the main parameters to start any evaluation procedure with regard to decentralisation. Nonetheless, there has not been an extensive institutional and political strategy and consensus between the different tiers of authority and the social sectors. Nor has there been enough information and training about how to combine legal, institutional, social and cultural frameworks in order to allow for effective and collective management to oversee and evaluate fiscal and economic policy outcomes at the macro, meso and micro levels in the country. The PRSP Guatemala profile should take a number of factors into account when undertaking poverty assessments including the difficulty in generating accurate data, the lack of trust the civil population has towards the government when providing information, and the purpose for which the information will be used. The inability to generate accurate information or the use of information by the government for inappropriate purposes can skew the poverty profile of the country.

A conceptual model of socio-economic development based on human and citizen rights is one that invests in and opens up choices for the poor. Thus, a comprehensive approach to assess the main historical and political causes of inequity and exclusion in the Guatemalan post-conflict environment has become essential. However, to expand the IFIs point of view, it is also crucial to examine the hierarchical, institutionalised and authoritarian tendencies in political power in Guatemala. These tendencies have severely limited the establishment and practice of more democratic and innovative approaches to generate and manage critical information about poverty.

Decentralisation is at the same time a means (to transform the health sector) and it is an objective (of the transformation itself). The experience to date has had both benefits for the population as well as setbacks in post-conflict environments. Theoretical arguments and technical reports have been developed by the IFIs, other international co-operation agencies and international NGOs. However, theoretical

and applied research frameworks to address post-conflict environments are a recent development (LSHTM, 2002 and Bush, 1998). According to the same authors, the tendency is to continue to apply structural-functionalist frameworks for ex-ante, middle term/ongoing and ex-post evaluations. Within the post-conflict environment of Guatemala the first issue of this research is to provide answers on how excluded social sectors are struggling to access power and fulfil their own expectations for health and development through the decentralisation policies implemented. The second issue of this research is to elaborate a conceptual framework using Naturalistic Inquiry (NI), and Peace and Conflict Impact Assessment (PCIA) for a better understanding of the potentials for, constraints on and setbacks of democratic participation at the community level within the sectoral decentralisation process. Both, NI and PCIA are elements of the third level of analysis according to the methodological framework of this research.

In Chapter 4, the political history of decentralisation in Guatemala is examined. This is done to provide a country context, within a post-conflict environment, for the generic issues discussed in Chapter 3. The generic issues and the political history of decentralisation in Guatemala are brought together in a critique of the challenges and limitations of decentralisation, based on the institutional definitions and the historical reality, in the post-conflict environment. The main conceptual goal of chapter 4 is to suggest a more comprehensive construction and application of some key analytical categories inherent to the Guatemalan reality and decentralisation process through a multi-dimensional approach (history, structure and supra-structure of the socio-political, socio-economic and socio-cultural model at the national and sub-national levels with emphasis in the former, rather than structural-functionalist approach based on a restricted sectoral analysis of categories.

Chapter IV
The Political History of Guatemala and the Context of the Thesis

4.1. A Brief Overview of the State and Decentralisation in Guatemala

In the previous chapter, I reviewed the definitions and approaches to decentralisation of the WB and the other IFIs. I also considered how such approaches impacted upon the realities of developing countries in general with a particular emphasis on the Guatemalan post-conflict environment. Through this initial review of literature I was able to identify the scope and remit of conventional evaluation frameworks and how these frameworks might fall short of addressing specific complex situations in a post-conflict environment, such as the Guatemalan one.

In Chapter 4 my aim is to focus the discussion of the thesis on the post-conflict environment in Guatemala by examining recent political history as it relates to approaches to decentralisation and the formation of the state. Thereafter, I examine the emergence of health sector reform policies and programmes under the Peace Agreements. This is done to provide a context for the discussion in the previous chapter of the particularities of health in a post-conflict environment and to review the current health status of the country, under a framework of decentralisation. These two sections together explain how the social fabric of a society was dismantled. However there is a turning point with the signing of the PAs and RSS where community participation is critical to the modernisation of the state. Community participation under Health Sector Reform (RSS) represented a vision of hope for the country. I use RSS as an example through which the impact of community participation and the decentralisation policies can be examined. I identify variables related to community participation in the post-conflict environment of Guatemala and argue that the hope placed in such processes has largely failed to materialise.

I have focused on four distinct periods (from 1871 to 1996) in the history of the formation of the Guatemalan state. The periods were chosen because they represent the roots of the formation of the authoritarian liberal and neo-liberal state. This chapter is based on many key themes and issues addressed by the research of Gálvez (1997a) from the historical and sociological point of view. His work is a

historical and political analysis, critical to this chapter. It encompasses the attempts, achievements, limitations and strategies of decentralisation at the national and municipal/local levels in the last one hundred and twenty-five years. Other authors also provide a historical overview of the socio-political role of the Guatemalan state, and the advancements or setbacks of community participation and decentralisation policies. The analysis includes the country's conflict and post-conflict situations, the nature of social relationships developed during the Civil War, and the impact of the peace negotiations with regard to decentralisation**,** community participation and health status.

In this chapter I provide an example of Critical Historical Analysis (CHA) as an example of methodological development and its use for the construction of an alternative and comprehensive evaluation framework. CHA is important in order to analyse the formation and complexities of the Guatemalan state. The main reason for this is that the state and the nature of its development, is integral to how decentralisation was conceived as a policy and practice. Through the discussion of the emergence of the state, it is possible to understand how political institutions were developed, the impact of these institutions on the process of democratisation (or lack there of) and the distribution of power. In this chapter, the history of the state in Guatemala is defined as authoritarian, despotic and oligarchic. These are recognised as the main features of the state under the Peace Agreements signed in 1996. However, if the transformation of the state is to be considered under a process of decentralisation then its very fabric must be dismantled. In short, for decentralisation to work, the state must be transformed from one which is authoritarian, because this limits the delegation of authority and independent political expression. New forms of expression must be introduced so that within the state, the power of the elites is resisted and the oligarchical nature of it functions is dismantled. However, decentralisation in the context of RSS cannot occur under the historical nature of the state. The discussion on decentralisation focuses on ideas about delegation of authority, deconcentration of state institutions to local levels and the importance of participation within the process overall. Also through CHA, community participation is explored in relation to the constraints of democratisation due to the nature of the state.

With regard to the need for an alternative evaluation framework, this discussion helps to identify the variables of political and social development relevant to a decentralisation model from a historical perspective. In synthesis, the analysis helps to understand the relationship between the state and the individual, and the ladino state and indigenous communities. The focus here is on understanding the development policies from a historical perspective, the roots of the exclusion model (and how it has been maintained), the characteristics of exclusion throughout history, the characteristics of the state throughout history, and the decentralisation policies that have been applied at the national and local levels in a given period.

4.2. The Political History of Decentralisation in Guatemala towards the Identification of Variables under a Critical Historical Analysis

A summary of the historical analysis is presented here as an example on how to use the CHA methodology for the construction of a comprehensive evaluation framework. The discussion begins with the formation of the new socio-economic order and then, examines ideas about democratic transition and the re-organisation of the state to a more decentralised form of power distribution, regional autonomy and participation, ending a period of heavy conflict. Through this discussion emphasis is placed on identifying themes which can be analysed under a comprehensive evaluation framework. This is done because for the development of a comprehensive evaluation framework it is important to understand what themes are critical in study from a historical perspective, how these are interpreted and conceived, and how these relate to present circumstances affecting the majority of the population in any attempt towards social development. This allows for understanding the complex inter-relationships between variables in order to arrive at a comprehensive evaluation framework.

4.2.1. Exclusion, Inequality and Racism

The first period, from 1871 to 1944, was called the ‘liberal revolution’ and this period was characterised by centralisation of the policy framework. According to Gálvez (1997a) the 'liberal' state was based on a new socio-economic order founded on coffee production and in this period legislative and political mechanisms were introduced to ensure the adequate supply of labour to coffee plantations. According to Castellanos-Cambranes (1992, 1994), large extensions of land that were held

communally were confiscated. The relationship of the communities to the land was permanently severed, and communities were transformed into a labour force, supplying a permanent workforce to the coffee estates. Export agriculture became the most important form of economic activity in the country. The concept of collective ownership was destroyed and the large plantations based predominantly on single crop production served the interests of landowners with links to the external sectors (Castellanos-Cambranes, 1992, 1994). This system has continued to exist to the present day and has influenced the development of economic and social relationships between the communities, the state and the landowning classes The main socio-economic characteristics of this period included the expansion of Creole[2] latifundia and commercial activities (Gálvez, 1997a). According to Amaro (1990) the policy changes from 1879 provided the framework which defined the terms of the economic relationship of the majority indigenous population to production (namely obligatory work on latifundia)[3] and clearly identified population control measures (such as indirect restrictions on movement). The municipality served as a vehicle through which large-scale production was promoted (Amaro, 1990). According to Gálvez (1997a) during the 1930s government policies focused on preserving centralised and autocratic influence in decision-making, and restructuring the state towards authoritarian centralisation in order to improve control at local levels. According to Villagrán (1993) this represented the most extreme form of centralism of administration under the responsibility of the national state. Rayo (1995) and Von Hoegen (1990, 1993) referred to this as the 'liberal Creole model' made up of the official party, the bureaucracy and the executive, which, relied on a style of personalised dictatorships.

4.2.2. Community and Democracy

The second period, from 1944 to 1960, was a period of revolution and counter-revolution' in which the need for a more pluralistic policy framework based on meeting the needs of indigenous populations in rural areas was identified.

[2] . Criollo (term used in Spanish) refers to those who are direct descendents of Spaniards or of any other European background, born in Guatemala, Central America and other parts of Latin America. The meaning is different from the term 'Creole' in reference to 'Creole groups' in the Caribbean from African or Asian descent.

[3] The term 'latifundia' is the technical term for extensive landholdings. The prefix 'lati' refers to 'extensive'. The term can be used similarly to the term 'fincas' however 'fincas' does not distinguish between the sizes of landholdings.

Decentralisation policy was based on a vision for municipal autonomy under a revolutionary framework and regionalisation under a counter-revolutionary framework favouring deconcentration, delegation and increased militarism. The political tendencies, present in the governments of Juan José Arévalo and Jacobo Arbenz (as indicated in the works of Le Bot (1992a), Gleijeses (1991) and Handy (1984)), were manifested in the following ways: land was seized from the trans-national corporations for the purpose of re-distribution among the peasant population in order to provide them with a means of production, the popular socio-economic sectors of the country were mobilised, economic diversification was promoted to create a more autonomous and self-reliant economy, and internal markets were created while the export market was diversified.

Rivera (1995) indicated that the period of the 'October Revolution' mainly favoured national development, which would benefit many sectors of society. Centralisation was linked to the idea of the development of society and a strong state was seen as instrumental in the development process. Gleijeses (1991) noted that:

> "…centralism was justified under a 'benefactor' state and a strong central government was viewed as an instrument to implement the political agenda and therefore centralism remained the dominant form of the state…" (Gleijeses, 1991:36).

According to Rivera (1995) –

> "…although within leftist groups of the government the aim of revolutionary change was generally accepted, the idea of a more participative democratisation process was not entirely embraced by the executive and legislative powers or by some sectors of the population. Despite this the poor were supported with public policies in the rural areas and a series of structural socio-economic reforms were carried out..." (Rivera, 1995:23)

As Rivera (1995) indicated, although government policies formally promoted pluralism (inclusion of formally excluded socio-economic sectors to development), empowerment (increasing access of social organisations to economic means), and participation (allowing people to organise themselves in the process of development) for the majority of the ethnic groups in the rural areas, these aims were not achieved. Rivera (1995), Amaro (1990) and Handy (1984), referred to the revolutionary reforms as being a mostly developmentalist conception (imposed 'from above' under the agenda of modernisation of the economic sector) where the

government was pursuing a political socialist vision based on central authority with directed welfare powers, and with full institutional leverage to vertically manage all the realms of the country's development. The government implemented a model based on the social democratic modernisation of the state (towards socialism) but maintained the authoritarian structure of the state.

In Guatemala, the socialist vision referred to the transformation of the oligarchical-authoritarian political, economic and social structures in order to reduce inequalities produced by the capitalist-peripheral system. Under the 'October Revolution' there were attempts to incorporate excluded social sectors of society into a modern social-democratic political system, in which one of the main goals was to increase the productivity of the agricultural sector for the benefit of large sectors of the rural population. The political and ideological tendency of the government during the period can be identified as centre-left, with its central decision-making and planning authority fomenting a benefactor state through social policies. The overthrow of the Arbenz government in 1954 initiated the period of counter-revolution and ended popular participation initiatives.

4.2.3. Human and Citizens Rights

The third period, from 1960 to 1986 was viewed as a period of reform, conflict and counter-insurgency', which coincides with the last cycle of the 36 year civil war. According to Aguiluz (1990) and Amaro (1990), decentralisation during this period was linked to regional planning, which was viewed as a corrective measure to address regional and sub-regional inequalities. The approaches to decentralisation were limited under the developmentalist and authoritarian state formed during the counter-revolution. Decentralisation was developed as spatial deconcentration and institutional delegation in that it was applied in the country through a counterinsurgency model (Amaro, 1990). These mechanisms guaranteed greater control of the territory by the state apparatus in order to neutralise the growing guerrilla threat under military command (Aguiluz, 1990).

Through deconcentration and delegation, the government set up local structures, linked to the military to undertake activities of surveillance and control over the population, which eventually led to population extermination and relocation

policies (Schirmer, 1999). An additional tier of government for developmentalist and militarist purposes was introduced under the Regional Development Council structure. It was seen as necessary in order to develop capacities that did not entirely exist at the local level (Gálvez, 1997a). The central government did not see regionalisation as a process through which democratisation and participation would occur (Gálvez, 1997a,1998). Schirmer (1999) noted:

> "…The 'Development Poles' with their 'Model Villages' were militarised high security areas built to control the rural population in all the realms of life. The displaced surviving population was integrated mostly forcefully to these areas for 're-education'. Also, the local indigenous population was compelled to participate in the counter-insurgency struggle as well as in the 'National Security and Development Project' of the military, which was integral to counter-insurgency policies. Four "Development Poles" were built and included within them, were twenty-nine villages in the Departments of Quiché, Alta Verapaz, and Huehuetenango in the North and Northwest parts of the country…" (Schirmer, 1999:124-125).

What existed in Guatemala were experiences of population control based on involving local people through coercion, threat and fear to support established political agendas. There was no voluntary participation. Thus, regionalisation existed mostly for controlling the activities and movement of the population, controlling political development in favour of the state, and identifying and exterminating suspected guerrilla sympathisers. These coercive experiences of involvement in many communities influenced how the communities would react to 'new' participation initiatives under RSS later on (for instance, with distrust and fear). Regionalisation implied a deconcentration of functions but it did not mean broadening participation or strengthening municipal autonomy (Von Hoegen, 1990). When participation was mentioned by central government it was perceived as collaboration through coercion exerted by the military and eventually by the communities themselves as they became militarised or formed paramilitary units called Civil Defence Patrols (PACs) (Von Hoegen, 1990).

Belil et. al. (1989), and Aguiluz (1990), noted that decentralisation was a response to the situation of centralisation and military control. According to Boisier (1995), another common theme was that municipalities continued to exist as minor and subordinate parts of central government. The subjugation idea was linked to the existence of a 'pyramid' state rather than a 'network' state where the regions implemented decisions taken by the centre (Boisier, 1995). Aguiluz (1990) and Belil

et. al. (1989) considered that proposals for regionalisation designed during the transition to democracy in 1986 were important for the development of decentralisation policies in that inter-institutional co-ordinators constituted the first practical experience of administrative deconcentration even though this occurred under a military network and was justified in the creation of Development Councils.

4.2.4 Multi-sectoral and Sectoral Reform

The fourth period, from 1986 to 1996, marked the need to address the economic crisis, achieve democratic transition and negotiate for peace. The IICA/FLACSO (1986) study identified the flight of capital, the crisis of the Central American Common Market, the bankruptcy of companies and businesses and increased levels of unemployment and under employment as the primary causes leading to increased levels of poverty in the country. According to the IICA/FLACSO (1986) study, the policies and proposals for decentralisation were re-introduced in Guatemala during the 'democratic transition' from military to civil rule (beginning in 1986). The war destroyed the infrastructure of the country (roads, bridges and highways) and also weakened the capacity of the state to provide public services, particularly in the rural areas (IICA/FLACSO, 1986). In Chapter 3, I discussed the impact of conflict on the health of the people and health system in general. Parallel to this was the increasing social conflict agitated by the government, which was still fearful of the strategic alliance between the popular movement and insurgency (IICA/FLACSO, 1986).

On the one hand, the civil war and internal repression accelerated the crisis of the service network, and on the other, increased the demands for services. Vast sectors of population who were 'displaced' by the civil war and their quality of life was severely deteriorated (PRG, 1991). The most affected were the most vulnerable: peasants, indigenous, women, children and elderly. Consequently, in 1990 the per capita income was similar to the 1973 level. 16% of the Economically Active Population were unemployed and 35% were under-employed, more than two-thirds of the population lived in conditions of poverty, illiteracy reached 52.3% of those 15 years or older while the level of schooling for children under 10 years of age was no more than 3 years, the infant mortality rate was 45 per 1000 and 80% of

children under 5 years experienced complications associated with malnutrition (PRG, 1991:1). It is further noted that:

> "…The new development policy had to be perceived as inclusive of the different productive sectors in order to break away from the limitations imposed under the country's existing economic model. With the inclusion of the population in economic activity, patterns of production also had to change as well as the control and influence of the elite and military in public life"… (PRG, 1991:1).

A number of options were available with regard to decentralisation. Under the 'Law on Urban and Rural Development Councils', decentralisation was conceptualised as a 'form of popular participation' (Gálvez, 1998,1997a and FLACSO/PADAM/SI, 1988). It was a way to promote and develop democracy under liberal and representative democratic approaches: formal and institutional representative authority and traditional and inclusive local representative authority. Moreover, decentralisation became linked to the broader discussion around themes such as liberty, democracy and the family, so there was very little opposition to the discourse (Boisier, 1991).

The 'Law on Urban and Rural Development Councils' identifies in Article 13, the need to promote the effective participation of the population in the identification and solution of their own problems (FLACSO/PADAM/SI, 1988:312). Also, the Article 14 of the same Law, gives the most important role to the 'Neighbours' Assembly' at the community level within the Local Councils. They have the authority in the local decision-making processes to prioritise and resolve their local needs through direct participation, voice and vote (FLACSO/PADAM/SI, 1988:313). However, Local Development Councils, conceived as the social base for community participation, were never formed because the population continued to be organised under the paramilitary model (Schirmer, 1999).

In the 1990s, the relationship between the market and decentralisation processes was becoming the rationale behind the government policies. They were directly related to the reform of the state. These relationships were not explicitly recognised in the government programme of 1996-2000 but were present in the proposals of private organisations involved in the process. In these proposals there was a distinction between "decentralisation of the market and transfer of resources"

(CIEN, 1995:74-77). This is the basic premise of the market mechanism approach. The first considered:

> "…The process through which functions and responsibilities are transferred to the private sector liberating the central government from its role as entrepreneur, producer and intervener in the economy. This encompasses processes of privatisation, deregulation, de-monopolisation, commissioning of services and transference of responsibilities to private entities…" (CIEN, 1995:74-77).

For the WB and the IFIs, decentralisation through the market mechanism approach is based on privatisation and Guatemala is a case in point:

> "…The government transfers public functions to individuals or associations referred to as social decentralisation…and decentralisation of public administration to local government and departments…a decentralisation process must be rigidly based on the following principles: sustainability, solidarity, market principles, competencies, citizen participation and administrative excellence…" (CIEN, 1995: 74-77).

As in other Latin American countries undergoing a structural adjustment process, which consisted of deregulation and privatisation of the state under a MMA, in Guatemala an emergency programme was established to compensate for the impact of the structural adjustment policies (CIEN, 1994). The programme was formed by different social funds, which functioned as safety networks and was combined with institutional reforms in the state sectors (CIEN, 1994). The creation of the social funds began in 1992, and became an important part of the social strategy as a means to achieve greater functionality and efficiency (Gálvez, 1997a).

In summary, there were three issues which illustrated the changing role of the state and the ideas that defined its policies between 1987 and 1996. The first was the initial discussion around the notion of social ownership and the implementation of an emergency process of recovery and re-conversion of the state apparatus through deconcentration, delegation and privatisation of the public sector. The concepts of social ownership and privatisation are mentioned together because the state formed a partnership with the private sector to provide services to the public. Responsibility for service provision was delegated to the private sector although the state maintained a certain degree of control over how these services would be administered (Gartz, 1993).

The second was of unity and coherence of economic and social policies but coordinated under the framework of the first period of social ownership and response to emergency (Gartz, 1993). This appeared in the first official document, which contained the guidelines of macro-economic adjustment of the regime, approved at the end of 1991 (Gartz, 1993). The social strategy was subordinated to the economic policy outcomes following this principle: "…an economic policy is the best way to visualise the social policy…" (PRG, 1991:6).

The third was the maintenance of unity and coherence of the economic and social policies but with greater functional autonomy of the latter (Gartz, 1993). However, the notion of continuity in public policy was challenged regarding the degree of 'political will' to activate the decentralisation process under the former 1986 'decentralisation model'. Development Councils were combined with public work, education and health as a form of institutional delegation for the Development Poles (former conflict areas) under military control (Gartz, 1993).

4.3. The Nature of the Post-conflict Environment in Guatemala

After forty years of civil war, the counterinsurgency campaign left approximately 200,000 people dead, 440 villages were destroyed, more than one million people became forcibly displaced, and approximately half million became refugees (Sieder, et. al. 2002; Schirmer, 1999 and Appendix 3). Thereafter, in 1996 the Peace Agreements were negotiated and signed by a small group of representatives from ‘direct parties involved in the armed conflict’, but excluding representatives of other sectors of Guatemalan society. These agreements were signed in a climate of fear, exclusion and repression, which also accompanied the formation of the state since colonial times.

Before I discuss what I have referred to as the ‘era of peace’, I will provide a succinct overview of the legacy of the civil war and its impact. There are many ‘black’ days in the country’s history, which had big impact in the collective memory of many Guatemalans like me. For example, on 3 September 1985, 500 soldiers occupied the campus of the University of San Carlos for four days (Kobrak, 1999). This was considered to be the worst violation of university autonomy since 1944.

The soldiers were sent to the university as retaliation against the student movement, which was demanding the resignation of the military government of Mejia Victores (1983-1986). Students were organised and participating in movements for change, addressing issues around the country's dependence on the United States and that country's influence and interference in Guatemala. After the invasion, the student movement was destroyed and the leaders disappeared. Teaching staff were arrested and disappeared. A generation of youth dispersed to the mountains to fight, whilst others involved themselves in urban campaigns and the remainder dismantled. The intelligentsia of the country was directly targeted and disappeared. Another example was the killing of Helen Mack, on 11 November 1990, which reminded and confirmed to me that the repression was against all of those who wanted to reveal the truth about what was happening in Guatemala during the peak of the counterinsurgency policies. Helen Mack was a Guatemalan who graduated from the University of Manchester, a social science researcher well known nationally and internationally in academic circles. She was assassinated because she undertook research in Quiche and Huehuetenango, in communities terrorised and displaced by the army.

Nevertheless, I had found some solace in working on the Peace Agreements because I believed in the vision of a better and peaceful Guatemala, knowing that many obstacles would have to be overcome. I continued to believe in ideas about peace – participation by the people of a country in the processes and systems that affect their lives, the spread of democracy through such processes and systems and access to opportunity and progress. But, the climate of repression and fear had not been eroded. To understand what was happening in the era of peace, I re-visited, as I had done on many occasions, the events that had occurred in the era of conflict. I am unable to describe events from a personal perspective in great detail. However what I have done throughout this thesis (in relation to the topic matter) is describe how the war changed society and the challenges that continue to face Guatemalans in general. But to re-visit the theme of the conflict era, I provide a particular perspective on the war. It is brief but one which poignantly describes how the conflict affected lives and destroyed and re-shaped society. I start with the notion of the 'disappeared'. In Guatemala there were no political prisoners. At the height of the war and repression, the 'disappeared' grew in number in the memories of loved ones but, officially, were non-existent.

During my travels abroad, when I confronted people with the reality of what was happening in Guatemala, I was often told that I must have misinterpreted facts because in every conflict in Latin America, there were always political prisoners. Political prisoners served as the examples of opposition to repressive authorities from one Latin American country engaged in conflict to the next. To the outside world, political prisoners represented hope for change and a better society, the new leadership full of ideas about equality, democracy and participation, which one day would be free and their freedom would become synonymous with the freedom of a country. But in Guatemala, there were no political prisoners.

Detention by authorities or paramilitary groups was commonly marked by four experiences: first was illegal detention or detention without charge and without a hearing before the judicial system, second was torture, third was murder sanctioned by the state, and fourth was disappearance. There were no political prisoners in Guatemala because once taken by the military or paramilitary groups, there was no survival. To many, this was the birth a new kind of war within the context of Latin America, a complete cleansing of the population through eradication of opposing voices, including those who were presumed to be linked to or a part of the opposition.

Growing up with the fear of disappearance, one learned to look for signals. There were a number of these signals, which created a climate of fear and paranoia among the population. For the ordinary Guatemalan in the urban areas, this process was identified by the roaming of white vans or jeeps in residential neighbourhoods with darkened windows and no license plates. The vans and jeeps scavenged, collecting the ‘soon to be disappeared’ from the streets of the city and from family homes. For the ordinary Guatemalan in the rural areas, in the villages and remote communities, the climate of fear was created through the introduction of additional sanctions apart from the four I described above. While Guatemalans in rural areas were ‘disappeared’, those who were not ‘disappeared’ experienced obliteration through scorched earth policies. They were compelled to participate or witness the massacre of their families, friends and communities. Such policies attacked the economic and social livelihood of people, leading to the phenomena of internal displacement and rupturing the cohesion and co-existence of communities, often

permanently. This horrific experience of intensive repression created polarisation within families and in communities, in urban and rural areas until today.

The repression during the forty-year civil war was successful because the social fabric of society was dismantled and reconstructed. This shaped how experiments in social participation would be articulated and perceived by the population. People were forced, through such circumstances to live in model villages. People were forced to join Civil Defence Patrols (PACs) that monitored activity in these villages and participated in human rights abuses: threats, torture and killings. In the middle of the 1980s, rural villages were undergoing a process of intense militarisation through the establishment of PACs. Although billed as voluntary, all males over sixteen were required to serve in the PACs and failure to do so meant being branded a guerrilla sympathiser. Typically, patrol duty consisted of guarding the village, checking the identification of everyone entering, and reporting anything suspicious to the PAC commander who in turn reported activities to the nearest military base. Patrols were also involved in periodic sweeps of the countryside to search for guerrilla units and, under the command of military commissioners, auxiliary mayors and chiefs in charge; civilians were responsible for army recruitment in each village. They became the eyes and ears of the army.

The PACs aggravated existing divisions within indigenous communities. At their height, in the mid-eighties, it is estimated that they had around 900,000 members (Costello, 1997:4). The militarisation of local, regional and national government throughout the 1980s displaced the influence of traditional authorities and fomented the widespread use of violence to resolve conflicts in the post-conflict environment. In some areas where the paramilitary structures were imposed during the war traditional authorities were permanently replaced. Over 300,000 civil patrols and 5,000 military commissioners were demobilised under the Peace Agreements. These groups have frequently been implicated in gross human rights abuses nonetheless, they have retained the protection of army hard-liners. This situation has meant that many rural areas remain highly volatile, and the legacy of fear and division may yet take years to overcome (Sieder, 1996:48). I studied this phenomenon throughout my own formation in academia and as a citizen who experienced the impact of such a reality (of a country plunged in war).

While my thesis shows how a peace-building process is destroyed and a post-conflict era becomes defined by a generalised culture of violence, here I reflect from a personal perspective, the inter-generational experience of conflict, and the social and psychological impacts which prevent new and more democratic experiences in the country. The economic power of the elite remained unaffected. The better-off economic groups, especially the urban middle and elite classes distanced themselves from the conflict era by ignoring or denying that the atrocities committed ever existed. At a certain point, this repressive violence had been mainly focused in the rural areas of the north, north-west, and western parts of the country, became inter-generational, inter-ethnical and inter-classist. It became the culture of violence, which dictated how people lived their lives and how they interacted and behaved in social circumstances.

The post-conflict era, for those who survived means that a child who is now an adult must deal with the massacre of a village including his/her own family and a family must deal with a member who 'officially' never existed and friends must be content with memories. A new youth culture, critical and conscious, has not emerged because the intelligentsia are not easily replaced. Social relationships are not easily formed because of the political, economic, social and cultural polarisation. Concepts of trust do not develop automatically. A culture of peace is not created simultaneously with the signing of the PAs, because a general consensus was not reached in the first place. After the signing of the PAs, there were little reconciliation efforts and a great deal of denial. A culture of violence does not dissipate because opportunities for the majority are not created at any level, especially with regard to the socio-political and socio-economic re-integration of large segments of the population. The social fabric, dismantled during the conflict era, needs to be rebuilt in the post-conflict era.

4.4. Decentralisation in the Era of Peace

With the final signature on the Peace Agreements (PAs) in 1996, the forty year of armed conflict formally ended. Some important contents of the PAs with regard to the categories of analysis of this thesis are mainly found in two PAs. The first one was entitled 'Socio-economic Aspects and the Agrarian Situation' –ASESA- (1996). Related to health issues, this PA described social participation (community

participation) as fomenting active participation of municipalities, communities and social organisations. Participation in the planning, implementation, administration and fiscalisation of services and the health programme, through local health systems and Urban and Rural Development Councils was clearly identified. Specific mention is made for the inclusion of women and indigenous peoples. Related to democratisation, the contents of ASESA identified the factors that have threatened democracy (and social peace) including the lack of social and economic equity, poverty and extreme poverty, social and political discrimination and corruption. Democratisation includes the extension of security and protection against threats, protection of human rights, social participation, social justice and the strengthening of institutional democracy (ASESA, 1996: 16-19). There are obligations of the state in relation to decentralisation, including modern political and economic structures, resolution to the agrarian question, improving internal relations among different social sectors, alleviation of poverty, reduction of social exclusion and a process of national reconciliation (ASESA, 1996: 16-19).

The commitments made by the government under the same PA framework included: (a) reform to the Municipal Code with greater local participation, (b) municipal autonomy and strengthening of decentralisation processes “to establish and implement a framework programme on municipal capacity-building with the National Association of Municipalities (ANAM), which serves as a framework for national and international co-operation efforts”, (c) promotion of legal reform and, (d) "regionalisation of health and education services to indigenous populations and to ensure participation of their organisations in the design and implementation of this process" (ASESA, 1996).

The second PA is entitled ‘The Identity and Rights of the Indigenous Peoples’ – AIDPI - (1995). It recognised the identity of Mayan indigenous and other ethnic groups in the country. It focused on eliminating discrimination against minority ethnic groups (indigenous groups, which comprise the majority, but are referred to as a minority in the PAs), guaranteeing their cultural, civil, political, social and economic rights. Sieder (1996) identified these concerns as central under the AIDPI, namely the need to transform existing relations between the state and society. Thus, political institutions are capable of advocating for the historical, socio-

political and socio-cultural problems of the poor through an equalitarian approach. According to Palencia (1997) to achieve this transformation:

> "…it is necessary to promote participative consultation, in the formulation, implementation, evaluation and monitoring of state policies. A culture of involvement in which public decision-making responds to the will of the citizenry and also the belief that strengthening the state will empower civil society has not yet happened. Although many communities have benefited materially from the peace process, there has not been clear co-ordination between the people and their elected municipal officials rather there has been a series of dangerous confrontations between both counterparts…" (Palencia, 1997:2).

The Government's National Programme for Peace and Development 1996-2000 (PNPD) considered that:

> "…decentralisation will be the principle to be followed for the organisation of the state and its relations with society. According to the National Programme for Peace and Development (1996) [the Government Program 1996-2000 based on the PAs], the objective of decentralisation was to strengthen democratisation of society, distributing decision-making power equally in society in order to avoid abuses of power and accelerate socio-economic development…decentralisation will be a new contractual model between the state and civil society, oriented to strengthening the state and place broad limitations on the discretionary powers of state authority…" (PNPD, 1996:40; parenthesis by the author of this research).

The PNPD also identified eighteen policies and guidelines for action, of which four, have a relationship to this thesis: (a) reconstruction of the state, moving it from being a benefactor state to one of solidarity, which will delegate functions to social organisations based closer to the population; (b) decentralisation through direct transference of decision-making power, implementation of projects, evaluation of them and other works either to the communities or government institutions closer to the population; (c) identification of services, which can be decentralised according to the following criterion: each service should be provided to the beneficiary that it is closest to; and, (d) increased coverage of services (PNPD, 1996:42-43).

The conceptual framework of the proposal to reform the Municipal Code was stated in the ASESA. It was taken from the Municipal Code of 1988 on the Law on the Development Councils. The ASESA was considered important to promote community organisation and participation in order to identify and resolve problems

that were recognised but not achieved since the creation of the Development Councils. Linares Lopez (1994) suggested that the new conceptual framework did not change the 'style of governance' overall, because the new laws did not help to change the social tradition and political authoritarian culture in the country. In this respect according to Solórzano (1987), the intentions were to:

> "…simplify the functions of bureaucracy where central administration relied only minimally on the office of the president however, it was necessary to substantively reform the law of the executive as well because the new law, characterised as 'omnipresent presidentialism', required that all decisions depended on the president's direct input…" (Solórzano, 1987:20).

The reason for the changes in the Municipal Code was to strengthen the office of the departmental governor, in order to serve as an intermediary between central and municipal governments (Linares López, 1997). The departmental governor was responsible for the deconcentration of institutions of the state in the territory where he/she governed (Linares López, 1997). The changes also included views from other officials who believed that a regional identity or regional tradition did not exist in Guatemala. According to the Code, the President would nominate the governor after a list of nominees had been presented by non-state organisations through the departmental Development Councils (FLACSO/PADAM/SI, 1988 and Linares López, 1997). In this way, it would be possible to avoid compromised nominations or politically motivated ones and this guaranteed that the governor would fulfil relevant functions and ensure credibility in the process within the departments (Linares López, 1997). The governor would also appoint a deputy governor and a departmental cabinet comprised of the mayor and a range of public institutions present in the department (FLACSO/PADAM/SI, 1988 and Linares López, 1997).

Gálvez (1998) summarised three key development goals in this period: (a) to implement policies on decentralisation and deconcentration through the system of Development Councils, (b) to promote sectoral decentralisation and, (c) to strengthen the financial capacity of municipalities. However, the decentralisation initiatives that were selected; were considered to be 'initiated from above' with an institutional structure that allowed for the further control of community participation (Gálvez, 1998). The community subsequently rejected those policy efforts that were viewed as conservative or a project of the political party in power (Gálvez, 1998 and

Gálvez, et. al., 1998). The 'design framework for decentralisation' and the practice to 'legislate in the first instance and fix later' were based on the bureaucratic tradition of legalisation of public management. Palencia (1997) referred to the decentralisation strategy as ambiguous and created what was referred to as a 'white elephant' with questionable capacity and initiative. Palencia (1997) pointed out that:

> "…while there was a good reason to expect that governability would be consolidated and extended, it remained unclear whether emerging changes would reflect much more than isolated political ambitions amongst the Guatemalan elite. Considering the country's violent past and a complex socio-cultural present, the establishment of participative democracy was always viewed as a [hard task to implement]…" (Palencia, 1997:1)

The government's primary need was to finance its political and economic programme through extensive privatisation, fiscal reform, decentralisation of public institutions and a drastic increase in public utility charges (Gálvez, 1997a). There was more public debate on national political issues, but it did not facilitate a new exercise in citizenship. Discussions around the transformation of the state institution and nation building were excessively compartmentalised (Gálvez, 1997a). Issues such as centralisation -vis a vis- devolution and the financial limitations of the state, were held at the highest levels of government and did not involve distinct sectors of society (Gálvez, 1998). Civil sectors should have had stronger presence and involvement at the local levels to direct their own development as part of a meaningful experience in the decentralisation of power and responsibilities (Palencia, 1997).

4.5. The Guatemalan Health Status under the Peace Agreements

Comprehensive and analytical Information by the government authorities on the health status of Guatemala is still incomplete at the moment; therefore, several sources were used to bring together a health profile at the time of writing the thesis.

The information in this section is from the following document sources (see bibliography): (1) PAHO/WHO - Pan American Health Organisation and World Health Organisation (2002 and 2001). (2) MSPAS – Ministerio de Salud Pública y Asistencia Social (2002). (3) MSPAS/OPS/OMS–Ministerio de Salud Pública y Asistencia Social /Organización Panamericana de la Salud/Organización Mundial de la Salud (2001). (4) WHO–World Health Organisation (2000). (5) INDH/PNUD

Informe Nacional de Desarrollo Humano/Proyecto de Naciones Unidas Para el Desarrollo (1998). (6) MSPAS – Ministerio de Salud Pública y Asistencia Social (1998a). And, (7) MSPAS – Ministerio de Salud Pública y Asistencia Social (1996).

The Constitution of the Republic of Guatemala recognises health as a fundamental right. The Peace Agreement constitutes another public policy instrument that supports health sector reform and extended coverage. The country's health services system is made up of three large sub-sectors: (a) The Ministry of Public Health and Social Welfare (MSPAS), which has an Area Authority in every department that runs a health services network made up of hospitals, type A and type B health centres, health posts, and convergence centres; (b) The Guatemalan Social Security Institute (IGSS), which is an autonomous institution with its own legal regime, is financed through employer and employee contributions. (It has 1.4 beds per 1,000 beneficiaries. The IGSS accident programme covers all workers in the formal sector, but coverage of common illnesses and maternity is limited to the metropolitan area and to some departments in the country. The private health insurance system is limited); (c) The private sector, divided into non-profit and for-profit sub-sectors. The non-profit private sub-sector is made up of 1,100 nongovernmental organisations (NGOs) and of these, 82% are national, and 18% of these, engage in health activities. The NGOs are important partners in the effort to expand the coverage of basic primary care services, with public financing from the MSPAS. The for-profit private sub-sector consists of private hospitals, clinics, laboratories, and pharmacies in the capital and major cities. Its coverage is limited.

The Health Code approved in November 1997 stipulates that the MSPAS is formally responsible for leadership of the health sector (Appendix 5). As defined in the Code, leadership includes the guidance, regulation, monitoring, coordination, and evaluation of health actions and institutions at the national level. This definition constitutes the legal basis for a sectoral reform that has the capacity to transcend the public institutions. The Ministry is obliged under the Code to provide free health care to persons without means. Health policies between 2000–2004 call for the development of the following: (a) integrated health care for families; (b) health care for the Mayan, Garifuna, and Xinca peoples, with an emphasis on women; (c) health care for the migrant population and strengthening of integrated health care for other groups; (d) broader basic health service coverage based on quality and

sustainability; (e) basic and environmental sanitation; (f) access to essential drugs and traditional medicine; (g) strategic distribution of human resources; (h) institutional development, deconcentration, and decentralisation; (i) intra- and inter-sectoral coordination; (j) improvement and optimisation of external cooperation; and (k) increase of health sector financing.

The objective of Health Sector Reform is the comprehensive transformation of the social health production model, including improvement (efficiency and equity) of service delivery. In addition, it has the following specific objectives: (a) extension of basic health service coverage with emphasis on the poorest segments of the population; (b) increased public expenditure on health and mobilisation of financial resources to ensure sustainability of the sector; (c) redirection of resource allocation; (d) increased efficiency of the public sector in the performance of its functions and the production of services; and, (e) social and community participation. Emphasis is placed on the organisation of publicly financed services to extend coverage to the rural population that currently has no access to health care. In 1996, the population without health service coverage was estimated at 46%. Between 1997 and 2000, coverage was increased to include an additional 35% of the total population. The strategy used was based on a partnership between the Government, represented by the Ministry, and non-governmental organisations. Water coverage reached 92% of the population in urban areas and 54% in rural areas, while sanitation coverage was 72% and 52%, respectively.

The regulatory role of the Ministry in the private sector is especially important in ensuring quality control, efficacy, and safety of drugs and related products. The Department for the Regulation and Control of Drugs and Related Products was created within the Ministry to enable it to exercise control in this area. The National Health Laboratory where physical, chemical, and microbiological analyses are performed supports the department. Drugs are sold through a network of public and private pharmacies. There are 85 national and 2 foreign laboratories that manufacture drugs. In 1999, the Ministry spent US$ 17,073,649 on drugs, IGSS spent US$ 24,000,000, and the private sector spent US$ 129,803,326. In 1997, a system was established for joint negotiation of drug prices involving the Ministry, IGSS, and the Military Medical Hospital.

In 1999, the MSPAS had 1,352 health establishments, 43 of which were hospitals (17 at the department level, 10 at the district level, 7 regional, 6 specialised, and 3 general hospitals that receive referrals). There were 29 type A health centres, 234 type B health centres, 973 health posts, 48 peripheral emergency centres, and 15 maternity centres. The bed-population ratio was 1.0 per 1,000 in the country. IGSS has 24 hospitals, 30 consultation offices, 18 primary care posts, and 5 services attached to national hospitals; 6 of the hospitals and 11 of the consultation offices are located in the department of Guatemala. There were 2,447 available beds, for a ratio of 1.4 per 1,000 beneficiaries. There is a 360-bed Public Psychiatric Hospital in Guatemala City, and six other national hospitals have mental health units. IGSS has a 30-bed psychiatric unit and is working on creating a mental health programme. The ratio of physicians to total population was 9 per 10,000. For every 3 physicians there was only 1 professional nurse. For each professional nurse there were 14 auxiliaries. Human health resources tend to be concentrated in urban areas: the ratio of urban to rural physicians was 4:1 and for professional nurses it was 3:2. Guatemala had 80 specialists in public health with a master's degree.

In 1999, health expenditure represented 2.8% of the GDP. Households were the most important source of health financing (42.9%), followed by the Government (27.3%), businesses (22%), and external cooperation (7.8%). The annual amount spent on health came to US$ 630 million. The MSPAS have decentralised their budget execution to sub-national administrative units called Health Areas. The MSPAS provisional draft budget is given to the Ministry of Public Finance (MFP). The MFP consolidates a preliminary draft of all the Ministries budgets into the General Income and Expenditure Budget of the Nation, which is presented to Congress. In the last five years, Guatemala's technical and financial cooperation amounted to US$ 2,386.6 million. Of this total, 37.3% corresponded to non-reimbursable cooperation and 62.7% of it was reimbursable. 75.2% was intended to support the peace process, 21.7% was for other programmes, and 3.1% was allocated for the Hurricane Mitch Reconstruction and Transformation Programme.

As discussed in Chapter 3, the health system is over extended and under-resourced. While there is no clear profile of the particularities of health in the post-conflict environment of Guatemala, the general health profile indicates the need for reform and more resources, which the RSS is designed to address. The agenda of

the PAs, the framework of decentralisation and the focus on participation are linked to address health inequalities specifically. However, more broadly, community participation, health sector reform and decentralisation are integrally linked to development and democratisation.

4.6. The Need for an Alternative Evaluation Framework based on the Historical Dimension and Linked to the Particularities of the Post-conflict Environment

The experience of decentralisation to date has demonstrated that it was perceived as a consequence of regional and sub-regional planning, under a counter-insurgency and verticalist techno-bureaucratic model (SEGEPLAN/SPG, 1996). The central point of regional planning was regionalisation, under which a more 'rational division of the territory' and 'more efficiency within the public sector in the regions was created (SEGEPLAN/SPG, 1996). However, upon analysis of the development agenda, evidence suggests that there was an interest in re-vitalising a developmentalist state and not to actually transform relations between the state apparatus, the different sectors of the population and the territory in the rural areas.

Many civil organisations lack confidence in the government's political intentions and have developed their own political agendas. The view of some indigenous Mayan organisations was that decentralisation, unless it contained a component of ethnic autonomy and revitalisation was questionable in terms of its actual or intended outcomes (Q'uq'kumatz-MENMAGUA, 1999). Other social groups considered that decentralisation was dangerous to state unity and to the stability of the country (Q'uq'kumatz-MENMAGUA, 1999). There was a lack of confidence between diverse sectors and decentralisation plans and policies (Dary, 1997). The popular organisations did not understand that decentralisation would be converted into a strategic instrument for more democratic participation. 'Democracy' in formal terms, has yet to guarantee the attainment of any direct and immediate satisfaction of needs, interests and expectations (governability, institutional credibility, transparency, security, justice, economic growth and steady employment) for the population. There have been many difficulties to achieve a representative democratic regime. On the one hand, the collective memory of the illegitimacy of administrations served to discredit new democratic initiatives. On the other hand, the absence of a democratic political culture weakened the notion of citizenship

especially in a society that is largely characterised by exclusion, the concentration of poverty, wealth, and racism (Palencia, 1997).

In the context of the post-conflict environment in Guatemala, the recognition of indigenous rights and historical vindication threaten established economic and political interests. Successful ethnic integration in Guatemala is likely to depend on solutions to the poverty and economic marginalisation of the indigenous majority. More 'traditional' consensual decision-making and other cultural practices associated to religion, health and education should be addressed in more concrete terms and under distinct approaches (Sieder, 1996). Although such developments do not constitute a coherent alternative to existing party politics, they are beginning to present a different vision of participation and governance than that traditionally practiced by the political parties (Sieder, 1996).

The final results of the decentralisation experience in Guatemala are still inconclusive with regard to democracy, inclusion, equity, poverty and other structural socio-political and socio-cultural issues not yet addressed by this process. The conceptual framework must fully consider the historical-political development of the country and how society has evolved. In examining the whole of the experience, progress has been limited and the setbacks many. In Guatemala the nature of decentralisation has to be linked to the particular complexities of the conflictive socio-economic, socio-political and socio-cultural, inter-relationships amongst the population. The PAs present new challenges for the country and as such, it will be important to consider the opportunities that exist under this framework. For example, the articulation of more democratic spaces (e.g. equality, representation, legitimacy) in political institutions and access to the benefits of the country for the majority of the population. The question ‘why is there such a focus on participation?’ particularly deserves answering. The political history of Guatemala has demonstrated the lack of political manifestation (access and practice) by the majority of the population of the country. Nevertheless, there is a need to encourage people for the role they can play, being subjects of their own development. They themselves will fulfil their own potentials and change their own situation, assessing their own problems and needs and having access and power over the means to improve their quality of life. The need for this can be seen as historically significant – people managing their own resources, acquiring and using skills, sharing and gaining experience and

knowledge, building and developing leadership, creating suitable organisational structures, and performing work for the common good, for their own well-being.

Chapter V
Current Approaches to Sectoral Decentralisation in Guatemala

5.1. Defining the Key Issues on the Outcomes of Decentralisation

In the previous chapter, I discussed the political history of Guatemala focusing on the emergence of the state and experiences of decentralisation. I ended the chapter by examining the kind of country that emerged after the signing of the Peace Agreements and the characteristics of the post-conflict environment (both general characteristics and related specifically to the health profile of the country). While Chapter 3 examined the generic issues relevant to decentralisation and health sector reform, Chapter 4 provided the historical context within which decentralisation policies and evaluation frameworks are applied. This allowed for the consideration of the theoretical assumptions about decentralisation in relation to a specific country context. In this chapter, the theory (Chapter 3) and reality (Chapter 4) are considered together.

In this chapter I use critical comparative analysis (CCA). My main goal in this chapter was to determine both critically and comparatively the outcomes of the approaches towards decentralisation. I determined the approaches as they were applied or are being applied within the context of the post-conflict environment (since the signing of the PAs in 1996). The main issues addressed in this chapter are: the assessment of the challenges of decentralisation as a Market Mechanism Approach (MMA) compared to the Techno-Bureaucratic System Approach (TBSA) and Democratic Participative Process Approach (DPA). This is followed by an appraisal of the limitations of the peace-building process and Health Sector Reform (RSS), the limitations with regard to institutional restructuring (the changes in the organisation of the Guatemalan health system) and limitations of financing with regard to the reorientation and implementation of RSS resources in the middle- and long-terms. The final section examines the impact of the lack of a more democratic form of community participation in the RSS process, as well as the need to prioritise non-mainstream evaluation activities in relation to decentralisation and post-conflict.

As a very important part of the analysis for this chapter, I gathered, compared and contrasted strategic conceptual and technical information from various secondary sources. The sources were directly related to decentralisation of

the public sector with emphasis in the RSS process both nationally and sub-nationally. Amongst the most important sources of information used were: technical evaluations, executive, managerial, administrative and financial documents for discussion within the health sector, health system profile analysis for the Guatemala case, country development and health profile documents and publications from multilateral and bilateral international cooperation institutions and agencies, government policy and multisectoral and sectoral documents, and academic and research documents from international and national research institutions.

5.2. The Challenges of Decentralisation as a Market Mechanism Approach

At the beginning of the RSS process in 1996, the aim was to devolve healthcare services to private ownership through delegation and devolution as considered appropriate by the international and national sectors (MSPAS/BID, 1995). The aim of the MMA approach was to create small-scale economies in different rural areas of the country. However, the technical expertise and evaluation reports (MSPAS/SIAS 1998 and MSPAS/BID/OPS/OMS, 1998a, 1994, and 1991) found high levels of inefficiency and major gaps in market formation, which would impact upon the implementation of policies under this approach.

According to the Samayoa Urrea (2003) and INDH/PNUD (1999 and 1998) most of the rural areas of the country, with majority Indian populations, experienced problems in the development and sustainability of markets due mainly to the levels of poverty and underdevelopment in various departments. Thus, the MMA approach was not considered entirely suitable for decentralisation through privatisation. I demonstrated (in Chapter 4), how policies around exclusion and inequality were used to create these conditions. There were a number of reasons why this approach was not suitable. First, the population in the rural areas had ‘no’ to ‘little’ access to good quality healthcare and levels of access varied across areas. Second, where better access was possible, it was very difficult to increase access to healthcare because the type of work they performed was mainly seasonal labour, which provided them with an income equivalent to £280 to £400 per annum (INDH/PNUD, 1999 and 1998). The overall amount of cash they handled was too low to enable them to participate fully in the market economy as consumers. And third, where

access to private healthcare was possible, most people were able to obtain initial treatment, but unable to obtain follow-up treatment because of the lack of money (INDH/PNUD, 1999 and 1998). So, the initial treatment left the population indebted because under RSS through the MMA, service fees were applied and provision was becoming privatised. The initial policies under the RSS, to generate service fees through the privatisation of health services, health insurance policies, paid allocation, provision and distribution of medicines was immediately revised and implemented at a slower pace (MSPAS/BID, 1999).

Evidence suggests that structural adjustment was not appropriate for Guatemala because it reinforced the free market ideology that emerged with the latifundias and reserved profit in the hands of the elite. The political and economic sectors required a new development model taking account the hegemony of the United States in the entire Central American region, the survival of economies of scale (if these existed) in relation to macro policy and increased participation in the social and economic sectors by the majority of the population. There was a debate between the left and right ideologies (the civil war was fought on class struggle and peasant revolution). In the debate within the right, factions emerged between the 'old' or traditional elite and the 'new' elite. The new elite were interested in transforming the state to a neo-liberal state of enterprises viewed as modernisation. The 'new' right were arguing for a new discourse but was made up of the same group of landowners and entrepreneurs.

5.3. The Challenges of Decentralisation as a Techno-Bureaucratic System Approach

The TBSA was developed under the 'Programme for the Improvement of the Health Services (PMSS)' as a modified version of the MMA. With the TBSA the government recognised the need for a transitional system before a market-mechanism approach, of the nature of the MMA, could be fully implemented (MSPAS/BID, 1999). The TBSA provided the government with opportunities to develop and implement managerial policies and promote, through gradual means, new cultures and values in the public sector (MSPAS/BID, 1999). Although the aim was privatisation in the long-term, in the interim, the government sought ways to develop rural infrastructures and attempted to re-align rural economic systems in order for them to

be compatible with the types of mechanisms necessary under privatisation (MSPAS/BID, 1999).

The TBSA combined sectoral reform in which, decision-making remained centralised under a dominant health administration (through international organisations and the public sector). But, simultaneously health services were delegated to the private sector to implement the Integrated Primary Healthcare System (SIAS) under the objective of 'partners in development' (establish by the IFIs). Thus, the government regulated functions and service provision through normative guidelines and agreements with institutional and civil sectors (UNDP, 1999). These sectors included international and national NGOs, CBOs, and other networks and local organisations (Nieves and La Forgia, 2000). The focus of the delegation process was the administration and provision of primary healthcare services and infrastructure (SIAS), at the local level under the PMSS. Further, the local population had some operational functions under this form of delegation in that, local participation in SIAS was formal and restricted and based on the requirements of each situation where the SIAS was implemented.

Health sector reform using the TBSA was considered a transitional phase towards MMA. The fast-track delegation process carried out by the MSPAS' highest authorities, raised concerns about managerial control and sustainability of health sector reform (RSS) (Nieves and La Forgia, 2000 and Munar, et. al., 1999). The principal challenge and the main reason why the MSPAS tried to implement TBSA faster than planned was the resistant managerial culture and values practiced by the public sector (Sánchez, 2000). The MSPAS and the majority of its health workers have viewed the decentralisation process in Guatemala as a negative process overall (MSPAS/BID, 1999). According to the MSPAS and Sánchez (2000) personnel in the public sector have not been fully receptive of the decentralisation process because of the perceived loss of corporate authority and decision-making power they currently exercise and the eventual reduction of jobs they envision (MSPAS/BID, 1999). Under the TBSA, central decision-making authority has been retained under a dominant medical and paramedical cultural and organisational environment (Nieves and La Forgia, 2000).

The SIAS was based on a normative framework and promoted the following: first, it was set up as a driver of the stages of decentralisation of public institutions and within this process, to consider the inclusion of local organisations (SEGEPLAN/SPG, 1996). Second, it focused on the need for institutional changes in healthcare provision to rural and indigenous populations (USAID/JHPIEGO, 2000). Third, it incorporated reciprocal and practical inter-cultural solutions to health problems at the local level (MSPAS/OPS/OMS, 2001). Under the SIAS community participation was viewed as the central axes at the primary healthcare level (MSPAS/PNS, 2000; and SEGEPLAN/SPG, 1996). According to the same sources, the aim of SIAS was to achieve the acceptance, adaptation and adoption of basic health services in the short- and medium-terms amongst different ethnic groups in the country. Within this process of integration at the local level, the Basic Health Teams (EBS) were established to interface between the Ministry of Health and the communities comprised of members both internal and external to the communities, contracted by different NGOs or by the Ministry of Health, and co-ordinated and supervised by health districts and municipalities. The membership depended on the population in the local towns. Further, Community Committees or Assemblies were created to co-ordinate functions of the EBS according to local health needs (Sánchez, 2000). Community organisations were established and these organisations managed Health Centres jointly with the EBS, within health district boundaries (Sánchez, 2000).

5.4. The Challenges of Decentralisation as a Democratic Participative Process Approach

The DPA represents an ideal vision for the Guatemalan case, which has not yet occurred. The ideological vision of the DPA is based on sectoral (health) and multisectoral agreements in Central America, Latin America and in Guatemala under the framework of the PAs. Both kinds of agreements stressed the need to overcome poverty, marginalisation, and discrimination through equity, equality, socio-political participation, economic and social integration and access to social services (CACAP, 2000). However, the lack of success in achieving policy values as stated in the agreements together with the prevalence of conservative and traditional political and socio-cultural values, embedded in the Guatemalan society, have made it difficult to implement this approach (CACAP, 2000; and Q'UQ'KUMATZ-MENMAGUA, 1999).

If the SIAS is developed under the DPA it would be based on a comparative assessment of the limitations of the first and second approaches, the MMA and TBSA. The goal under the DPA approach is to evaluate the possibilities and constraints for a more participative and democratic development of the SIAS within a decentralisation framework at the local level (MSPAS/SIAS 1997a). DPA would represent potential and substantial improvement of health sector decentralisation efforts in a post-conflict environment.

To summarise, the strengths of the decentralisation experience in Guatemala have been: (a) the MMA was not fully developed or developed solely without consideration of other approaches; (b) there was recognition at the national level that a multi-sectoral approach was necessary involving an array of organisations as well as the private sector; and, (c) the peace and development initiatives were still critical to the government at the time in question. The weaknesses of the experience are noted by the lack of local participation. The vision for reform imbedded in the PAs has not fully materialised. The PAs provided an opportunity for the country to implement health sector reform. However, this has not been adequately articulated under a national political agenda, among sectors of civil society or elite groups. Major obstacles and limitations persist and threaten the PAs agenda. The DPA is more of an ideological vision but, the second approach (TBSA), is viewed as feasible and sustainable in current circumstances by the IFIs, the MSPAS and the majority of its workers.

5.5. Peace Building Process and Limitations of Health Sector Reform (RSS)

The macro-economic policy programme to reform the public sector initiated through the policies of the IFIs (for this case WB, and the Inter-American Development Bank - IDB) has had little impact overall. The Public Sector Reform (RSP) programme has been a part of the economic and financial support package offered to implement the PAs. The RSP has been developed under the planning framework of the government's National Programme for Peace and Development 1996-2000 (PNPD, 1996). The conditions for the disbursement of funds were prescribed by the WB and IDB technical staff and thereafter, negotiated with the country’s health authorities (Finkelman, et.al., 1996).

The RSS agenda is part of the RSP, which has been defined by the guidelines proposed, in the terms of the loan agreement (La Forgia, et. al., 1995; and MSPAS/BID, 1995). However, the Guatemalan health authorities have been negotiating with the IFIs on the future objectives and contents of the RSS (Nieves and La Forgia, 2000 and Munar, et. al. 1999). The current RSS objectives according to the terms of the loan agreement are (a) to expand health services coverage, targeting populations that lack access; (b) to improve the response capacity of the services by decentralising planning, financial and technical management; (c) to increase the level of public expenditure and expand financial sources for the RSS, mainly targeting the first and second healthcare levels, through the implementation of the SIAS; (d) to redirect allocation of public resources on the basis of criteria defining equity and efficiency; and, (e) to generate an organised social response for the mobilisation and control of public resources (MSPAS/OPS/OMS, 2001; MSPAS/BID, 1999 and 1995 and Munar et. al. 1999).

With regard to the first three RSS objectives the system has been relying on the participation of NGOs and private enterprises in the delivery of services and is in the evaluation and redesign phase (already explained above). However, there is no specific way to guarantee the right to healthcare. A basic package of services has not been clearly defined and promoted. The health services do not always have the capacity to provide these services and users do not demand them. Specific programmes to expand coverage are being introduced gradually. The SIAS intends to provide a basic health services plan (designed by MSPAS staff) to populations that have never received healthcare. These neglected groups are, for the most part, indigenous peoples living in rural areas in the northern and western parts of the country. These are also the populations with the highest rates of poverty and the worst health indicators. In both the MSPAS and the IGSS there is a trend towards increasing private participation in the delivery of services financed with public resources. The MSPAS is contracting NGOs for the delivery of services in rural areas and the IGSS is contracting private providers (laboratories, clinics and hospitals) to deliver services such as childbirth, prostatectomies, and eye care. The two institutions continue to directly and simultaneously assume the tasks of financing, delivering, and regulating health services.

Health expenditure has increased and health coverage has been expanded to the population (MSPAS/OPS/OMS, 2001). The IGSS has developed the RSS at the three healthcare levels in the country and has reduced waiting lists for surgery and for specific tests by contracting private health providers (MSPAS/OPS/OMS, 2001). However, since 2001, the rate of health coverage overall has slowed down. The reasons for this include the fact that the supply-side of the health service delivery model was not organised and did not raise sufficient awareness among the target population therefore it was not able to create stable demand at the local levels in the middle- and long-terms (APRESAL, 1999). There has been dependency on bringing in national and foreign technical health personnel, which have not been incorporated to the organic structure of the MSPAS and who, have not been 'institutionalised' appropriately within the process (Angel, Deman, and Sánchez, 1998).

With regard to the following RSS objectives - to expand coverage, to improve the response capacity of the services by decentralising planning, financial and technical management; and, to increase the level of public expenditure and expand financial sources to the RSS - guidelines have been implemented under the RSS and the most significant advances have been made in financial reform and expansion of coverage. However, these components have not been sufficiently developed in order to have a visible impact on the health situation of the population (MSPAS/DGSS/OPS, 1997). Further, the evaluation criteria have not been clearly defined within the MSPAS, nor does an evaluation plan exist to monitor the whole process (MSPAS/BID, 1999). The output of the health information system has improved through monthly and trimester reports generated by the health districts and areas, however, the information systems continue to be inadequate for the purposes of decision-making and resource allocation (MSPAS/OPS/OMS 2001). Information on the technical quality of service delivery and data on 'public perception' has not been prioritised under the current objectives of the RSS (MSPAS/BID, 1999). Moreover, there have been few attempts to eliminate the widespread corruption throughout the sector (MSPAS/BID, 1999).

Further analysis indicates that under the new health model, the delegation of authority and responsibility to local institutional and community levels has not been adequate. It has been controlled (from the top) and subordinated (at the local level),

rather than being an open, active, and equal process (CACAP, 2000 and CONIC/CNM, 1996). This has meant that while there has been formal change in the delegation of responsibilities to health agents, there has been no extension in the health package in terms of both institutional and traditional health providers as stated in the PAs (CACAP, 2000 and CONIC/CNM, 1996). In relation to the healthcare management model, public facilities have not been organised on the basis of local self-management and in some cases local management has come from the Community Centres (APRESAL, 1999).

A number of sources have identified the weaknesses of the RSS under TBSA. First, lack of political continuity, changes in political and other vested interests, and therefore changing priorities. 'Short-termism' in the hiring of technicians who are replaced within the different institutions, which form the health service networks at the central, sub-national and local levels. Until now, economic incentives have not been linked to the individual and collective performance of medical and paramedical personnel, and volunteers from communities (PHRP, 1998). Second, there has not been a clear plan for future staffing to assess the capacity of the public and private sectors to absorb trained human resources at the area and district levels (Angel, Deman and Sánchez, 1998). And third, there have not been mechanisms responsible for the accreditation of service quality, either in clinical healthcare or staff training (as a human resource office created with this specific purpose). Quality assurance in terms of services and human resources has only been generally stipulated in the contracts with NGOs and CBOs participating in developing the SIAS or for health technologies deployed in the public or private sectors, but with hardly any control over them (MSPAS/IGSS 1997).

In relation to the following RSS objectives - to redirect allocation of public resources on the basis of equity and efficiency and to generate an organised social response for the mobilisation and control of public resources - the outcomes have varied. First, public financial resources for sustaining the increase of SIAS coverage have been reduced and the strategy to expand coverage has been affected by the lack of liquid assets resulting in the failure by MSPAS to pay the NGOs under contract during the first half of 2001. Further, recent evaluations have led to the termination of contracts with several NGOs, CBOs, and civil and private sector suppliers. In relation to this, only 'urbanised' populations have benefited from

expanded coverage (MSPAS/OPS/OMS, 2001). Second, the cost of expanded coverage has been neglected because the population in need of healthcare has exceeded initial cost estimates applied to certain sectors of the population. The impact of health expenditure has not been accurately assessed (ENSMI, 1998-1999). Third, under SIAS, there have been no guarantees to the right of healthcare for all of the population living in the rural areas. Users have not demanded such rights because they have not been made aware of their rights as deemed under the Constitution and the PAs. Albeit, the resources allocated to the SIAS have represented an increased percentage of overall health expenditure during the last six years (MSPAS/OPS/OMS, 2001; Q'UQ'KUMATZ-MENMAGUA, 1999 and Costello, 1997). Fourth, the re-allocation of resources has not been directed to healthcare activities or the prevention of highly prevalent diseases (MSPAS/BID, 1999). Fifth, the level of productivity between health areas and districts has not constituted a criterion for the increase or decrease of budget allocations (MSPAS/BID, 1999). And sixth, the income collected through service fees has not been significant and has not provided a large enough contribution to be used in new activities (MSPAS/BID, 1999).

The performance evaluation entitled 'Participación Comunitaria en la Provisión de los Servicios Básicos de Salud' (MSPAS, 2000b), indicated that social participation in health was as important as reducing the health impact of emergencies and disasters. Social participation was also important in quality assurance functions to monitor health personnel and health services. An evaluation of the primary healthcare services found that the performance of several NGOs, which were contracted to provide primary healthcare under the SIAS was unsatisfactory because performance measures relating to service provision had not been adequately defined (MSPAS/OPS/OMS, 2001). My participation in the MSPAS evaluation on community participation in health also provides further insight (see Chapter 6). The main characteristics of the redefined healthcare model have been the explicit development of basic service plans and the contracting of private entities (mostly NGOs), for the delivery of publicly financed health services. In the communities that now have services provided by the SIAS, community centres have been established. The MSPAS central administration has set up an evaluation and monitoring system that has led to the termination of several agreements with NGOs for non-compliance. However, the system should be more comprehensive in its

indicators composition and variables for quality assurance. It should also include assessments of views on health by the population, patterns of active participation and decision-making behaviour.

Therefore, there is no evidence to demonstrate that through the RSS acceptable standard of performance into local health services have been introduced (MSPAS/OPS/OMS, 2001). The following reasons have been identified for this inadequacy: first, the actual target population has been smaller than the number declared by some NGOs (MSPAS/OPS/OMS, 2001). Second, there has been a lack of incentives to progress from the data collection and service-mapping phase to the actual delivery of health benefits because of insufficient resources and high service delivery costs (MSPAS/BID, 1999). Third, there has been a lack of formal accreditation of some of the NGOs under contract, and many of them lack basic competencies (Nieves, et.al. 2000). And fourth, the SIAS has been attempting to provide health services to populations that have hardly received any public healthcare or that have not approached such services before (UNDP, 1999 and PHRP, 1998).

New clinical procedures combining traditional local medicine with institutional medicine have generally not been introduced at the health district level under SIAS (de León and Quinto, 2000; MEDES, 1999 and OPS/OMS/FUNMMAYAN 1999a and 1999b). Furthermore, it is necessary to define and promote the kinds of health services offered at the primary and secondary levels with the procedures of referral and back-referral within the SIAS implementation process, combining both types of medicine –traditional and institutional - (OPS/OMS/FUNMMAYAN, 2000; MEDES, 1999 and Haeussler and Lima, 1996).

5.6. Limitations with Regard to Institutional Restructuring and Financing

The Guatemalan institutional experience towards decentralisation has been defined by sectoral experiences although there have been a few links between the public sectors at different levels. For instance, while there has been co-ordination between MSPAS and the MFP to carry out the RSS in relation to local financial allocation, the Institute of Municipal Fomentation (INFOM), which provides managerial and technical support to municipalities involved in the administration and provision of

health services has not been included (Sánchez, 2000). Also, the local Councils of Urban and Rural Development have not been transformed through adequate legislation so they did not have a key role in local development issues or a role in the local RSS through SIAS (CRG, 2002; GRG, 2000 and CRD/CDD, 1997).

The RSS was designed to support the implementation of policy and financial reforms in the middle- and long terms. In other developing countries the financial support of the RSS was extended through the balance of payments under macro-economic policy arrangements, for example through SWAPs or sector-wide and multi-sectoral approaches to health. In the case of Guatemala, the annual financial allocation from the national budget decreased with the exception of the first two years of implementation -1996-1997- (MSPAS/OPS/OMS, 2001 and Sánchez, 2000). Although services had been maintained cost-free at the primary and secondary healthcare levels, hospitals were authorised to administer fees as a cost-recovery mechanism.

The PMSS was designed to be delivered in two phases, of which the SIAS is an important component. The first phase was implemented between 1996 and 2000, and the second phase between 2000 and 2004 (Munar et.al, 1999 and La Forgia et. al., 1995). However, both phases have been disrupted due to the lack of political and economic commitments by the last two government administrations (ASIES, 2001; IPES, 2001 and Noriega, 2001). For instance, overall programme activities have been reprogrammed and reduced, and institutional personnel have been dismissed from posts for an indefinite period of time and this jeopardises the start of Phase 2 in 2002 (two year later than originally planned) thus diminishing the capacity of the PMSS and SIAS at the local level (MINUGUA, 2002; and PL, 2002 and 2003 and CIEN, 2000).

The agenda promoted under the PAs has now almost completely been abandoned, since the outcome of a national referendum in 1998 in spite of pressure of the international community, which supported and financed the peace process (MINUGUA, 2002 and INDH/PNUD, 2001). The objective of the referendum was to implement necessary constitutional reforms to enable the country to carry out the structural changes as agreed under the PAs. Furthermore, the macro socio-economic agenda has been the dominant agenda, whilst the peace agenda has lost

all its relevance causing additional structural problems such as increased unemployment, poverty and inflation (Noriega, 2001; Gálvez, 1997b and Palencia, 1997). If both agendas had been balanced under a vision of inter-sectoral reform, then the medium- and long-term objectives of social inclusion and participation under the RSS would have been guaranteed (Q'UQ'KUMATZ-MENMAGUA, 1999 and Gálvez, 1998)

The process of transformation planned under the RSS has met with a number of institutional limitations. First, modernisation of the MSPAS financial administration has not proven to be the most adequate platform to achieve efficiency and cost-effectiveness in healthcare investment. The MSPAS has so many existing internal administrative weaknesses. Conflict among techno-bureaucrats who have threatened the allocation of national and international financial resources necessary for the gradual implementation of the RSS model also hinders progress (MSPAS/OPS/OMS, 2001 and Sánchez, 2000). Second, the new Health Code (HC) and a new Internal Organic Regulations (ROI) have served as instruments to promote and facilitate the implementation of the RSS (MSPAS, 1999a and 1999b). The management and application of the HC and ROI has been placed under the MSPAS high-rank central regulatory authority and PMSS officials. However, the other organisations involved in the RSS process, have had no regulatory functions delegated to them. Therefore, knowledge of the HC and the ROI has remained low among institutional and non-institutional personnel, and practice has not been clearly or systematically evaluated (MSPAS/OPS/OMS, 2001 and Sánchez, 2000).

5.7. Limitations with Regard to the Reorientation and Implementation of the RSS Resources

Three areas of resource development had been identified under the RSS: first, institutional development and strengthening; second, financial resource provision; and third, community and social participation processes. Even though priorities have been identified, the financial, physical and human resources have not always been available because of the reduction of financial resources necessary to carry out the transformation of the PMSS. Further, conditions of recruitment have not been attractive for medical and paramedical personnel (OPS/OMS, 2001 and MSPAS/BID, 1999). The new healthcare model (SIAS), has failed to become widely

accepted by different counterparts including by the opposition parties in Congress and various rural communities (ASIES, 2001 and IPES, 2001).

Continuity of the RSS process under a new political authority is also a critical problem. Historically, it has meant that incoming governments have erased the political priorities established by previous administrations (MINUGUA, 2002; IPES, 2001; PL, 2002,2003 and ACPD, 1999). A new political party entered government for the 2000-2004 period, which did not commit to the RSS and the SIAS. The leader of the party in power –the Guatemalan Republican Front (FRG), a retired general, is accused nationally and internationally of human rights violations and acts of genocide during the 1980s. Thus, there is no interest to pursue and fulfil the contents of the PAs, which have strongly condemned the counterinsurgency role of the military governments during that period.

A number of sources have also considered that the implementation of the RSS has required the recruitment of qualified personnel specifically involved in the transformation of the SIAS (MSPAS, 2000a,2000b; MSPAS/BID, 1999 and Haeussler and Lima, 1996). There is a tendency to contract personnel directly chosen by the non-government organisations and community-based organisations, using random and undefined criteria. This encourages practices of nepotism and politically motivated appointments (MSPAS, 2000a,2000b; MSPAS/BID, 1999 and Haeussler and Lima, 1996). Although the MSPAS has implemented and coordinated actions with IGSS, (including a framework for joint contracts, plans for the extension of healthcare coverage, and purchasing of medical equipment and, guidelines on the purchase of inter-institutional health services at the different levels of provision (MSPAS, 2000a,2000b; MSPAS/BID, 1999 and MSPAS/IGSS, 1997). This coordination between the two institutions has been abandoned and a competitive environment has been formed between the two extensive bureaucracies (APRESAL, 1999).

Also, more profound behavioural changes of the technical-professional personnel are required when they interact with the local resources and the communities (de León and González, 2001a; OPS/OMS/FUNMMAYAN, 1999b and MotherCare, 1995). For example, the mechanisms to sustain institutional and community agreements with the executives of hospitals, health areas, health

districts, and municipalities have not been clearly defined, validated and promoted (de León and González, 2001a; OPS/OMS/FUNMMAYAN, 1999 and MotherCare, 1995). The same situation has occurred between the Basic Health Teams (EBS) and the participant communities in the SIAS. Thus, it has been difficult to empower local actors to more effectively negotiate their health priorities within SIAS (MSPAS, 2000a,2000b and APRESAL, 1999). The attitude of mutual distrust has perpetuated, which has affected the quality of discussion on health issues and the planning and direction of services and beliefs about practice.

Through the Health Information Management System (SIGSA), the government initiated a monitoring and evaluation process to improve healthcare services at their three levels of provision (MSPAS/BID, 1999). The outcomes of the monitoring and evaluation process were limited because: (a) a baseline for further monitoring and evaluation was not clearly established through the RSS process; (b) monitoring and evaluation, as a component of the RSS within the SIGSA was not considered strategically as a way to provide information and feedback on the RSS process; (c) monitoring and evaluation and planning activities were not promoted or reinforced through operational decision making or as a way to achieve coherent co-ordination between distinct groups; (d) the analyses of monitoring and evaluation reports were not used systematically to measure the performance of administration and service provision entities participating in the RSS; (e) the MSPAS was not able to incorporate a monitoring and evaluation system to obtain information from all the counterparts involved in the RSS and the SIAS; and, (f) a situational analysis through a monitoring and evaluation system was not achieved which should have included different social sectors, specifically at the local and grassroots level (MSPAS, 2000a and 2000b).

5.8. The Impact of the Lack of Community Participation in Health Sector Reform and the Need to Prioritise Evaluation Activity

Not all of the views of non-government organisations (NGOs), community-based organisations (CBOs) and other civil organisations completely agree with the RSS implementation policies coming from the MSPAS to develop the SIAS at the local level. NGOs have perceived that the MSPAS' central authority has been verticalist, developmentalist and authoritarian in nature within a framework of the techno-

bureaucratic vision to regulate and co-ordinate RSS implementation policies. Also, there have been indications of the low level of incorporation and active participation of traditional medicine and traditional health providers in the SIAS model.

The new circumstances affecting the RSS process, has not given way to a planned process or to internal and external arrangements between technical and social counterparts. There has been a lack of continuous planning procedures and communication between central and regional institutional authorities and the NGOs, CBOs and other sectors involved in the implementation of the RSS. This problem has affected the capacity of social actors to adjust to the changes and become aware of all of the inherent processes involved. Therefore, it is important to design and organise alternative community participation, together with the local authorities and local social groups. The objective of this is to reinforce the change process, and encourage the legitimisation and acceptance by rural communities of the health decentralisation process in the middle- and long-terms.

Furthermore, profound behavioural changes are necessary amongst technical-professional human resources interacting with the communities' local resources. The un-equal distribution of power, has created the following problems: feelings of rejection in many local communities of external organisations imposing changes, discrimination of local knowledge and resources by some of those organisations, and the lack of participation by local groups. The RSS, and SIAS at the local level, has not yet made profound changes in the way health activities are carried out for instance, in providing healthcare (including the management of human resources), in finding solutions to address health needs by the communities, and in engaging the local populations in discussion and planning. Therefore, it is necessary to systematically promote diverse mechanisms of consciousness-raising and awareness about the perceptions, practices, attitudes and interactions around healthcare to the MSPAS, IGGS, and other institutional personnel involved in such processes (de León and González, 2001a,2001b and Haeussler and Lima, 1996).

The MSPAS has not yet promoted, empowered or reinforced the strategic role that a Monitoring and Evaluation System can play in various key activities of the RSS process. Amongst these kinds of activities are: planning, operational decision-making, coherent co-ordination between distinct groups, and assessment of the

whole SIAS process. Monitoring and Evaluation has not widely and systematically been used to measure the performance of entities providing and administrating health services within the RSS. The MSPAS as an Executive Unit has not been able to incorporate a Monitoring and Evaluation System or systematic information network involving all counterparts participating in the RSS and the SIAS.

In several communities the operational links between the EBS and the health and development committees, as explained above, have been very weak or non-existent in the rural areas. Monitoring and Evaluation mechanisms for promotion and reinforcement have not been completely established according to the local situations. There have been communication and decision-making problems between central headquarters, health areas and municipal co-ordinations. These problems have affected the organisation of municipal, departmental and national health services and the management of physical, human resource and infrastructure networks. Due to the reasons mentioned above, the RSS has not been coherently, consistently and decisively developed as a health production model. The focus under the RSS process must be on guaranteeing social participation and community fiscalisation. Communities should have more voice, decision and involvement in the planning, programming and management processes of the health service, in order to increase the quality and extension of coverage at the local levels.

This chapter has provided an initial analysis of the limitations of the RSS in recent years in Guatemala. It raised important issues with regard to the role of institutions, organisations and actors within the RSS process. Some issues were raised specifically to examine the post-conflict environment. Although the post-conflict environment is an important determinant, it is argued here that it is the particularities that are key to understanding the implementation of the RSS. Community participation is most significant within this context. Considering Chapters 3 through 5, I have mapped the generic issues pertinent to decentralisation providing both an overview of institutional policies, evaluation parameters and the particularities of the post-conflict environment. I have mapped the specific situation of the post-conflict environment in Guatemala showing both the challenges and limitations of decentralisation in the health sector. I have also mapped the historical dimension of problems associated with community participation and decentralisation providing an overview of conflict, the antecedents to peace building and the emergent country's health profile. Two themes – community participation and

evaluation – appear to be absent or underdeveloped as initiatives and processes of the RSS. In the next chapter, I will discuss my role in the mainstream evaluation carried out by the MSPAS and identify scope for the consideration of alternative frameworks.

Chapter VI
Phase 1 - Evaluation of Community Participation and Health Sector Reform

6.1. Epistemological Role of the Evaluation

In the previous chapter I undertook an analysis of the variables relevant to community participation in RSS under approaches to decentralisation in a post-conflict environment. I did this by bringing together the analysis from the literature review in Chapters 3, 4 and 5. This allowed me to explore the degree to which the variables presented in the former chapter were relevant in providing some of the most important factors of Guatemala's post-conflict environment and in providing studied experiences upon which further research could be developed of like situations. In this chapter I present the findings from the mainstream evaluation of the MSPAS/PMSS/UME. This represents Phase 1 of the research for this thesis. The research was developed in two stages: first, I present examples of the gaps and limitations using a conventional (mainstream) evaluation framework. The aim of the conventional framework is to measure the level of community participation related to the RSS (decentralisation). Second, I provide examples of the understandings and interpretations of conventional evaluation, constructed through institutional and technical-professional knowledge and experience. This knowledge and experience came from the technical personnel working in the design and implementation of the evaluation from the MSPAS/PMSS/UME and the External Advisory Team (EAT). I present some observations about their points of view through brief descriptions of what happened whilst working together with them, as a member of the EAT.

Chapter six sets the stage in epistemological terms by critically examining the conceptual and methodological framework used in the Evaluation of the SIAS. Therefore, the main purpose of this chapter is to analyse the conceptual framework of the evaluation rather than the results themselves. The following sub-objectives are addressed in this chapter: (a) to analyse the variables and indicators (in relation to the contextual framework) that were taken into account for the evaluation; (b) to identify the kinds of questions asked and the outcomes achieved based on those variables and indicators, and; (c) to assess the context of the evaluation questions with regard to the main themes examined. These sub-objectives are connected directly to the main objectives (a) and (b) of the thesis presented in Chapter 1. This includes assessment of the conditions and situations that were assumed and or

believed to exist (according to the methodological design of the institutional evaluation), which either enabled or restricted community participation in the rural areas.

The evaluation of the Integrated Primary Healthcare System (SIAS) was conducted by the operative unit of the MSPAS called the Programme for the Improvement of Health Services (PMSS) and the Monitoring and Evaluation Unit (UME), as part of the first phase assessment of Health Sector Reform (RSS). The SIAS evaluation was requested by the World Bank (WB) and the Inter-American Development Bank (IDB) and carried out by the MSPAS/PMSS/UME over a ten-month period beginning in 2000 and completed in 2001. SIAS was a fundamental part of the RSS process that started in 1996 across the country. The Pilot Plan to implement the SIAS in rural communities started in 1997. The evaluation measured the level of development (mechanisms, systems and processes) in the implementation of the SIAS in the rural areas (local communities) and its level of impact (achievements and limitations) under three key themes: accessibility to health services, quality of the services delivered, and community participation. The evaluation was carried out in sixteen communities in the rural areas representing a national sample (some conceptual mistakes were made in its design, as I analyse below). The evaluation specifically focused on community participation. The evaluation activity also fulfilled the requirements set by the above International Financial Institutions (IFIs) in order to continue to receive funds for the second phase of RSS in 2002.

6.2. My Contribution to the Evaluation - Participant Observation

Part of the information for this chapter draws on direct experience, as I was a member of the external technical team commissioned to provide technical input and appraisal. Through participant observation, my intention was to be directly involved in the evaluation process from within the MSPAS and in co-ordination with the IFIs. It was also important to have direct access to the overall assessment, which was measuring the partial impacts of decentralisation implementation policies at the primary healthcare level. The advantages of using participant observation were: (a) I participated in the discussions on the design and implementation of the conventional evaluation. (b) I had the opportunity to know the criteria to train the technical

personnel who carried out the fieldwork in the communities and accompany them to obtain the information from the communities. (c) I understood the conceptual ideas and key issues that both members of the UME and EAT technical teams agreed and disagreed with throughout the evaluation process. (d) I had the possibility to be aware of the politics behind the technical decisions either supporting or rejecting the content, approach, focus and scope of the conventional evaluation exercise.

The limitations of using participant observation were: (a) there was not enough time, space and willingness to increase the level of mutual trust between the teams. I overcame this by personally trying to get along with MSPAS members: one or two members belonging to the UME team as well as with one or two of the PMSS officers through the interaction I had with them. (b) In some instances, there was limited access to high rank meetings between the MSPAS, WB and IDB representatives responsible for the evaluation process. It was difficult to know in detail, the discussions and decisions made in that regard. (c) I was not allowed to mention what was discussed nor what was written in the minutes of the meetings I participated in. These were protected by agreed ethical principles and confidentiality protocols of EAT. I overcame this by either avoiding or making only general references to meetings and background. (d) Some key technical-methodological aspects were included under the monitoring framework, others were overlooked even though there had been critical discussions between the EAT and the MSPAS/PRSS/UME team responsible for the evaluation. As participant observer I could offer my views and opinion however direct decision-making was not within my scope. Further at this stage of the research, my remit as part of the technical team was to have interaction with the institutional personnel carrying out the survey in communities but not to interact directly with the communities where the research was taking place. This was done purely for contractual reasons with the MSPAS and in exchange, I was given support for Phase 2 of the research reported in Chapter 7.

The strategic decision to participate directly inside the MSPAS is justified under Critical Ethnographic Analysis (CEA) as a part of Naturalistic Inquiry (NI). While the evaluation provided some valuable insights, it also represented a lost opportunity to create a detailed baseline for further longitudinal evaluations using a more comprehensive model of analytical and qualitative variables and indicators. My role in the evaluation was to cast a critical eye over the evaluation process and

present detailed information about how the evaluation was carried out as well as detail about the methodology and findings. I also present personal critical analysis of the limitations and the methodological approach adopted by the IFIs and the MSPAS to undertake the evaluation. The objective of the critical analysis was to arrive at the theoretical, conceptual and methodological categories used by this research to build up an alternative and more comprehensive and qualitative approach to evaluate the level of implementation and impact of the SIAS at the local level. In this chapter the socio-political, socio-economic and socio-cultural issues addressed by mainstream evaluation on the decentralisation process in the Guatemalan post-conflict environment were analysed by my research through a chosen set of analytical questions presented in the tables of Chapter 1, and specified and summarised in Appendix 6.

As a result of the critical analysis I provided of the MSPAS/PRSS/UME evaluation, a comprehensive set of variables and indicators were suggested. It was argued that in order to have a thorough picture of the status of community organisations, the trends, types and context of, complementary macro- as well as micro indicators were required. A conceptual and methodological construction, determination, and validation of the variables and indicators were explained. These observations criticised the three key themes: accessibility to health services, quality of the services delivered, and community participation established under the conceptual framework of the MSPAS/PMSS/UME evaluation in order to determine the themes/problems, which were addressed by this research.

The main objective of the evaluation - to examine community participation in RSS within the pilot areas where the SIAS model was implemented - was considered in the critical observations of findings. The objectives were identified according to their theoretical and conceptual understandings. For example, the PAs clearly identified the levels of participation expected at the community level in health programmes and initiatives. The documents of the WB and the other IFIs, under their programmes for decentralisation also defined participation. The communities where the evaluation took place also discussed ideas about participation through SIAS. These definitions were cross-referenced against the main objectives of the evaluation. The following sub-group of analytical questions constructed from the CHA, CCA, CEA and PCIA main analytical questions (see Appendix 6) were used to

undertake the critical analysis of the interpretation of results of the evaluation. This set of analytical questions allowed the assessment of the evaluation components. It also allowed for further methodological interpretations within the context of the theoretical discussion. The objective of the analytical framework was to identify key issues of knowledge so that these could be explored further. As a result of the critical analysis of the MSPAS/PMSS/UME evaluation presented in this research, an alternative proposal for comparative analysis is considered. This comparative and in-depth analysis identifies, determines, designs and validates a system of qualitative and descriptive variables and indicators for carrying-out a comprehensive evaluation in a post-conflict environment.

The objective of the critique of the conventional evaluation was to identify key issues of knowledge, interpreted as variables and indicators in Phase 2 of the fieldwork. The analytical framework was developed around the analytical questions appropriate for the critique of research focusing on: (a) the behavioural elements intervening in the institutional and human resource conversion process through decentralisation; (b) the composition of planning and managerial attitudes and behaviours with regard to the political decision–making processes; and, (c) the follow-up of international and national policy procedures by the national institutions and organisations through the outcomes of these political and technical decisions related to structural adjustment programmes, decentralisation processes, institutional, physical and human resource conversions.

6.3. The Evaluation of Health Sector Reform According to the WB/IDB/MSPAS Specifications

The conceptual framework used in the institutional evaluation of the MSPAS/PMSS/UME was designed around the need for community participation in Guatemala. Burgos (2000) identified the following body of legislation to support the conceptual framework:

(a) The Constitution of the Republic of Guatemala (1985) established and guaranteed municipal autonomy, legal rights and community participation in public affairs (FLACSO/PADAM/SI, 1988);

(b) The Preliminary Law on Regionalisation (Decree 70-86) of 1986 recognised that in the eight development regions, government actions should be carried out

according to the “needs of the population and organised participation” (FLACSO/PADAM/SI, 1988);
(c) The Urban and Rural Development Councils (CDURs) were ratified under Decree 52-87 to serve as the mechanism for social participation in the formulation of public policies by coordinating actions between public and private institutions at the national, regional, departmental, municipal and local levels (FLACSO/PADAM/SI, 1988); and,
(d) The new Health Code (HC) approved in 1997 by the National Congress, includes fifteen articles on the inclusion of community participation through diverse forms in activities of prevention, promotion and monitoring (MSPAS, 1999a).
In the majority of the articles mentioned above, the explicit or implicit mention of organised community participation usually related to committees or groups rather than individual participation.

The theme of participation was also critical in the creation of the Social Funds (FSs) and development programmes in specific sectors between 1990 and 1994. Burgos (2000) identified the following funds: the National Peace Fund (FONAPAZ) to be used to implement the Peace Agreements, National Land Credit Fund (FONATIERRA) to be used to resolve land tenure issues, Social Investment Fund (FIS) to address social problems, Social Fund for Community Development (FSDC) to resolve development problems at the community level in the rural areas, National Agriculture Fund (FONAGRO) to resolve the agriculture problems, Indigenous Development Fund (FODIGUA) to resolve the ethnic-indigenous problems, and National Programme for Education (PRONADE) to resolve the education problems. Under the Social Funds, the traditional model of management was substituted in favour of models based on the collective demands and priorities of the population.

With the signing of the PAs in 1996, commitments were made to continue the policies and strategies in favour of social participation. The following were established:
(1) Under the Agreement on Reinstatement an explicit commitment was made to gradually transfer decision making power, resource management and administration of services to municipalities and communities. This signalled the need to strengthen community organisations as a self-managing agent of development;

(2) Under the Agreement on the Identity and Rights of Indigenous Populations further commitments were identified to define and recognise forms of indigenous participation in public management including facilitation and consultation;
(3) Under the Agreement on Socio-economic Aspects and the Agrarian Situation the importance of social participation in the framework of municipal autonomy was ratified and social participation was recognised as playing a fundamental role within the CDURs to reform the education and health sectors by reinforcing active participation at the local level in planning, implementation and fiscalisation of services and programmes; and,
(4) Under the Agreement on Strengthening Civil Power and the Function of the Army commitments aimed at strengthening Community Health Participation (PCS) were agreed at the community level and capacity building of social organisations under which, Local Development Councils (CLDs) were established (Acuerdos de Paz, 1996).

Within RSS, social participation was a part of the original objectives to generate an organised social response for the mobilisation and fiscalisation (accountability) of public resources by increasing effective social participation (OPS/OMS/USAID/PHRP, 1998 and Acuerdos de Paz, 1996). The Government Programmes 1996-2000 and 2000-2005, included policies and guidelines for action to promote delegation in the provision of public services and administrative deconcentration, strengthening departmental levels of government, local power, municipal autonomy and the participation of communities including its organisations and socio-cultural practices (MSPAS/SEGEPLAN, 2000; MSPAS/SIAS, 1998 and OPS/OMS/USAID/PHRP, 1998).

6.4. Perceived Limitations of the Mainstream Evaluation

I used the analytical questions from CHA, CCA, CEA and PCIA described above focusing on the conceptual framework of the conventional (mainstream) evaluation framework. The outcome was that the framework had many shortcomings because of the lack of in-depth analysis on the country's decentralisation history and multi-sectoral and sectoral development issues. Some important limitations were:

(a) The constitutional guarantees, although recognised by law were not reinforced in practice, which meant that participation in the public realm (policies and decision-making) was not guaranteed;
(b) The Preliminary Law on Regionalisation (decentralisation by delegation) was actually used to implement the Development Poles in the rural areas under the counter-insurgency strategies of the 1980s, which created fear in communities, co-opted its members to join the PACs and reinforced the presence of the military in the community;
(c) The CDURs at the municipal and local levels were declared illegal under the constitutional amendments of 1992 although legalised again at the end of 2002 and the periods of disruption did little to encourage social participation in policy formulation;
(d) The MSPAS tended to reinforce the prevention aspects of community health but not the promotion or monitoring aspects. Conflicting institutional and corporate values of the medical and paramedical personnel contributed to this tendency, and this was manifested in the lack of desire on the part of the above, to seek community participation;
(e) In relation to the role and performance of the Social Funds, the 'Funds' safety network had become over-politicised under the peace process, which fostered corruption amongst government administrations and institutions. In the worst case, structures of clientelism were created and/or reinforced in the municipalities struggling for resources;
(f) Under the PAs framework, the CLDs were created to improve conditions for the local population (including conditions of indigenous institutions and committees) and,
(g) The re-militarisation and increasing authoritarianism of Guatemalan society was already present at the time of the MSPAS/PRSS/UME evaluation, however, this was not mentioned in the final evaluation document.

With regard to the methodological framework, the MSPAS/PRSS/UME evaluation focused on input from the 'social actors and the processes of sensitisation, visualisation, deliberation and negotiation that they were involved with at the community level'. This focus determined the level of voluntary or consensual acceptance of and adoption to the changes in the health sector and all that it encompassed especially the forms of management utilised to transform community

organisation structures. In this sense, the analysis of social participation identified: the level of development of collective organisation and the individual as social actors, the process of convergence of change factors in relation to participation (including valorisations, behaviour and practices, management, correspondence or relevance) and, the factors of consensus for change (negotiation, concertation, agreement, deliberation and implementation). The responsibilities of the community organisations were also included in the design of the evaluation. These responsibilities were: planning, implementation, monitoring and fiscalisation of health actions in the elaboration of projects to improve the environment (MSPAS/PMSS, 1999a, 1999b; and MSPAS/SIAS, 1997a, 1997b).

Under the methodological framework, the Basic Health Team (EBS) was recognised as implementing health services. The EBS included institutional personnel, community personnel and traditional structures and institutions in the transition of community organisation towards institutionalisation. The design identified the community organisation as responsible for managing the 'Community Centres', which provided services at the primary level of healthcare, located in areas accessible by the majority of the population. These Centres provided preventative and curative care as well as the provision of basic medicines free of charge. The following activities and roles carried out by the centres were measured:

(1) The Institutional Facilitator (FI) which administered vaccination and controlled the spread of disease;

(2) The Mobile Physician (MA) which provided a monthly surgery and treatments as necessary;

(3) The Community Facilitator (FC) who attended to emergencies and those referred by the Health Monitors (VS)[4] and Traditional Birth Attendants (TBA);

(4) Health Committees (CS) which provided transport to people referred with acute illnesses to community health centres and hospitals.[5]

[4] The word in Spanish used in documents detailing health sector reform is ‘vigilante’. The political reference of the word is associated with militarism where vigilance was a part of the counter-insurgency strategy. The ‘vigilante’ in the context of health sector reform performs the role of health monitor or overseer working at the community level. The terminology used here is ‘health monitor’.

[5] Although the roles and functions have been translated from Spanish to English, the acronyms used are kept in the original Spanish to maintain relevancy and to avoid the creation of acronyms, which will have little meaning outwith the context.

Further measurements included the participation in activities of the TBAs, health monitors and community facilitators in health education actions at the household level and the levels of support they provided to the mobile physicians and the institutional facilitators at the community centres. Complex cases, were referred to other members of the team or other centres capable of providing a more 'complex and integrated service', were also measured.

I used the questions from CHA, CCA, CEA and PCIA (see Appendix 6) and discovered that the MSPAS/PRSS/UME methodological framework also had many shortcomings, and omissions, which I have summarised as follows:

(a) The approach of the evaluation was functional rather than critical. While aspects of participation were discussed such as management and organisation structures, and analysis of the socio-political conditions present in the communities and in the lives of its inhabitants, the socio-cultural differences that persisted were not included.

(b) As part of the definition of the research problem, the evaluation protocol concentrated specifically on the level of involvement in the managerial model and in this case, referred to community participation as a SIAS process that was imposed on the local communities. Under this perspective the desirable characteristics of decision-making power and level of efficacy in the implementation of the model were subordinate to the predetermined model characteristics. Additional key external and internal variables, as factors that conditioned community choice and other mediations for preventing or promoting local participation were not taken into account.

(c) According to the conceptual framework of the research the assumption was that within the health system, the process of community participation was encouraged through the establishment of the SIAS and subsequently continued beyond this perspective to the decentralisation of local organisations and institutions. The notion of 'continuing beyond' was based on the recognition and incorporation of intercultural reciprocity and practicality in the solution to health problems at the local level. Community participation was a central focus of the SIAS, and a strategic factor in the extension of coverage under such a model. It was also important for the acceptance, adoption and adaptation of basic health services in the short and medium terms. This statement was again quite rhetorical because there was a gap

in terms of achieving reciprocal exchange (at the institutional level), and in developing a practical solution-based focus. It was only at the end of 2002 that 'the National Plan on Traditional and Alternative Medicine' was formally approved by the MSPAS.[6] An initial pilot phase started through political and technical negotiations with some of the indigenous organisations representing the departments of Quiché, Alta Verapaz and Chimaltenango. Some municipalities of those departments had already started traditional and alternative medicine projects with the support of national and international NGOs with very little contact with the MSPAS. Nevertheless, there has been strong opposition from the Medical Professional College amongst other social sectors in Guatemala towards these projects.

(d) The responsibilities of community organisations in the activities cited above have not been fully articulated or elaborated within the context of the RSS since the creation of SIAS and the establishment of the EBS in the rural communities. The results of the MSPAS/PRSS/UME evaluation were explicit in this regard.

(e) The role and function of the EBS and the service provision activities carried out by specific personnel was a theoretical statement about how SIAS should function, but not how it was actually functioning.

6.5. Primary Research Objective of the Evaluation - Community Participation within the SIAS

Whatever the level of participation achieved, the desirable conditions of social/community participation as defined in the evaluation protocol were: (a) active level of involvement; (b) inclusive of choice (level of decision-making power that affects life); and, (c) effective in terms of the level of efficacy in implementation. The new HC provided a number of articles on community participation to be included within Primary Healthcare services as key elements for the improvement of health from a multi-sectoral perspective. Fifteen areas were identified in the HC, which were integral to the evaluation framework. These are detailed in the table below:

[6] Upon writing this thesis, this is still awaiting constitutional approval by the National Congress, although the programme was scheduled to start in 2004, and the first phase is expected to be completed in 2007.

HEALTH CODE COTENTS RELATED TO COMMUNITY PARTICIPATION

CHAPTER		SECTION		ARTICLE	COMMUNITY PARTICIPATION TO BE INCLUDED IN THESE ACTIVITIES:
I	Fundamental principles		Community participation	5	The partial or total administration of health services and programmes.
IV	Organisation and functions of MSPAS		SIAS model at the primary level	18	The definition of an integral model of healthcare.
II	Health and life styles		Mental health	40	Promotion, prevention and rehabilitation within the framework of primary healthcare and a focus on mobile attention.
			Nutritional security	43	Guarantee availability, consumption and utilisation of foods products.
III	Prevention of illness	I	Health vigilance	52	Avoid the diffusion and eradicate transmittable diseases.
				59	Institutional cooperation in cases of epidemics or socio-environmental risks.
		II	Control of illnesses	61	Control and eradicate preventable illnesses through vaccination.
				65	Protection of the environment, prevention, and elimination of transmittable diseases by Vectors.
IV	Health and environment	I	Environment quality	68	Promotion of a healthy environment.
				70	Vigilance to ensure a quality environment.
				72	Promotion of prevention programmes and control of environmental risks.
				77	Prevention, attention and rehabilitation of people and environments in cases of disaster.
		II	Drinkable water	85	Establish priorities with NGOs that should provide these services.
		III	Availability of residual water	93	Promotion of universal coverage of these services and education on good sanitation.

II	Organisation and development of services for the recuperation of health		Levels of healthcare (primary, secondary and tertiary)	152	Coordination with the institutional sector to organise health services based on the current levels of healthcare.

The stated aims were not achieved by SIAS. Based on the analytical questions from CHA, CCA, CEA and PCIA (see Appendix 6), I identified the following causes:

(a) The majority of the HC articles consider the concept of organised community participation only in the form of committees or groups as opposed to individual participation (other than between the EBS) or any other alternative form of organisation suggested or requested by the communities.

(b) The policies of the health sector continue to be distant from levels of active participation in relation to involvement in the implementation, evaluation and monitoring, and planning of programmes.

(c) The activities in the table above were categorised under three headings – (1) Not achieved and not developed by the institutional structures implementing SIAS. (2) Partially achieved and partially developed by the institutional structures implementing SIAS. (3) Achieved and developed by the institutional structures implementing SIAS. The main findings were: ten out of fifteen activities of the HC were not fulfilled by the institutional structures implementing SIAS.[7] Four out of fifteen activities of the HC were fulfilled by the institutional structures implementing SIAS.[8] Only one out of fifteen was partially fulfilled by such structures (article 85).

(d) Thus, discussion and consensus has been insufficient between all sectors involved in the model of community participation, which should have started before the implementation of basic health services at the primary healthcare level as part of SIAS. The values, visualisations, attitudes and practices of the institutional sector and the polarisation of the communities caused by the civil conflict have been two of the main factors preventing and affecting the mechanisms and procedures of participation in the processes of planning, management, organisation, and monitoring and evaluation of health services.

(e) In the rural areas and especially amongst the indigenous population, social and political valorisations were accentuated especially among municipal and community

[7] This included the following articles 5, 18, 40, 43, 68, 70, 72, 77, 93, and 152.
[8] These included articles 52, 59, 61 and 65.

units. They were linked to their social, cultural and economic reproduction and how different socio-ethnic groups considered beliefs about creation, re-creation, conservation and defence of their culture. This includes forms of authority and influences of social structures. The population in general continues to consider that, the provision of certain services such as electricity, education and health (especially hospital services) was an obligation of the central government and its institutions established in the rural areas. Moreover, decentralisation was little known as a concept, strategy and process and was not considered especially desirable or beneficial in the health sector towards which expectations of free service access remained high even though somewhat paternalistic attitudes prevailed about the 'caretaker' state.

(f) Reviewing this statement, the technical justification for the passive role of the communities and the population in general and the acceptance of institutional paternalism overlooked the importance of the following socio-political, socio-cultural and socio-historical aspects of the problem: firstly, the level of exclusion from participating in and benefiting from development, the high level of repression suffered in the rural areas and the fact that populations existed in this situation for a prolonged period of time. Secondly, the level of formal education and skills that most of the rural population possessed was low to non-existent. Thirdly, and most importantly, the consideration of free service provision was related to the overwhelming level of poverty in the rural areas, a condition that makes it almost impossible for the majority of the population to access health services in the middle and long term. These three factors were consequences of Guatemala's structural problems and the despotic-authoritarian functions of its institutions throughout the history of the country. So, the justification of the state for changing to a user fee-based health service and the 'community participation process' within this new framework of service delivery was not well evidenced.

(g) This situation contrasts notably with the valorisations of the population in which, on a number of occasions it has been documented that there was a positive preponderance towards: first, forms of community organisation as the best way to promote the interests of the population and to value its rights and, second, participation to resolve problems and manage interests of the local unit, was considered more significant and advantageous. It appears that within the population there was a generally favourable attitude towards organisation and community

participation, which was not necessarily related to judgements and opinions about the real expression of these conceptualisations.

In identifying and analysing the problems of the MSPAS/PMSS/UME evaluation, it is important to take the following in to account (related to the post-conflict environment). First, in a society such as Guatemala where the culture of social participation was destroyed, absent or incipient, as a result of repression, exclusion and other social, political and ethnic problems, the conception of community and/or citizen participation in the collective conscience was not expressed under the SIAS. The SIAS implementation approach did not have the impact expected in terms of inherent rights, responsibilities and capacities undertaken by the communities. The communities saw the SIAS approach as another instrument to request for conjunctural interventions (the MSPAS have been perceived as interventionist, mostly appearing when a critical or emergency situation arose, such as epidemics. Otherwise, on the daily basis the MSPAS is considered far removed from the communities' pathos). With the long lasting effects of the civil war and the setbacks in the peace-building process, even in communities with greater cohesion and potential for participation, the possibility of participating in the long term is still difficult and complicated. Community participation in those communities may only be considered transitory according to SIAS terms - just for short periods of time - and aimed at achieving specific benefits. Thus, the SIAS implementation strategy has to address this problem in the long-term. Second, there are a number of indications that certain tendencies and strategies of the government and SIAS have conspired against achieving an adequate and acceptable level of community participation. These include:

(a) The desire for participation and community organisation is often expressed vertically without delegating and promoting the ownership and leverage based on local knowledge and experience;

(b) The emphasis on the completion of goals is not necessarily related to the level of participation expected and the long-term objectives;

(c) The emphasis is on remedial solutions to critical conditions through indirect community participation; and,

(d) The basic lack of confidence in the decision-making structures at the community level is nurtured by the fear of speaking out against the status quo and, it is also

expressed in the form of ethnic passive resistance or the 'memory of the silenced' amongst the indigenous population.

Added to this list was the notion that the individual or the micro-group represented the views of a community. This was not always the case and the following factors should also be considered:

a) The levels of satisfaction with actions and services benefiting the community were not necessarily related to the direct approval of any institutional or formal community agent of development (either individual or group);

b) The categories of approval (leadership, training, management, and social mobilisation) of an agent of development (either individual or group) for community representation were not necessarily the same as all types of actions and services that were required;

(c) The valorisation on the concentration of power and functions (decisions, and management) and the personal characteristics of agents (age, sex, level of education and income) were not necessarily uniform to local units (municipalities, and communities) in the types of action and services required;

(d) The exercise of power and right of community dissension towards the agents of development (either individual or group) was not necessarily related to benefits of the services provided; and,

(e) The multi-functionality of agents of development (either individual or group) as approved community representatives were related to diverse means of social status within the community. The means of acquiring status were appreciated by the community based on concrete actions of collective benefit mainly for the rest of the population, and not based on individual achievements or the fulfilling of tasks like the ones presented in institutional development projects.

6.6. Sample of Rural Communities Selected by the MSPAS/PRSS/UME Evaluation Research

The evaluation selected communities as a part of the sample. The majority of community centres were located in small villages and hamlets. Sixteen rural communities were part of the sample for the evaluation with regard to the theme of community participation and these were spread out across the country. They were

identified through random selection according to the criteria of the MSPAS/PMSS/UME technicians (the criteria were never officially stated in the technical documents or in final meetings with the EAT). The sample included one community located in the central metropolitan area around Guatemala City, three communities located in the northern part of the country - two in the department of Alta Verapaz and one in Baja Verapaz, three communities located in the east and south-eastern parts of the country - one in department of Chiquimula, one in the department of Santa Rosa and one in the department of Jalapa, four communities in the centre and southern parts of the country - one in the department of Chimaltenango, one in the department of Escuintla, one in the department of Sololá, and one in the department of Suchitepéquez, and four communities in the west and north-western parts of the country - one community in San Marcos, one community in Huehuetenango, and two communities in Quiché and one community in the far north region in the south west department of Petén (Tables 1 and 2).

TABLE 1: COMMUNITIES SELECTED FOR FOCUS GROUPS
Users, Health Committee and Health Monitors

Department	Community Centre	Users	Health Committee	Health Monitors
Guatemala	Las Anonas	X	X	X
Baja Verapaz	Pampá	X	-	X
Alta Verapaz	Los Mangales	X	-	X
Alta Verapaz	Canaan	X	X	X
Chiquimula	Buena Vista	X	-	X
Santa Rosa	Las Nueces	X	X	X
Jalapa	La Montaña	X	-	X
Chimaltenango	Tioxyá	X	-	X
Escuintla	Buena Vista	X	-	X
Sololá	Pahichaj	X	X	X
Suchitepéquez	San Antonio Las Flores	X	-	X
San Marcos	Las Marías Nueva Esperanza	X	X	X
Huehuetenango	Guachipilin	X		X
Quiché	Chiul	X	X	X
Quiché	Pie del Aguila	X	-	X
Petén (Sur Occidente)	Nueva Vista Hermosa	X	-	X
TOTAL	**16**	**16**	**6 (of 14)**	**16**

TABLE 2 COMMUNITIES SELECTED FOR INDIVIDUAL INTERVIEWS
Institutional Facilitator (FI), Mobile Physician (MA), Traditional Birth Attendants (TBA), Traditional/Popular Medicine Provider (PT)

Department	Community Centre	MA	FI	CT	PT
Guatemala	Las Anonas	X	X	X	X
Baja Verapaz	Pampá	X	X	X	-
Alta Verapaz	Los Mangales	-	-	X	X
Alta Verapaz	Canaan	X	X	X	X
Chiquimula	Buena Vista	X	X	X	X
Santa Rosa	Las Nueces	X	X	X	X
Jalapa	La Montaña	-	X	X	X
Chimaltenango	Tioxyá	X	X	X	X
Escuintla	Buena Vista	X	X	X	X
Sololá	Pahichaj	X	X	X	X
Suchitepéquez	San Antonio Las Flores	X	X	X	X
San Marcos	Las Marías Nueva Esperanza	X	X	X	X
Huehuetenango	Guachipilin	X	X	X	-
Quiché	Chiul	X	X	X	X
Quiché	Pie del Aguila	X	-	X	X
Petén (Sur Occidente)	Nueva Vista Hermosa	X	X	X	X
TOTAL	**16**	**14**	**14**	**16**	**14**

EAT, of which I was a member, discussed the composition of the sample with the MSPAS/PMSS/UME technical staff. The classification suggested that the sample design included five aspects related to the population's socio-demographic composition: (1) ethnicity, (2) rural-urban differentiation, (3) level of literacy and/or schooling, (4) poverty and/or level of need, and (5) stability or instability of geographical residence. Also, three aspects related to the community's characteristics were suggested: (1) size, (2) accessibility to the health services, and 3) location in terms of coverage of the health system. The EAT indicated to the MSPAS/PMSS/UME technical staff that the selection of the classification of variables had to be based on the relevance of the community characteristics chosen at the national level (further evaluation exercises for the future) and the availability of information from reliable secondary sources. The chosen variables had to be sufficiently ample to elaborate lists of local units relevant to the analysis and to construct composition scales within the interior of each classification based on descending or ascending socio-demographic groups (population profile, population size, age cohorts, and economic activities).

However, the MSPAS/PMSS/UME technicians distrusted a complementary qualitative analysis, using an ethnographic approach through opportunistic sampling. They did not like the idea of having a sample and methodology, where the communities could not be grouped according to homogenous or heterogeneous traits or identified on the basis of similar and dissimilar tendencies of response. The MSPAS/PMSS/UME technicians were interested in demonstrating that the final methodology allowed 'statistically significant' extrapolation of data with respect to the rest of the research components and the variables around community participation. Also, they recognised that the resources and the timetable would not allow an appropriate sample to be drawn that achieved 'national representativeness'.

For reasons described previously, the evaluation design gradually moved towards a combination of quantitative/qualitative methodologies but under an incomplete conceptual framework for the reality it was designed to address. The sampling should have been utilised better by relating the conglomerations of communities grouped by similar or dissimilar characteristics. It should have been combined with the level of accessibility of the communities, to the community and institutional health infrastructure, and according to their location within the health system and their administrative boundaries (municipalities, health areas and districts). For instance, no analysis was generated about the relationship between municipalities and health districts as part of the study. The EAT never knew the intentions behind the final selection procedure of the sub-sample of 16 communities studied in the evaluation. It did not appear in the final version of the document given by the UME to the EAT and analysed in this chapter.

Applying the analytical questions from CHA, CCA, CEA and PCIA (see Appendix 6), I identified the following weaknesses of the conventional (mainstream) evaluation: First, the MSPAS/PMSS/UME technical staff lacked awareness and understanding of the post-conflict environment in the communities, in which they carried out the conventional evaluation even though it was discussed with them and with the PMSS authorities. Second, the epistemological category of exclusion was never applied, although it was suggested by the EAT to address problems of health inequality in the rural areas. This criterion included key variables such as poverty, marginalisation, social economic and cultural inequities, psychosocial violence,

insecurity and violation of human rights. The information could have been gathered through different institutional and non-institutional means such as the Poverty Reduction Maps from SEGEPLAN, the Guatemala Human Development Report from the United Nations and the NGOs working within SIAS as trainers and providers amongst others. Therefore information was available but not used. Third, reproductive health in the broadest sense was not included except for the maternal-neonatal healthcare aspects. Fourth, no mental healthcare questions, variables and indicators were included as stated in the HC. Although mental health is a very important component of the SIAS, it has not been adequately considered in the implementation of the health model by the MSPAS. Furthermore, was a lack of co-ordination with the National Mental Health Programme.

Another very important observation of this evaluation process was that fieldwork was completed almost entirely by people who were a part of SIAS. Thus, the interviewers ignored very important social and cultural aspects about community participation because they were simply considered irrelevant or because the interviewers did not see the importance of them. For example, I observed that the questionnaires for traditional birth attendants (TBAs) and other traditional health agents asking their opinions on SIAS and community participation and others inter-related themes were practically left incomplete, while questionnaires to trained TBAs were complete. A similar pattern was noted on questionnaires from the Health Committees. From my personal observations I was aware that local people had strong opinions on these questions and therefore, it was inconceivable that they did not answer questions because they had little or nothing to say.

6.7. Analysis of Results by Component: Component I – The Stages of Health Service Management and Community Participation

The sections below present findings and methodology of the evaluation. There were four stages of the evaluation. The first stage of the MSPAS/PMSS/UME evaluation included questions about the following aspects: (a) identification of health needs and resolution of problems at the organisational and managerial levels; (b) establishment of goals and priorities; and, (c) programming. With regard to community participation in the identification of the health needs of the population, information was obtained from users, Health Committees and Health Monitors.

With regard to the question ‘was the community taken into account in the identification of health needs?’, the evaluation found that an average of 81% of responses from the user groups and the health monitors (VS) indicated that the community was taken in account, 11% indicated that the community was not taken into account and 8% indicated that only the community leaders were taken in account. No information was available from the Health Committees on this question. With regard to the second question ‘what mechanisms existed for the community to express its needs’, responses from focus groups with user groups and the Health Committees found that in 58% of cases an established mechanism for participation did not exist, 32% indicated that the community was consulted occasionally about management issues and 10% stated that a mechanism of communication existed with the community. No information was available from Health Monitors for this question. With regard to community participation in the establishment of objectives and priorities for the provision of health services, information was obtained from users, Health Committees and Health Monitors however it is only available from the Health Monitors. With regard to the question about ‘how respondents considered that the health needs of the community were determined’, 89% responded that they undertook direct observation by visiting the households in the community and 11% responded that they would consider the active participation of the VS in clarifying and determining needs. Effective diagnosis of health needs in order to establish the health services were not given as an answer. With regard to community participation in programming, the question was directed to users, Health Committees and Health Monitors. Information was only obtained from Health Monitors. With regard to the question ‘how would you co-ordinate and take into account the needs of people in the community’, 50% indicated that they had no mechanisms to carry out direct consultation with the community, 44% responded that there was frequently established direct consultation with the community and Community Facilitator and 6% indicated occasional consultation with the community.

The second stage of the MSPAS/PMSS/UME evaluation included: (a) service administration; (b) implementation of technical activities; (c) education activities; and, (d) use of the services. For the implementation of the technical activities, the following questions were asked: the first question referred to vaccination, mosquito and pest control, and environmental sanitation and asked ‘who organised these activities and how did the community participate in them’. The

evaluation found that 19% indicated they did not know who undertook these activities, 31% indicated that the activities were exclusively organised by the health services, 40% indicated that the activities were organised by the health services with the community's prior knowledge, and 12% indicated that the activities were organised by the community through their local representatives. However, when the Health Committees were asked about community participation, 21% responded that the community do not participate, 29% indicated that the community and its representatives participated only in health promotion activities, 43% indicated that the community and its representatives participated in promotion and implementation activities, and 7% indicated that the community acted as a receptor of services only. The VS were questioned about the above issues and 94% of their responses indicated their participation in education activities focused on health prevention in the household visits. These responses reflected the visualisation of the VS within the SIAS model, as a part of the strategy to reinforce the health education activities at the family level. Another 6% indicated that they had an information provision role within the health services provided at the community level.

The results of community participation related to educational activities were presented in the following way: the users of the public health services were interviewed by the MSPAS evaluation team about hygiene and nutritional activities. Fifty percent responded that these activities had been carried out collectively, 39% indicated that these activities had not been carried out, and 6% indicated activities had not been undertaken individually through home visits or undertaken individually or collectively at all. The Health Committees were asked whether they organised such activities and half of the groups responded that these activities had not been organised while the other half indicated they had been organised. Also, the VS were asked if they had been trained in these kinds of activities and 100% indicated that they had had training.

Three questions were asked around community participation and the use of health services. The first question was 'what do you do and where do you go if you feel sick, and if you do not go to the community centre' Responses from Health Monitors and users indicated that 25% went to the Health Post or to the public hospital, 17% went to the EBS, 11% used popular medicines or consulted the pharmacist, 6% went to a doctor and 46% used a combination of options. The

second question was ‘do you like to come to the Community Centre (CC)?’. Information was obtained from users and 83% indicated that the population used and accepted the CC, 11% indicated some use and acceptance of the CC and 6% indicated little acceptance and use of the CC. The third question was ‘do you believe the community uses the services at the CC?’ and 57% indicated that the community used and accepted all of the services at the CC and 21% indicated little demand, use and acceptance of consultation services.

The third stage of the MSPAS/PMSS/UME evaluation referred to community participation in the monitoring of health service activities. The first question asked by the evaluation team was about ‘how was the work of the EBS supervised?’ Information was obtained from Health Monitors and users. Forty-two percent indicated that they did not know how the EBS was supervised and 58% responded that the supervision was carried out according to an internal EBS and health service hierarchy. The VS overwhelmingly indicated the presence of an internal institutional hierarchy (72%). The question asked to the Health Committees was ‘what kind of role they have with regard to the monitoring, evaluation and supervisory activities they carry out?’ Sixty-four percent responded that they did not monitor or evaluate any activity, 14% responded that they occasionally undertook monitoring and evaluation activities, and 21% responded that they permanently undertook monitoring and evaluation although they did not specify how these activities were conceptualised.

The fourth stage of the MSPAS/PMSS/UME evaluation process referred to community participation in the valorisation of health services. Information was obtained from Health Committees by the evaluation team. Eighty-six percent of all the responses indicated that the health services can be improved if they consulted the community and followed the requirements requested by the community. Only 14% indicated consultation with the community when making decisions as a way to improve the services at the CCs. With respect to the improvement aspects of the health services, 17% indicated that more furniture and equipment were needed to improve services at the CCs, 78% indicated more medical instruments and a greater variety of medicines were needed, and 6% indicated the need for improving the quality of EBS members and additional staff.

6.8. Analysis of Results by Component: Component II - Evaluating the Level of Community Participation

The evaluation assessed the following aspects on community participation: (a) determination of needs; (b) leadership; (c) organisation; (d) social mobilisation and resources; (e) management; and, (f) decentralisation. With respect to the determination of needs the results were presented as part of the first and second components of the evaluation by the MSPAS/PMSS/UME team. The main question asked by the evaluation team was about 'the leadership role of the health committee and its relationship with the community'. Information was obtained from users, committees and Monitors and on average, 82% indicated that the community was in agreement with the health committee and the community was represented in consultation exercises, 6% indicated that the community was only represented in consultation exercises in special cases, 6% indicated that the health committee was not necessary and 22% did not respond to this question. With regard to the question on 'whether the community was supported and was involved in the activities, 92% of the focus groups participants involving health committees indicated that the community was involved while 7% indicated the community was not involved. With respect to the level of community organisation in the localities surveyed, in 17% of those localities there was no community organisation or health committee established, 39% indicated they did not know how the health committees were formed, 44% responded that the health committee was established by the EBS with the participation of the communities, leaders and other development committees; and, 17% responded that the EBS and NGOs established the health committee without the participation of the communities.

In relation to social mobilisation, the MSPAS/PMSS/UME evaluation included a question on whether 'the community [is] able to pay for health services'. The evaluation team found that 33% of the communities were not able to pay for services, 48% indicated the community made some contribution, and 19% indicated that a contribution was only be made after consensus. In relation to the question 'does the community provided financial contribution to improve community centres?', 36% indicated the community did not provide money to community centres, while 64% indicated that it had provided money. In relation to the question about the participation of the health committee for improving the CCs, 64% responded that as members of the committee they were in agreement that the EBS should be

completely managed, 26 indicated no agreement on management arrangements for the EBS and 10% indicated partial management of the EBS. This question took into account considerations for the decentralisation process of the health services.

6.9. Analysis of Results by Component: Component III - Analysis of the Participation of Actors in the Technical Administrative Process

The MSPAS/PMSS/UME evaluation assessed the following aspects: (a) planning; (b) implementation; (c) monitoring; and, (4) evaluation. The MSPAS/PMSS/UME evaluation team evaluated the performance of each actor involved directly or indirectly in SIAS. Individual community actors, VS and TBA were mainly undertaking implementation activities. Eighty percent to 100% of their activities were directed towards implementation. These actors undertook 'very little' to 'no' planning and monitoring activities. Although MAs and FCs mainly undertook implementation activities, they had considerable planning responsibility. Twenty-two percent and 25% respectively were dedicated to planning activities. The actor undertaking both planning and implementation activities was the health committee with 40% in each aspect. Monitoring appeared to represent between 16% and 22% of total activities in MA, FI, FC, VS and CS. The only actor who did not undertake monitoring activities was TBA. The weakest activity for all actors was evaluation. None of the actors undertook evaluation and the model did not contain evaluation activities as part of their functions.

In relation to planning, the evaluation team found that the MA, FI, FC and CS undertook 50% to 68% of these functions. Only 6% of VS activities were designated to this function. For the evaluation, two MA activities were included and 14 MAs were interviewed. The average number of activities reported was 68%. The maximum and minimum values were 71% and 65%, respectively. Fourteen FIs were interviewed and 8 monitoring activities were included. This represented 73% of activities with a minimum value of 64% and a maximum value of 86%. The average obtained for the 16 FCs interviewed was 54% and 7% for the 61 VSs interviewed. The average figure for EBS institutional members (MA and FI) and community members (FC and VS) represented a difference of 30%. The TBAs did not have planning activities.

With regard to implementation functions the evaluation team found that the MAs undertook a greater percentage with 80%, followed by TBAs with 77%, FCs with 74% and FIs with 67%. The Community and the Health Monitors represented 50% and 51% respectively. In relation to monitoring activities, MA, FI, FC and VS had a distribution between 72% ad 85% in completing these functions. Fourteen MAs reporting monitoring activities achieved an average of 86%. The minimum and maximum values were 77% and 93% respectively. FIs were interviewed which included 15 monitoring activities with an average of 73% and minimum and maximum values of 64% and 86% respectively. The Health Committee was underrepresented with just 8%. For this evaluation, only 2 activities were included in the interview.

The average obtained from the 16 FCs interviewed was 75% and, 79% for the 61 VS actors. The average figure obtained for institutional members of EBS (MA and FI) and community members (FC and VS) was very similar (80% and 79% respectively). This figure was higher than average for the 8% reported for Health Committee (CS). This indicated that the 2 institutional members and 2 EBS communities implemented a good level of monitoring activities. TBAs were not included in the study because according to the programme implementation they did not "undertake monitoring activities". Also, Health Committees did not develop an acceptable level of monitoring, they were not well established, and their members felt that a clear purpose and agenda was needed to develop the model.

6.10. Critical Observations – Questions Raised and Gaps Identified Towards an Alternative Evaluation Framework

In relation to the EBS members, the VS interacted between the community and SIAS. The VS was principally involved in community participation working in health education and promotion. The VS tried to involve families in prevention activities. The VS carried out half of his/her functions according to the stipulated HC norms. The FC interacted between the community and the institutional health system. She/he had an acceptable level of participation and implementation of monitoring and evaluation functions. However, only half of the planning functions were implemented by the FC according to the HC norms. This indicated a low level of community participation and involvement by the rest of the local population. This was also important because the VS and FC groups were based in the communities.

These two groups of community actors had undertaken planning and monitoring activities with relatively low positive results. Community actors (including the VS and FC groups) were mainly responsible for the implementation of tasks however they did not have too much involvement in planning and did not have enough knowledge of their responsibilities and roles. Therefore, the model was functioning under institutional direction almost entirely rather than under community leadership and management. This meant that the SIAS model had been more institutionally than communally oriented in its objectives and results overall.

According to the health norms, the EBS encompasses institutional personnel, community personnel and traditional and emergent structures of community organisation being incorporated to the SIAS. The community members of EBS (Health Monitors and Community Facilitators) were selected by the population in community assemblies to organise and coordinate the EBS. However, there were some important contradictions between the EBS and the health or development committee members as the survey showed above. The contradictions were: (a) there was no equal participation in the decision-making and accountability processes; and, (b) institutional rationale and sectoral practices had been dominant over community beliefs and tasks assigned under the SIAS norms to the committees and communities. This problem stemmed from the way SIAS implementation policies had been applied at the local levels. The process of community participation had been fomented only sectorally through the establishment of the SIAS. This was evident in analysing the conceptual framework of the MSPAS/PMSS/UME evaluation. Community participation had only been the central focus of the institutional culture for policy implementation, but the structures of the MSPAS had not been transformed from within. Thus, community participation has not been accepted, adopted and adapted institutionally by SIAS in the short and medium terms. However, if active participation at the community level goes beyond the narrow perspective of the current SIAS implementation policies, it could present a different scenario in the middle and long terms. The medical and paramedical actors within the EBS may establish more participative local processes toward democratic decentralisation of local organisations and autonomous health institutions. They may be based primarily on the institutional recognition and incorporation of intercultural reciprocity and community ethno-cultural practices and values (such as religion, cosmovision, and traditional medicine). Also, taking more account of the

population's experience in identifying health needs and solutions at the local level, reinforcing the contents and objectives of the PAs.

Thus, the former analysis did not provide clear and comprehensive findings regarding what kind of community organisation existed in each community, what level such an organisational process developed and under what conditions it was developed. I examined what happened with the issues that were left aside or missed. Therefore, I again applied the analytical questions from CHA, CCA, CEA and PCIA (see Appendix 6). I present some analytical observations throughout this section of the chapter on several critical issues, which the methodological approach of the MSPAS/PMSS/UME evaluation did not appraise: (1) The kind of community organisation that existed in the localities before SIAS was implemented. (2) The elements of community organisation, when it started to work and how it worked. (3) The type of problems that community organisation faced and how it coped with the problems derived from the civil war and post-conflict environments. (4) The level of impact in the middle and long terms of these problems affecting the communities as a whole. (5) The relationship between the above problems related to the socio-economic, socio-political, and socio-cultural exclusion model of the country. (6) The assessment of the above problems and the country's model using macro-indicators and trends at the national and sub-national levels focusing on the communities being evaluated.

The data for the first component analysed presented the following trends: the communities partially participated specifically in the assessment of health problems and the identification of needs. There was no community participation in activities that established priorities and goals or in the programming of health services and activities related to local implementation. In relation to the second component of the evaluation, the methodological observations to establish a more comprehensive set of variables and indicators in order to have a deeper and broader understanding of the status of community organisations, the following issues could have been addressed: (1) The meaning of health, need, problem and solution from the perspective of community members. (2) The community's point of view on needs, problems and solutions and their priorities (3) The similarities in need and the views of all the community sectors depending on location and ethno-demographic composition. (4) The coherence of views and conceptualisations with the priorities of

the health decentralisation policies through SIAS. (5) The need for a historical comparative analysis about the evolution of community organisation structures related to the nature of the leadership formation (traditional and non-traditional structures, religious structures, and civil-military structures). (6) The way the community is compelled to organise (mobilise) itself to face problems and needs. (7) The way the community understands and practices management including the level of capacity building the community members have or need to develop under the SIAS and other inter-sectoral areas.

The communities had very little impact on supervision and evaluation activities, which referred to the level of direct community participation. It appeared that the communities attempted to promote leadership features in the mobilisation of health resources and in the management of services. However, this was not entirely achieved because of the lack of a strong organisation process and the absence of more empowering mechanisms for local participation. In general terms, according to the above information, community participation in health activities was limited. In many aspects the questions for this component referred to the communities' potential and their possible role rather than what they were actually doing with regard to health and local development.

In relation to the third component of the evaluation, the methodological observations to establish a more comprehensive set of variables and indicators were as follows: each of the above managerial categories encompassed specific activities that were inter-related. Nonetheless, this component provided important information (although incomplete) for identifying which activities and stages of healthcare provision involved individual institutional actors and features of community participation. The set of indicators were insufficient to measure the variables that intervened or determined the answer to these questions in any depth and breadth. For instance, the model as explained above was functional, a-temporal, not contextualised amongst the communities studied and unable to identify the role of the actors as individuals or whether they belonged to the communities. The socio-economic, socio-political, and socio-cultural problems were not confronted. The third component of the evaluation revealed important information relevant to an understanding of the problems faced in the implementation of SIAS. Nevertheless, the evaluation could have included and inter-

related the key issues described above in a more comprehensive and critical way. For instance, (1) The kinds of factors (variables) intervening in preventing organisational and managerial skills from developing in the community and therefore, directly or indirectly affecting the implementation of SIAS. (2) The meaning of power, decentralisation, democracy, participation, inclusion, equality and empowerment among other conceptual categories related to community organisation. These issues would have been asked of SIAS members, the community, and the PRSS staff and related to the national and sub-national situation in the country. (3) Before or after the implementation of SIAS, the kind of community skills that existed. (4) The development process of those skills that already existed before the SIAS implementation. (5) The degree to which, the community's skills were disrupted, diminished or destroyed during the civil war. (6) The potentials of community resurgence (re-organisation) in the short, middle and long terms. (7) The promotion and support of community resurgence (re-organisation) in those communities affected. The methodology of this evaluation thus did not present enough information to establish an effective evidence-base.

With regard to the stages in the service administration process and how the communities chosen participated in the four managerial stages of the SIAS - planning, implementation, monitoring and evaluation - the implementation stage was where the community had the greatest level of 'indirect participation' (limited decision-making power). This was not only valid for community members but also for the EBS. The communities through their health committees did not undertake health service administration as part of the four implementation activities designated by SIAS. However, there were a number of activities that should have been administered by the committees to maintain the community centres according to the norms of the HC. There was an acceptable trend in participation in terms of health promotion. However, participation would have been reinforced within the SIAS policies, extending participation to planning, monitoring and evaluation activities at the community level. The healthcare provision defined by the SIAS model was acceptable in terms of encouraging community participation according to the information of this evaluation. Nonetheless, expanding participation of individual community actors in planning, monitoring and evaluation would have clearly strengthened it. All the local actors either institutional or community would have been strengthened to undertake evaluation activities, which appeared to be weak.

The low percentage of monitoring and evaluation activities indicated that the communities were not performing their key accountability functions.

With regard to the collection, systematisation and presentation of results according to the conceptual methodological framework: first, the in depth analysis on the higher number of cases should have taken into account variables such as the region, ethnic identity and level of illiteracy to show distinctions and trends in levels of provision and participation based on geographic and socio-cultural factors. Second, from the 16 communities selected for the evaluation, data related to health committees (CS) was only reported on 6 communities (37.5%), despite the fact that 14 CS were originally registered. There were not sufficient numbers of CS in the selected sample, because there were not enough CS actually formed or working on verification of functions. Again, the data omitted the factor of geographic representation given that with the small number of cases studied it would have been difficult to discern tendencies. More communities as direct replacement (proxies) were not considered even though they could have been included in this evaluation. The results for the group of Health Monitors were different from the rest because equivalency did not exist between the number of selected communities for this analysis and the maximum number of providers who had information. In the selection of the 16 communities the number of monitors that were informed of the MSPAS research per community was between two and seven for a total of 61 individuals (they were the social base of the EBS in the communities 'participating' in SIAS). This was an overwhelming number in comparison with the other group members. Third, the completion figures per type of evaluation indicators of the FC were not completely assessed. This partial omission was an error of methodology and supervision of the fieldwork.

The issues requiring answers with regard to the methodological approach for the completion of the items list according to the norms were: (1) The Health Committee (CS) groups working did not correspond with their registered numbers. (2) The motivational aspects that diminish or increase organisational initiatives (like the CS) within SIAS. (3) The kind of environment (as political, social, economic, and cultural variables) that prevents or promotes community organisation related to SIAS or any other development initiative. (4) The implementation problem with the SIAS norms, for instance, the low level of completion of norms. (5) The level of practical

understanding of the norms. (6) The level of formal understanding of them. (7) The capacity building procedures (education, promotion, resource management and training), to improve the level of understanding amongst the EBS members and the community.

The data included in the final report encompassed 16 communities with regard to community participation as part of a longitudinal pilot study. The numbers of interviewees in the MSPAS/PMSS/UME evaluation were: MA n=14, FI n=14, FC n=16, VS n=61, CT n=16, CS n=6, (an average of 12 members per CS), for an approximate total of 193. The MSPAS/PMSS/UME's quantitative/qualitative evaluation results on community participation were incomplete in terms of an extensive assessment of the different kinds of direct and indirect variables to be included in the evaluation. Special attention should have been paid to an array of alternative categories for the more substantial statistical analysis (both descriptive and comparative) on community participation. It would have been useful to this aim, to design sets of macro variables and indicators to assess the historical, political and socio-economic problems of the country at the national and sub-national levels and sets of micro variables and indicators for the conceptions, valorisations and attitudes of the participant population in SIAS. Therefore, comprehensive critical analytical variables and their use as indicators should have been elaborated and a conceptual and methodological approach to appraise key macro and micro variables and their indicators, with examples of analysis and outcomes supported by an array of sources (bibliographic, documental, instrumental and empirical) were required.

The conceptual model used by the MSPAS/PMSS/UME was an ambiguous and limited version of a standard or "mainstream" quantitative/qualitative evaluation framework, which was not reliable in elements of its design, the analysis undertaken and results obtained. The methodological approach to the evaluation was based on insufficient variables because meaningful indicators were insufficiently developed to address the evaluation from the different cognitive angles and analytical levels that were relevant to the complexities of the theme/problem. With a more epistemological criterion and a detailed phenomenological scope, a broader set of variables could have been identified in order to achieve a better quality evaluation. These variables would have more effectively addressed the three methodological questions fulfilling the specific objectives of the evaluation. Thus, some of the main

limitations that the evaluation model presented were: the model was entirely structural-functionalist, a-temporal and not contextualised in that, the national and sub-national levels of the country, and the particularities of the communities studied were not taken into account. The epistemological framework was designed to be limited (in the scope of the study), superficial (in the breadth of the issues it explored) and uncritical (a-political, a-historical, and un-aware of the circumstances in which the evaluation took place). In the next chapter, I present fieldwork results and analysis of Phase 2, where these issues are explored further in order to move closer to the construction of a more comprehensive framework for evaluation with macro- and micro- qualitative variables and indicators to fulfil the objectives of my research.

Chapter VII
Phase 2 - Fieldwork Findings on Community Participation and Health Sector Reform under a Model of Decentralisation

7.1. Observations from Phase 1 and the Epistemological Approach towards an Alternative Evaluation Framework

The findings from Phase 1 (which came from participative observation where I was a member of the External Advisory Team, EAT, providing technical support to the MSPAS/PMSS/UME evaluation) suggest that there were major weaknesses in the analysis of community participation coming from that mainstream evaluation. First, the MSPAS/PMSS/UME evaluation focused on functional and not critical criteria to address the problem of participation. Social, political and economic conditions in the past and present, which impacted the population were not critically analysed in the communities evaluated. Second, the MSPAS/PMSS/UME evaluation did not address the changes in traditional or institutional authority and decision-making throughout time, either individually or collectively. Also, the evaluation did not address the positive or negative impact of those organisational changes, and their advantages and disadvantages in the short and middle terms with regard to democratisation, participation and decentralisation processes. Third, traditional healers and shamans and other community leaders who had an impact and interaction with the community were not considered under the MSPAS/PMSS/UME evaluation. The traditional source of their knowledge was missing from the questions asked by the evaluation. Fourth, community participation was defined narrowly under the MSPAS/PMSS/UME evaluation framework and there was no framework for considering the complexity of community participation through interrelationships within the community. Fifth, under the MSPAS/PMSS/UME mainstream evaluation, the assumption was that community participation could be nurtured and established only through the development and establishment of the SIAS model. The methodological limitations of the MSPAS/PMSS/UME evaluation did not enable a clear and more profound testing of assumptions, because there was no framework for the identification of key variables and indicators. And, sixth, the MSPAS/PMSS/UME evaluation did not take into account the limitations of participation as part of the structural problem of exclusion in most of the rural communities where the exercise took place.

Traditional medicine represented a manifestation of the knowledge of the community, which held specific benefits for community members. It was central to a cosmovision (a way to view life, nature and the universe) shared by the community and important to the community identity, which was adversely affected during conflict and continued being affected in the post-conflict environment. Also, traditional medicine was one of the first ways the population sought treatment for health problems. It was cheaper and easier to have access to traditional medicine than institutional medicine, and rates of success were within acceptable levels in many cases. Through traditional medicine specific roles within the community were identified through which social relationships could be fostered and stabilised. Traditional medicine could be an important factor to bring together the community. During the civil war, and now in the post-conflict environment, traditional medicine represented a strong collective socio-cultural link for the survival and reinforcement of ethnic identity in the communities. RSS had mostly promoted institutional medicine without taking into account the importance of traditional medicine according to the contents of the PAs. Local knowledge was disregarded with respect to the implementation of RSS policies.

In Phase 2 of my research, I realised that I could not speak about community participation in health sector reform under decentralisation, without accounting for the role and importance of traditional medicine in the life and culture of the people. Traditional medicine was a form of community participation (because of the social inter- and intra-relationships it produces) and its recognition and incorporation to institutional medicine is an essential part of RSS and SIAS according to the PAs. Thus, through the analysis in Chapter 6, I linked these problems to participation, and then to the difficulties of the peace-building process in the post-conflict environment of the country. The persistent socio-political and socio-cultural inequity of authority between the communities and the MSPAS at the local level, made the incorporation of the alternative knowledge-discourse of traditional medicine into SIAS very uncertain, vis-à-vis the hegemonic knowledge-discourse of institutional medicine.

The issues from Phase 1 that shaped my thinking for Phase 2 included the degree of collective organisation within the SIAS from the institutional perspective, the conceptualisations and valorisations (knowledge), attitudes and practices of the SIAS related to institutional organisation, and, the level of deliberation, consensus,

agreement, and implementation of policies to achieve institutional co-ordination and organisation within the SIAS. I wanted to focus on more critical factors such as the socio-political conditions within communities and socio-cultural differences. I wanted to focus on additional key external and internal variables, as factors that conditioned community choice. Factors that either prevented or promoted local participation and which, were not taken into account. I wanted to look at the true significance of intercultural reciprocity and practicality in the solution to health problems at the local level, which the MSPAS evaluation failed to do. The objectives of the MSPAS/PMSS/UME conventional evaluation to measure active participation needed to be re-assessed from the perspective of the community, how they were and wanted to be involved and, how they perceived and expected to obtain health sector reform.

7.2. Phase 2 – Research Methodology

I divided Phase 2 fieldwork into two components – Component 1 included focus groups with four groups of professionals: (1) high rank officials within the health sector and other government bodies directly or indirectly involved in health sector reform and decentralisation policies, (2) advisers and consultants involved in health sector reform and the decentralisation process either working within or outside of the government sector, (3) representatives from the civil and academic sectors, and (4) officials from international cooperation agencies supporting/working under the framework of health sector reform and/or decentralisation policies. Component 2 involved focus groups with personnel from the institutional medical system, which included (1) doctors, graduated and auxiliary nurses assigned to the Health Centres in the municipalities of Chamelco and Tucurú. (2) Members of the Basic Health Teams which included Mobile Physicians, Health Monitors, Community Facilitators and Trained Birth Assistants. (3) Health providers from the traditional medical system which included Healers, Herbalists and Traditional Birth Assistants and (4) community members including users of both traditional and institutional medicine. The results of the fieldwork are analysed under each component according to the sub-group of respondents. The results for Component 1 represent an example of the macro level of vision, analysis and experience. The results for Component 2 represent an example of the micro level of vision, analysis and experience. The

micro level of analysis is broken down into two parts– analysis by thematic area and analysis by sub-group of respondents (types of responses and of respondents).

To undertake Component 1, I used purposive sampling based on criteria to classify and contrast profiles, knowledge, experiences and backgrounds according to considerations proposed by Patton (1990). Twenty-four participants, from the groups mentioned above took part in four focus groups comprised of six participants each. I used this criterion sampling method because I needed to interview individuals who had in-depth knowledge and a high level of authority and responsibility (either as decision-makers in policy and/or contributing knowledge through research) in the process of decentralisation in Guatemala. My intention was to identify key individuals within each sector. The criteria I used to identify individuals included: (a) a body of experience in health sector reform and decentralisation working multi-sectorally (outside of the health sector) and sectorally (inside of the health sector), and within the academic and research realms; (b) a high level of responsibility in policy formulation, decision-making, health planning and/or monitoring and evaluation activity; and, (c) working at one or more of the levels of interest of this thesis. For practical reasons, participants had to be available during the fieldwork period.

Interviews took place between 12 January 2001 and 23 February 2001. Six high rank officials within different government bodies directly or indirectly involved in decentralisation policies were interviewed on 12 January 2001. Six high rank officials from international cooperation agencies were interviewed on 26 January 2001. Six advisers and consultants from the health sectoral reform and decentralisation process were interviewed on 9 February 2001. Six high rank officials (3 from influential and recognised academic and research institutions working at the regional or country levels and 3 with NGOs working on the theme of decentralisation) were interviewed on 23 February 2001.

According to the ethical considerations contained in the Research Protocol and the Ethical Approval Form, any information about the interviewees was maintained under strict confidentiality as requested by all the members participating in the focus groups. Direct quotes (individual or personal) were, under the protocol, not included in the final analysis of information. Therefore, the information presented

under Component 1 makes minimum reference to those interviewed as per mutual agreement.

It is important to note here the implications of the focus groups being held between January and February 2001. During this time, the FRG, headed by Efraín Ríos Montt, formed the government of the country. Threats and other forms of repression had started again in various sectors of society and were used to control criticism of government. It was not easy for people to participate in research especially where they were required to express views and opinions about social issues and policies. Confidentiality and security protocols had to be maintained at all times to ensure that issues of personal safety were not compromised. The kinds of participants who were involved under Component 1 of the research had higher levels of professional risk given the positions they held, their previous convictions against the government in power, which were known, and due to the ease at which they could be identified.

The fieldwork tools for Phase 2 were designed around the analytical questions discussed in Chapter 1. These analytical questions were used as parameters for the design of interview guides using CHA, CCA, CEA and PCIA (see Appendix 6). The interview guides addressed the themes and general spirit of the questions. The information for primary research was obtained through the use of interview guides, which are linked to the analytical questions. The responses are written up in this chapter divided by sub-group of respondents. The questions also correspond to variables, which are introduced to the sub-groups of respondents, considered and interpreted by them, and defined within the given context of the research. These variables are then used to construct the output of this research in the form of variables and indicators appropriate for comprehensive evaluation of reform processes in post-conflict contexts.

The purpose of the questions was to expand knowledge about many related issues, such as institutional culture and power relationships and struggle, political corporative and invested interests, institutional and bureaucratic environment and transitional reforms, and social and institutional hierarchies. Also, the interviews emphasised certain consciousness and self-awareness about the lack of clarity, uncertainty and confusion of some basic concepts and categories related to

decentralisation: devolution, deconcentration, democratisation, participation, self-empowerment and quality of life improvement at the local level. The themes addressed were: the political and technical-administrative processes involved in decentralisation of health services and the replacement of central authority to local level management; innovative or non-traditional forms of social participation and education methodologies, traditional and combined and institutional medical practices in the process of decentralisation within the health sector; and, the expansion of mechanisms and democratic forms of management at the grassroots level.

For the groups under Component 1, questions were designed to specifically identify key knowledge available from them. The epistemological framework required that questions be asked to not only obtain perceptions, views and opinions, but also to contextualise this information within historical, political, social and cultural perspectives. This was best handled through the use of interview guides because these enabled in-depth discussions around key issues, which could not been administered through structured or semi-structured instruments. The interview guides also allowed me to fully explore the scope of the discussion and to encourage engagement in the process (through probing and follow-up). Focus groups assisted this process because the methodology provided a natural environment for the exchange of views. This was integral to the research design and possible under strict confidentiality protocols. Participants in the focus groups were known to each other through professional relationships. While I thought about conducting individual interviews with them, I saw many advantages in creating the kind of space where dialogue, exchange and debate could take place. The focus group methodology enabled me to do this. I also felt that the most important strength of the approach was self-reflection through dialogue, exchange and debate, which I encouraged within the confines of the interview guides.

I wanted to come close to organising fora for thought and discourse and the focus group methodology allowed me to come as close as possible to that within a structured research environment, applying a set of instruments, designed around a specific aim and set of objectives, to obtain results. I wanted to avoid a two-way relationship between interviewer and interviewee and create a multi-layered relationship between the researcher and participants in the research and also

among the participants themselves. It was important to the research process that others heard and reacted to the ideas being expressed. I considered that this process was more active and less passive especially within the context of the post-conflict environment, where debate, exchange, dialogue and challenge were missing. I briefed participants prior to the focus groups about the thematic areas of discussion, through a protocol, to avoid direct identification of participants in the text, and through careful selection to avoid discomfort between participants. This would also avoid a situation where engagement was likely to be reduced. I used prior knowledge of some participants and knowledge of posts and roles to create a balanced group dynamic within a controlled environment.

7.3. Fieldwork Component 1 - Lines of Response from Group One - High Rank Officials within Different Government Bodies Involved in the Sectoral Reform Policies

The sectoral technicians, experts and officials considered that the government was making contributions towards the implementation of multi-sectoral, sectoral approaches to RSS (decentralisation). Respondents identified four main components for the improvement of health: (1) coordination of the Units of the Project in charge of the process of the sectoral reform; (2) re-organisation of the MSPAS; (3) expansion and reorientation of the Health Services Benefits System; and, (4) modernisation of hospitals. Participants highlighted that the extension of coverage at the primary healthcare level began in 1997 in the Department of Alta Verapaz. Since the pilot, 25 out of the 27 Health Areas were incorporated under the process. These areas adopted multiple strategies in order to extend the coverage of Basic Health Services (SBS). Coverage was extended through their own Health Districts (HD), under the category of 'institutional extension', or through non-government and other grassroots organisations (such as NGOs and CBOs). The organisations were working as Health Service Providers (HSP) and Health Service Administrators (HSA). The implementation of the SIAS at the first healthcare level was negotiated with different HSPs and HSAs by signing formal bilateral agreements.

The health sectoral proposals for change, focused on determining, assessing and measuring the trends with regard to political administration, management and decision-making processes. They include:

(a) Re-initiate discussion on the concept of the ‘politics of health’ to promote the sector as a priority at the national level. This would achieve continuity in terms of the country’s development and to avoid governments discarding important initiatives and projects during periods of national political change.
(b) Undertake campaigns, through the means of communication for the effective promotion of health at all the socio-economic levels. The concept of the ‘politics of health’ needs to be ingrained to the national political fibre.
(c) Generate new forms of education in order to increase the levels of understanding and awareness around preventative health and the contents, structure and functions of the SIAS.
(d) Establish better relationships between the MSPAS, other public health institutions and organisations, and work with an array of functions and roles especially in the countryside at the primary and secondary healthcare levels.
(e) Unify efforts and approaches amongst different personnel and other human resources to improve the sector's performance at each healthcare level and of the system as a whole.
(f) Promote basic knowledge around health issues related to epidemiological variables and hazards through a social education and sensitisation campaign on the importance of vaccination in the schools and communities. These initiatives would not be costly for the government to pursue reducing rates of morbidity-mortality and improving upon other indicators.

Most of the respondents agreed that the best way to compare different desirability parameters with indicators is to systematise the advances, achievements and failures of the model. The parameters are already established in the form of goals for the existing norms, such as regulatory and conventional procedures. For instance at the primary healthcare level with regard to the provision of human resources, the norm is to provide one doctor per 10,000 inhabitants. The current figures should be compared against the desirability parameters to review whether this norm is acceptable or not, given the health conditions of the population. The ‘Situation Rooms’ (regular meetings to assess the health situation), should also be used to review norms. They bring together health authorities and local communities. The Situation Rooms are set up in the health districts to address inconsistencies in service provision through technical analysis, monitoring, and open discussions with the communities. Additionally, there should be a comparison between the resources

required and the impact produced on the service provided. For instance, as indicated in the PAs, a comparative analysis should be conducted against the goals of health and nutrition nationwide. The PAs provide political and social framework indicators, which should be aggregated to and compared against those obtained and discussed in the Situation Rooms. In the cases in which these parameters are not explicit, their development should be induced through other alternative means, at the institutional and community levels. Since it is not feasible to work with all the possible indicators, the selection of a minimum of trace indicators for groups of variables should be examined. These types of indicators would provide a clearer idea of the tendencies in each aspect of the performance and evaluation of the components of the SIAS.

Progressive changes measured by health indicators should be compared with the established goals with regard to the quality of the service, real coverage, and levels of community participation. The epidemiological profile of a community with other communities in the vicinity that have similar health profiles and conditions can also be compared. This should include:

(a) The direct biological impact of a preventative immunological-epidemiological intervention at the local level. For instance, the proportion of the population vaccinated vis-à-vis the total amount of population in a community.

(b) The levels of efficiency and effectiveness in the use of resources, including productivity, quality and satisfaction in the service provided, such as the number of hours dedicated to medical consultation, the actual number of patients seen, and patient views on the service received.

(c) The cost of the inputs and the cost for the provision of services (costs for medical consultation, vaccination, and type of medicine) and the cost-impact achieved (cost of preventing death, preventing measles and other diseases).

The SIAS is conceived as a model of decentralised administration, organised at three levels related to the reference of cases at the community level, and supported by ‘active community participation’. For the respondents, the first level of healthcare constitutes the most direct type of contact of the population with the health services regardless of how they are provided. The actions and responsibilities of the MSPAS are encompassed by a group of basic clinical and non-clinical services, namely promotion, prevention, recovery and rehabilitation in order to solve

health problems using appropriate technologies and resources (logistic and human). This is also appropriate for a reference system for cases that are not adequately resolved. The human resources component within SIAS needs to improve the level of technical skills and provide consistent technical training to the EBS. Health personnel should also create strategies for motivational stimuli and incentives to encourage ownership of the SIAS.

With regard to the infrastructure, which is known as the Community Centres of Convergences (CCs), the EBS provides health services because the CCs are reference centres. In general, CCs provide primary healthcare made up of basic medicine, which is provided free of charge. However, such medicines are either scarce or not completely adequate for certain needs or for epidemiological emergencies, which occur more frequently. Mobile Physicians visit the CCs at least once a month, however this duty is not fulfilled in all cases. Community support includes among other things, the organisation and rapid provision of transportation for referral of ill or injured people to health centres or hospitals that require emergency attention. However, there are often problems associated with the availability of transportation or with accessibility to roads. The geographical areas and demographic profiles where the EBSs operate constitute a mobile's medical jurisdiction. Presently, more than 2,500 CCs exist in the country located in 25 out of the 27 Health Areas of the country. A Health Area covers approximately 10,000 families, with an average of four to eight CCs, each of them covers between one to three communities on average. In spite of this established health network, it is necessary to create more EBS teams, more CCs per community, and more alternative emergency evacuation procedures.

7.4 Fieldwork Component 1 - Lines of Response from Group Two - Advisers and Consultants Involved in Health Sector Reform and the Decentralisation Process either Working Inside or Outside of the Government Sector

With regard to the questions around the visions, definitions and practices related to decentralisation approaches, the majority of respondents in the second group indicated that the objective of a decentralisation process is to contribute to systems of local governability. Decentralisation may improve the implementation of priority policies at the municipal, departmental and regional levels. Therefore, the decentralisation process is directed to the strengthening of the local institutions, of

political and administrative authority and sovereignty. The development of local government, according to the country's constitution should be based primarily on the principle of respect to municipal autonomy. The principle of autonomy should be re-considered within the new political reality of the country, which means, it should be included within the framework of the PAs. Within this framework, it is important to design and implement two main political and administrative initiatives nationwide: a Decentralisation Programme and a Monitoring and Auditing Programme both at the municipal level. Both programmes should also be integrated focusing on representative and participative democracy, municipal administration, management, and development of information systems. This focus should be reflected in the decision-making processes of strategic developmental issues with the communities. The decentralisation programme should also provide a set of legal and regulatory initiatives to support and provide guidelines and procedures, to devolve the entire public administration to the municipalities.

Most of the respondents stated that the initial structure of political legitimisation and political consent for strengthening the programmes mentioned above should include organisations such as ANAM (National Association of Municipalities), AGAI (Guatemalan Association of Mayors), departmental Development Councils, and local governments. Another objective of these programmes is to promote institutional arrangements and clarify the limitations of these arrangements related to competing interests of central government offices (ministries, secretariats, Development Councils and Social Funds) with other institutions of the state. This would ensure that the implementation of government policies would depend on co-ordinated efforts with the 331 municipal governments and the problems and affairs that they prioritised for action. This strategic achievement should rationalise policies, programmes and projects of public administration to achieve the objectives of decentralisation in a viable and sustainable way to all the members of such networks. These should be sustainable providing technical support for the elaboration of manuals and other training/learning/education materials detailing arrangements for competing institutional interests and functions linked to decentralisation.

With regard to the support of political development of citizenship and participatory democracy, the respondents identified various proposals for

consideration. For instance, an Exchange Programme for the development of a political democratic culture with regard to a legal framework for public administration and participatory democracy (with a vision of pluralism and inclusion). With regard to the latter, respondents also suggested a revision and transformation of the mechanisms of civic democratic participation and in the processes of auditing and monitoring functions and responsibilities in the administration of municipal governments. Also, it is necessary to introduce ethics and values related to administrative decentralisation of public administration at the local levels. Additionally, decentralisation should include consensus, consultation and agreement in order to socially, politically and culturally legitimise and validate municipal or local legislation. In the short term, the aim would be to adopt initiatives for an effective juridical framework and this should include the following actions: working meetings with the juridical team in order to elaborate proposals, diffusion of legal proposals in the appropriate context, lobby and promotion of initiatives before the Commission on Decentralisation in the Congress, legal reforms in the medium and long terms, the presentation of proposals for constitutional reforms, negotiation of proposals for the approval of constitutional reform with the support of backbenchers in Congress, the design and analysis of new proposals on political decentralisation (at local government, departmental and regional levels), reforms relating to the Development Councils and, support to the functional and administrative organisation of the Councils.

The respondents also mentioned the Fiscal Pact agreement and approval by most Guatemalan social sectors to develop and establish the operational principles of fiscal decentralisation. The following principles of the Fiscal Pact were considered important:

(a) Creation, systematisation and co-ordination of the institutional networks in support of decentralised financial administration;

(b) Support to the formulation of decentralised financial policies in co-ordination with the sectors involved;

(c) Evaluation programme on the effectiveness of deconcentration initiatives of financial resources;

(d) Evaluation of fiscal decentralisation policies;

(e) Financial modernisation programmes that include fiscal autonomy, administration, public investment and debt relief;

(f) Viability studies related to fiscal decentralisation projects that include land deeds, wills, tax record and others;
(g) Consultancy and training programmes on financial management and financial information and accounting systems; and,
(h) Programmes on forming administrative units with technical teams in financial administration and accounting.

The respondents were mainly concerned with proposals for civic participation, which should be supported by study programmes for the development of cultural plurality. It was indicated that political actions around this theme should include:
(a) A programme of inclusion based on participation, inter-cultural exchange and assessment of impacts;
(b) A programme of studies on municipal administration with local participation and input;
(c) Social participation in health, education, employment and sustainable development; and,
(d) An information and communication process for the evaluation and promotion of environmental health through participative and non-formal education campaigns among others.

Although the instruments of data gathering could be based totally on attitudinal scales or valuations, it is advisable to include and differentiate indicators of accessibility for suppliers/services and users/clients such as:
(a) Accessibility according to the perspective of the supplier/service;
(b) Accessibility according to the perspective of the user/client;
(c) Physical or environmental location of health sources;
(d) Transportation time required by the user to the necessary health service;
(e) Travel distance required by the user in order to be assisted at the health service;
(f) Economic or financial costs to collect the supplier/service;
(g) Family costs that include cost of attention and medical stay;
(h) Functional or organisation schedules of attention (days and times);
(i) Language that is used;
(j) Awareness of health service users in order to look for and obtain attention;
(k) Waiting time;
(l) Knowledge of the user's practical socio-cultural history for medical assistance;

(m) Perception of health necessities in practical services and cultural conceptions of users; and,
(n) Perception of health necessities between users.

The operationalisation of the variables is focused mostly on the perspective of the user. Although the opportunities for obtaining quantitative and qualitative information on accessibility are attributed to the users of health services, this cannot necessarily verify the institutional perspective. It is necessary to contrast the perspective of the user with the conditions of accessibility. Also, to establish approaches in order to determine this on a scale from minimum access to good levels of access. The sampling procedure therefore, should include the user families inside and outside the area of coverage, plus the information recorded in the health area.

On the indicators of physical accessibility, analysis of the percent of families of a service or the community should be compared to the percent of roads. These indicators do not make reference to the utilisation of these roads by the user, but to the quality of the infrastructure. It would be preferable to assess this in terms of the 'percent of families that have the possibility of obtaining services (from mobile physicians, specialised care, and emergency care) by means of roads appropriate for a conventional or standard vehicle'.

On the indicators of economic accessibility to health services, the respondents consider that the following issues are relevant: a need for a more frequent survey of revenue and expenses at the national level and to do a more accurate cost-benefit analysis to determine the overall figures in that regard. On the indicators of functional accessibility, the respondents consider the following issues as relevant: the office hours of the health facilities are an important variable for users as it is for institutional suppliers/providers at the community level. These indicators focus on the perception of the user exclusively but should be open to other variables as well. Examples of facilities exist that provide continuous medical healthcare and the most extended level of healthcare possible in order to reduce the number of consultations. The language spoken in the health services would be considered an indicator of functional accessibility. If the language impedes access to health services by the user before the user has an opportunity to obtain such

services, a socio-cultural obstacle exists. If ignorance of a certain language is an obstacle to the initial contact, then a functional obstacle exists. Of the indicators on socio-cultural accessibility the respondents considered that the following would be important: as different from other variables on accessibility, indicators measuring 'respect of human dignity' and 'respect of cultural practices' which do not exist in the documentation managed by the SIAS.

From the perspective of these respondents the desirable conditions of social participation in health provision are: an active degree of involvement that includes options for users, a degree of decision making on the aspects that affect the life of the users, and a degree of efficacy in the implementation of the Basic Health Services (SBS). It is necessary to identify whether an association exists between community participation and the quality and coverage of SBS. Qualitative information (open interviews, focus groups, and semi-structured interviews with key informants) for the evaluation of such indicators should be supplied from:

(a) Health suppliers or workers at the first level of attention;

(b) Authorities and community leaders;

(c) Local organisations; and

(d) Members of the community (users and non-users of services).

7.5. Fieldwork Component 1 - Lines of Response from Group Three - High Rank Officials from International Cooperation Agencies Supporting/Working under the Framework of Health Sector Reform and/or Decentralisation Policies.

Responses from this group were very similar to responses from Group 2. One of the main tendencies in the response from this group was the need to contribute to local governability as well as the need for a Support Programme for Civic Security, which would include provisions for the involvement of citizens through participation in local security, investment in basic infrastructure services, cultural plurality, and sustainable development and social participation. Effective policies have to be carried out at the municipal and local levels (either under a reduced or extended spectrum). Under a framework of juridical and constitutional reform, the design and consensus of decentralisation policies should be carried out through public and institutional consultations. The respondents stressed the importance of the principle of municipal autonomy linked to the new political reality of the country, including the framework of the PAs in the middle and long terms, for example, the Programmes of

Decentralisation and Auditing and Monitoring of Municipal Administration. Other initiatives considered important were electoral reform, institutional strengthening, consensus building processes, development of information systems, participation initiatives and systematisation and regulation of public administration as mentioned above by Group 2.

This group, as with Group 2, mentioned the positive potentialities of the Fiscal Pact. This group also identified a number of other programmes relevant to sectoral and multisectoral decentralisation: The Programme on the Evaluation of Impacts of Fiscal Decentralisation and Programme to Improve the Financial Capacity of Municipal Governments implemented through consensus, representation, and political financial decentralisation. Suggested measures include the evaluation of the achievements and limitations of fiscal decentralisation (such as the transfer of 10% of revenue to the municipalities by the central government) and the analysis of the normative, bureaucratic, fiscal and political obstacles to municipal autonomy related to the political and fiscal capacity of municipalities. The Programmes of Fiscal and Administrative De-bureaucratisation (simplification of procedures) and Training Human Resources in Fiscal Policies, consider the revision of initiatives, projects and policies dealing directly or indirectly with fiscal decentralisation (such as the Unified Property Tax –IUSI-, cadastre, and other taxes). The Programme on the Evaluation of Projects and Fiscal Decentralisation Policies consider the formulation of employment policies and economic projects at the local, municipal, departmental and regional levels; the systematisation and co-ordination of institutional networks in support of decentralised economic administration; and, support to the formulation of decentralised economic policies in co-ordination with other sectors involved in health services. The Programme for the Design and Implementation of Employment Policies in the diverse areas of economic activity and the Support Programme to Promote Municipal Development Studies around the reform of the legal framework, employment standards and modernisation proposals.

Respondents identified some of the programmes with regard to the promotion and development of the internal market, to combat poverty and, the improvement of the quality of life in the municipalities, departments and regions of the country: (a) Evaluation Programme of Internal Market Indicators, with the

intention to combat poverty and improve the quality of life, (b) Decentralisation Programme on Health, Education and Infrastructure Services, (c) Training Programme for Municipal Governors and Municipal Authorities on Labour Rights, (d) Support Programme on Monitoring and Evaluation of Labour Means, (e) Support Programme for The Formulation of Municipal Policies on Occupation and Employment and, (f) Support Programme on the Elaboration of Municipal Jobs and Wages. These programmes will define the employment and labour policies in agreement with departmental, municipal and local authorities, populations and organisations. The majority of respondents indicated that local development implies changing the organisational culture and the development of public municipal institutions to support the changing role of municipal government as the providers of services.

Finally, the respondents in group 3 also talked about studies related to decentralisation, dealing with qualification and professionalisation of the profiles and potentialities of the economically active population (EAP) on the following issues: development and equality, socialisation and dissemination of the practices and values of local development, the legal framework for employment policy and modernisation, support to modernise and develop the underdeveloped sectors in the municipalities, departments and regions of the country, participative co-ordination between the municipal governments, private sectors, labour organisations, development and support of sustainable and productive employment, elaboration of a project profile for development promotion, the design of the strategy for negotiation, implementation, support and evaluation of the productive sectors, studies on situations and potentialities of development of the economic sectors, and, strategies of integral development and economic growth.

7.6. Fieldwork Component 1 - Lines of Response from Group Four - High Rank Officials or Representatives from the Civil and Academic Sectors

To encourage changes in health policies, respondents considered the need to redesign the healthcare model, training procedures and extension of coverage. Respondents indicated that the health crisis in Guatemala also required political redefinition. The group interviewed suggested that it is necessary to prioritise health at the national level. There are budgetary imbalances between the health budget and other budgets. As a result of this there is a lack of qualified personnel and

training opportunities to resolve such problems. The last two government administrations have also managed the crisis in different ways with little effect.

The disparity in health in the country is not only a question of the budget. According to most of the respondents in this group, investment in health mainly occurs in curative rather than preventative aspects. According to the School of Physicians, of 12,500 existing doctors in the country, more than 9,000 work in urban areas making health inaccessible for many people living in rural areas. Health problems do not end once the user is discharged from the health services. General practitioners no longer exist in medicine as they are increasingly being replaced by specialists. There has to be a supply of qualified people who should be constant regardless the government's political agenda. Respondents indicated that the stability of many political and technical positions is essential and that there is no need for new authorities to terminate contracts in order to form a new government. Another key problem with regard to monitoring data is political and institutional manipulation. An approach is required to prevent the government from manipulating data on the rate of mortality and reporting rates below the actual rates. Decentralisation policies would become a way to assure continuity so, that changes will not continuously take place with the arrival of a new government.

The government should prioritise investment in health in order to provide better services to the Guatemalan population. The condition of the hospitals is notorious because of the lack of space, equipment and personnel. The MSPAS should be reformed so that expenses are distributed in a better way and economic resources are available. Hospitals should have enough funding and more nursing schools are needed because of the scarcity of nursing personnel. According to this group, governments have made decisions of a more political nature rather than technical. These decisions affect the development of an integral policy on health issues nationwide.

There should be regulations for monitoring and evaluation procedures, the intention is to systematise the use of information to measure the impact of health services. The process would include all of the aspects related to the form in which the services are provided, including logistic aspects related to the environment. An important part of this process constitutes the quality of the delivery of the SBS, civic

participation and the incorporation of the family in healthcare. The impact evaluation refers to the effectiveness and efficacy of healthcare measured by the achievement of goals, for instance, the decrease of the maternal infantile mortality, the improvement of the nutritional health of children under two years and the reduction of the prevalence of specific illnesses. Another aspect of interest is the cost-effectiveness information of the group of EBS under SIAS and how they have adapted to the national strategies of social development.

7.7. Fieldwork Component 2 – Focus Groups with Institutional and Traditional Health Providers, and Users of Both Medical Systems in two Chosen Rural Municipalities.

Focus groups were also held under Component 2. The first set of themes covered were health sector reform (RSS), cultural values, inclusion of the indigenous population and participation. The second set of themes addressed incorporation of traditional medicine into the institutional medicine according to the PAs contents, the HC norms and the SIAS implementation policies. Both themes were explored and inter-related as part of the microanalysis that corresponded to the thesis fieldwork. By taking account of the value of traditional medicine under the framework of RSS, questions around the nature of reform, who was included in the reform process and who was not included, and whose cultural visions and beliefs were reflected within a process of decentralisation, were addressed.

The general objective of these focus groups was to create the mechanisms for discussion, sensitisation and acceptance of some of the procedures used by traditional and popular medicine in the treatment of Acute Respiratory Infections (ARIs), Diarrhoea and Parasitic Diseases (DPDs) and vertical childbirth delivery within the structures and practices of institutional medicine and its agents. These illnesses and situations are used as examples in order to engage participants in dialogue around common problems found in the communities. I do not intend this to be an exploration about the correct treatment, only a way in which to engage with diverse groups of participants about their experiences and approaches to healthcare. In the evidence presented below, the reader will find different viewpoints emerging about health which speaks to much broader perspectives and ingrained differences. Further, it was important to identify ways to justify and incorporate practices that serve as medium- and long-term examples of complementarity

between both kinds of medicine. It was equally important to promote acceptance of the cultural sufferings manifested in what is referred to as 'cultural illnesses' ingrained in the cosmovision of ethnic groups and to incorporate the suppliers' of traditional medicine under the SIAS. The specific objectives were to: (a) re-evaluate perceptions and opposing views between institutional and traditional medicine; (b) contribute to the validation of healthcare norms of traditional medicine as an effective alternative for primary healthcare within the SIAS; (c) balance the provision of healthcare, the coverage of health services using traditional medicine for the treatment of ARIs, DPDs and vertical childbirth delivery; (d) consider the possible alternatives that traditional medicine resources represent in relation to the diagnosis, treatment, and reference of the affected patients for the above mentioned illnesses; and, (e) transmit and acquire knowledge on traditional medical practices by the population, which implies awareness and acceptance of those practices as mainstream by both types of medicine and their agents. For the groups interviewed in the course of Component 2, participants had engaged in group discussions on numerous occasions through the EBS and community meetings and organisations and they were therefore familiar with the kind of approach being applied.

A co-ordination meeting was held on 27th March 2001 with the Chief of the Health Area of Alta Verapaz, the Chiefs of the Health Districts of the two Municipalities participating, the Director of FUNMMAYAN (Foundation of Mayan Women from the North of Guatemala) and its facilitators who participated in this research. I had an initial meeting with the health personnel of the Health Area of Alta Verapaz on 28th March 2001, to explain the fieldwork agenda and gain their support. On 29th March 2001, I had a morning meeting in the Health District offices of San Juan Chamelco, and in the afternoon a meeting in the Health District offices of San Miguel Tucurú, both located in the Health Centres at the municipal level. These meetings were held with the health personnel of both Health Districts, the EBS working in the districts, a group of traditional medicine agents and users of both types of medicines. These meetings were facilitated by FUNMMAYAN, which was previously contacted by the SIAS central authority and myself, to organise the meetings following up the fieldwork plan. The purpose of the meetings was to invite participants to the focus groups sessions. Meetings with the facilitator(s) of FUNMMAYAN were held on 30th and 31st March 2001 for the purpose of translation, validation and re-validation of instruments. The fieldwork team de-briefing took place

on 13th April 2001 after the focus groups had been held to discuss results and observations from both Health Districts between the facilitators and myself.

FUNMMAYAN is a Kekchí women's non-government organisation, which has been working to improve the level of development and participation of Mayan (indigenous) women. FUNMMAYAN was founded in 1995 and has had continuous presence since in the departments of Petén, Izabal, Baja and Alta Verapaz in the northern part of Guatemala. It has been carrying out the following programmes: SIAS, the National Plan for Reproductive Health, the National Plan for the Reduction of Maternal and Child Mortality, the National Programme on Violence Against Women, and the Human Rights National Awareness Programme. FUNMMAYAN was commissioned as administrator and provider of SIAS by the MSPAS/PMSS in the municipalities of Tamahú, Chaal, Fray Bartolomé de las Casas, San Juan Chamelco and San Miguel Tucurú. The foundation provides the financial and administrative skills and resources and supervises the co-ordination of town halls in the above-mentioned municipalities, with other NGOs, CBOs, the MSPAS/PMSS/SIAS and PAHO/WHO. I worked with them to organise and undertake the facilitation of the focus groups in the communities. They helped me with the translation of the focus group sessions, which were conducted in both languages - Kekchí and Spanish.

There were a number of reasons for co-ordinating my fieldwork with FUNMMAYAN. First, the organisation spoke the language of the people – Kekchí. I could come as close as possible to the true meaning(s) of what people said with their simultaneous translation and a translation analysis of the statements recorded throughout the sessions. Second, the organisation had a number of years of experience working in the area therefore they had in-depth knowledge of the area, understood the experiences of the people through the different political epochs, and were a part of the same cultural group as the communities. The latter was important because it established a commonality between members of the fieldwork team and the communities. Third, the organisation was familiar with how people interacted within communities and with health services and providers. This afforded me with a solid experience base to draw from. Fourth, as I wanted to explore the incorporation of traditional medicine within institutional medicine, it was important for me to work with a group which had a profound understanding about traditional medicine and

respected local views about it. Given the above, FUNMMAYAN was trusted by the people with whom they worked.

The latter point deserves further elaboration. It was perhaps the most important aspect of doing the type of research I wanted to do. It was not easy for 'outsiders' to gain the kind of trust that the organisation had. One of the first aspects of life that was eroded during the conflict and post-conflict periods was trust. The organisation gave me access to communities which otherwise would have required a longer period of time to develop, if it had developed at all. The concept of trust was also important with regard to the thematic areas of the research. Issues around health were not easily discussed in public fora.

A training plan was agreed with FUNMMAYAN. Six people including a principal facilitator and an assistant facilitator were involved in the fieldwork. The number of facilitators depended on the experience of individual members in areas of research and fieldwork. Over a training session (two days) with the facilitators, the questions for the focus groups were reviewed and a translation from Spanish to Kekchí of the interview guides was completed. The level of comprehension of the questions for participants was also assessed and the questions were validated with voluntary receptors within the same organisation or with those convened for the validation and re-validation procedures to undertake the fieldwork. Conventional information procedures for recording information were discussed and revised and this included interaction, observation, and recording of interviews.

I used purposive sampling to select participants in the communities of both municipalities, based on a criterion case approach, as well as combination case approach, as identified by Patton (1990). Participants were identified through FUNMMAYAN, which had been working with them in the two municipalities since 1997. In 1997, FUNMMAYAN started to work in the two municipalities with the pilot plan to implement the SIAS. I undertook the selection of participants on 29th March 2001 as stated above. The criteria for selection of health providers were: (a) those who had a social and professional/social role within the community in the health sector as providers of both institutional and traditional medicine; (b) a minimum of three years experience living in the areas (in order to have knowledge of the people, the places, and cultures); (c) recognised in the communities for their performance

and leadership in health issues; and, (d) with good or excellent knowledge of the Kekchí language. The selection criteria for the user groups were: (a) those who had used both traditional and institutional medicine; (b) those who had visited the health service and/or providers at least two or three times over the last two years prior to the fieldwork start date; (c) those who belonged to the Kekchí group; and, (d) those who were willing to participate in the research during the time period it was scheduled. Age, level of education, and economic status were not taken into account in strict terms. It was assumed from the information available on the socio-demographic profiles of the population in both municipalities that, they were living under conditions of poverty, had low schooling and high illiteracy.

Component two of the fieldwork consisted of focus groups with personnel from the (a) medical institutional system including doctors of the Health Centres, graduate nurses assigned to the Health Centres, and male and female auxiliary nurses of the Health Centres and Posts; (b) members of the EBS including Mobile Physicians, Health Monitors, and trained TBAs; (c) personnel from the traditional medical system including TBAs (no formal training), healers and herbalists; and, (d) community members including users of both traditional and popular medicine and institutional medicine. In total 42 people participated in the focus groups. Four focus groups were undertaken in the Municipality of San Juan Chamelco on 3rd and 4th April 2001. Of which, 3 groups were held with 5 participants each and 1 group was held with 6 participants for a total of 21 participants. The groups were comprised of the members of the Health District and Health Centre including the following: 1 physician of the Health Centre, 1 graduate nurse, and 1 auxiliary nurse. The following members of the TBS participated: 2 mobile physicians, 2 traditional (trained) birth attendants and 4 health monitors. The following traditional medicine providers were involved: 4 healers and 4 herbalists and 2 traditional birth attendants. Four users of institutional and/or traditional medicine were involved. Four focus groups were undertaken in the Municipality of San Miguel Tucurú on 10th and 11th April 2001. Of which, 3 groups were held with 5 participants each and 1 group was held with 6 participants for a total of 21 participants. The groups were comprised of the members of the Health District and Health Centre including the following: 1 physician of the Health Centre, 1 graduate nurse, and 1 auxiliary nurse. The following members of the TBS participated: 2 mobile physicians, 2 traditional (trained) birth attendants and 4 health monitors. The following traditional medicine

providers were involved: 4 healers and 4 herbalists and 2 traditional birth attendants. Four users of institutional and/or traditional medicine were involved. All focus groups were combined that is, they included representatives from both user and stakeholder groups as described above.

A number of difficulties had to be overcome in order to conduct the focus groups. The questions, which appeared in Chapter 1, had to be revised so that participants could understand the terminology. The questions were re-formulated with more simple questions and some questions were intentionally repeated to obtain an adequate level of information for the purposes of analysis, to verify interpretations and understandings by participants of the questions asked of them, and to ensure the quality control of information. Some of the expressions used by participants were only expressed in the Kekchí language. Although attempts were made to translate these directly from Kekchí to Spanish, in some cases direct translations were not found, therefore descriptions of what participants said were used to arrive as close to the original meaning as possible. Participants' names when they referred to themselves as a form of introduction were excluded from the quotation, as well as names of health personnel mentioned by participants in the course of the discussion. The results from all focus groups were analysed together and are presented in this chapter in summary format. Quotations are used to exemplify perceptions and views around relevant themes. In all cases, the community is identified and any variation is accorded to the specific communities. The questions asked to participants are contained in the context of the report on findings. Where direct quotes are provided, these represent the views of the majority of participants in the focus groups. Key analytical questions (stated in the epistemological framework in Chapter 1) are used to construct the interview guides for this part of the research (interview guides in Appendix 7).

The information from the fieldwork was reported and the variables identified. Some of the information was summarised as examples provided by the respondents. While some analysis is offered, it is not my intention to evaluate key issues but rather to use the information (which comprise the perceptions, attitudes and values of the participants in the fieldwork) to create a framework of analysis of the variables in keeping with the aim of this research. Two levels of analysis are conducted. Responses are initially considered under thematic areas. The themes

are identified and extracted from the overall analysis. The thematic areas extracted from the fieldwork and relevant to this thesis are: RSS (decentralisation), structures of provision, democratisation, community participation, and traditional medicine. Secondly the analysis by sub-group of participants is done to understand how key concepts are defined, interpreted, and contextualised. Locality is not identified because the overall number of participants, when broken down per sub-group is low. Further, there were no discernible differences in response of sub-group by locality.

7.8. Fieldwork Component 2 - Lines of Response on the Theme of 'Process of Health Sector Reform'

Participants were asked to comment on the process of RSS overall. Participants from San Miguel Tucurú indicated:

> "…It should be at the rural level because that is the level we think at. Commissions and training have not been created, people do not have confidence in the municipalities and everything must be based on this, the commissions will never be completed so that the rural and community levels can undertake a health programme…"

Participants commented on plans for decentralisation by the MSPAS under the agenda of RSS. Participants were asked to consider whether such plans were important for them and their communities and how they viewed the role of the health providers and administrators within this context. For the participants in San Juan Chamelco, decentralisation is important:

> "…Where the intention is to bring resources to the community. However these are not arriving even though the providers are working within the [SIAS] norms of what they are supposed to be doing. The problem is that SIAS suggests that all women and men who are providing health services are trained as midwives, the provision of training has been guaranteed and more people are now assisting in pregnancy…."

Participants from San Miguel Tucurú commented on administration and provision of health services under a model of decentralisation:

> "…We think that administration and provision is important to the communities because it is the process that will be organised step by step, integrating people around health and prevention and so eventually they are able to do it themselves and also when illness decreases. We want to see reform at the rural level in the provision of services in the communities around the

> municipality. We need continuous support at the community level so that there is continuity in the actions already undertaken…"

Participants from San Juan Chamelco agreed with the process of RSS and considered that through the reforms undertaken, the community was being helped in significant ways. Since reforms were implemented participants had noted the following changes: community leaders were being considered more in decision-making processes and health personnel coming to the communities took their role and responsibilities seriously, which was of benefit to the population especially around issues such as maternal-infant health.

Participants also identified that there were weaknesses at the local level in that the health monitors did not complete the tasks that were assigned to them because they had not been given sufficient financial incentives to undertake their work. Participants considered that the 'situation rooms' in the communities would involve all of the community leaders and not solely depend on the health monitors. Furthermore, participants indicated that EBS and health committees should oversee the work of the health monitors to improve the quality of the work they were delivering. A number of ideas about decentralisation were identified and discussed by respondents, which were interpreted as variables in the analysis. Decentralisation was linked to ideas about local administration of resources, continuity in provision, and local involvement and empowerment. Decentralisation was viewed as a process of change and local priority setting. The community is clearly viewed as playing a central role in decentralisation initiatives. Participants also identified the role of the municipality as a central theme. Comments from participants from San Miguel Tucurú suggested:

> "…I consider healthcare to be very important for the well-being in each community because it is important to have provision frequently and now the administrators and providers are giving us a better quality service and more people are accepting the service. I consider the municipality of Tucurú will be better organised because the only thing that is lacking is more trained people…"

With regard to decision-making and the role of municipalities, the following comments were made:

> "…Municipalisation is the key to decision-making at the municipal level and everything should be done at the municipality and that all decisions relating to health should be taken there because it is not a departmental thing, the municipality knows the health issues, the diagnostics and the economic problems that exist…"

> "…A study of municipalities found that they were capable of confronting their problems, become more capable than the MSPAS at certain times. Each municipality is best placed to make decisions because as it has been said already the municipality knows its problems and how to solve them from the perspective of health, what influences these problems is the economic situation and financial problems. A study on the municipality suggested that the process could be much more rapid at the municipal level than the rural level because the municipality knows its problems and can react quickly to resolve them because with health you cannot wait for years. The MSPAS has prioritised maternal-infant health but it is important to provide healthcare to all of the population…"

The role of the municipality under decentralisation was viewed as important for participants. The idea of strengthening the municipality was linked to improvements in the administration of services through community development, better decision-making, knowledge generation and awareness. Municipalities in the countryside are closer to the people affected by the decisions. Participants acknowledged the importance that local knowledge plays under a decentralisation model. Participants also identified local problems and made a crucial link between health and poverty. Participants considered that the problems were immediate, therefore requiring immediate response, and that poverty was a key factor in such problems.

About SIAS in general, a number of comments were analysed. With regard to the initiation of the system, comments made by the majority in both communities were:

> "…We heard that SIAS personnel have been working in communities that SIAS is helping women and there are doctors…who do consultation…"

> "…This work started little by little at the beginning and it was difficult to learn although it is fundamental for our families, before we heard that pregnant women were dying during delivery because assistance did not exist and now the health monitors are there…they told us there should be a centre to support this work and the mobile physician…and others are in the area…"

With regard to the role of the community within the SIAS, participants from both municipalities indicated:

> "…I live in Chicujá (a village located in San Juan Chamelco) and in my community we started working with SIAS in 1998. Our community was in agreement…and since that time we constructed the Centre of Convergence and today nobody dies because there is help…and there are doctors who give vaccinations. Before we did not have this help and we are grateful for it now…"

> "…My community started in 1997, in May or April, I forget now, it was reinitiated…met with the people of the community and there were promoters and then seven health monitors were selected with the help of FUNMMAYAN and this made the community happy. Now I see that the health monitors come to the community each week…"

> "…In my community, Caquipec (a village located in San Miguel Tucurú), SIAS started in 1997 but work was not starting so it actually began to work better in 1998 and now we have better dialogue and more assistance for women and we have the benefits of training…with the help of FUNMMAYAN. We have progressed and we see the protection provided by FUNMMAYAN…"

Participants indicated a high level of awareness of SIAS, its structures and personnel who provided health services. Participants also identified benefits of SIAS, linking improvements in health to access to medicines and healthcare. Different levels of care were also identified. Further, access to health at the community level was viewed as important to the functioning of SIAS. While the majority of participants in both communities identified the benefits of the SIAS, some also recognised the persistence of some problems such as access to transport, communication and distance and isolation of some communities. Most communities required greater links to other centres especially hospitals in emergency cases therefore the need for transportation and communication were viewed as vital in the provision of health services under SIAS. The comments included:

> "…In my community a facilitator arrived and we have an Improvement Committee and because of this we did not have a centre because vaccinations were done in the schools. This took time away from teaching so the ones from SIAS gave us a Centre of Convergence. SIAS is very good but the only thing is that we do not have an emergency vehicle and radio…"

Healthcare for women and children was viewed as a positive impact of the SIAS in the communities, in terms of curbing mortality rates especially of pregnant women. The child immunisation programmes have made a significant contribution to improving the health profile of the communities. These impacts were noticed over a

relatively short period of time since the implementation of the RSS in 1997/1998. The contributions were tangible in that the communities were able to receive health provision and they associated this provision to some degree of improvement in their quality of life. The process of implementation of SIAS was facilitated through dialogue. The benefits of SIAS were related to addressing the economic conditions of the population and the isolation of communities from municipal services. Through SIAS, communities developed close relationships with health personnel. The community health providers (EBS members) viewed themselves as integral to the SIAS, making a significant contribution to their communities' health profiles. Most communities indicated that FUNMMAYAN, working through the SIAS, was instrumental in delivering health services to the community. FUNMMAYAN is also viewed as an organisation protecting the interests of the population.

7.9. Fieldwork Component 2 - Lines of Response on the Theme of 'Levels of Knowledge and Understanding of Structures of Provision'

Participants were asked about their knowledge of the SIAS structure and organisation. The main comments representing views from communities were:

> "…There are five health monitors and our community [Salqui'k] is divided into five sectors. We have a Health Committee and an Improvement Committee, we have a [auxiliary] mayor and five health promoters and the facilitator….

> "…Seven promoters participate from Kaq'ipek and they go house to house. The promoters help with communication and the people are happy….in the community of Kaq'ipek the monitors are sent by the community facilitator and the one who sends the facilitator…We have seven monitors and we have the support of the [auxiliary] mayor…."

Participants were also asked how they contacted health services under the decentralised model:

> "…When the facilitator started….and they always remember that all children need to have vaccinations and each month the doctor arrives, we need more medicines because we only have pills for headaches and fever. Mrs [confidential] told me about this meeting otherwise I would not have known…"

> "…The health monitors are in charge of giving an injection to each family and the community facilitator sends the health monitors and the one who send the community facilitator is the institutional facilitator and then the

institutional doctor arrives who is able to send people to the hospital because he is in charge of this…"

Participants were asked about how they would like to see SIAS function in the communities. Participants from San Juan Chamelco commented:

"…If we are in agreement, it should function the way it is now but the weakness is in the transfer of patients to other centres for assistance, which require, on occasion transportation that the community does not have or radios to call for assistance to prevent deaths in the communities…"

There is general awareness of how health personnel from SIAS interact at the community level and how authority is distributed among personnel. While there are formal structures in place, which involve an array of people including the mayors (of the municipal townships and the auxiliaries in the communities), in some instances to organise services. There are also informal channels of communication (such as churches and corner stores), which serve to inform community members of the services that are available to them and when they are available. Participants also seem to view health personnel as a team of health providers, or as a network through which health problems are addressed. Most participants agreed that the doctor arrived in the communities on a monthly basis, and had responsibility for referring people to the hospitals. The main contact for the communities was the health facilitator who kept vaccination records on households. The health facilitator also sent the health monitor to the communities. The health promoters provided home services and attention to children and pregnant women. Some communities had Health Committees and some had Improvement Committees or a combination of both. Some communities indicated the visible presence of the elected mayor in health issues and were able to identify a role for the mayor in relation to decentralised health services. The total numbers of health monitors ranged and depended on the size of the community and how it was sub-divided.

7.10. Fieldwork Component 2 - Lines of Response on the Theme of 'Decentralisation of Resources, Functions and Responsibilities'

Participants were asked to comment on the pace and degree of transfer of responsibilities and resources from the Ministry of Health to the health providers and administrators. The main comments representing both communities were:

> "…I prefer that the transfer of responsibility and resources from the Ministry of Health to health providers and administrators was rapid and effective and on occasions I have waited for responses to questions however they have taken a great deal of time to answer and the response has also come back negative…."

> "…If the committee is weak in its knowledge then it will not work and we will not achieve anything. We appreciate SIAS because of the support they have been providing and in sending doctors to the communities. CARE said that they would provide us with a botanical garden and they have lied to us and have not given us one…SIAS is efficient and has doctors and monitors…"

Participants were asked whether the decentralisation of resources and responsibilities should only come from the Ministry of Public Health and Social Welfare to health providers and administrators who provide services to the community or whether other organisations should also be involved in the process for instance, would the municipality extend the jurisdiction of the Health Committee. Participants from San Juan Chamelco commented:

> "…Decentralisation of resources and responsibilities should involve all actors, the process of health should be an integral one, decentralisation should be generalised and everything should be decentralised and the municipality should be a part of the decentralisation process…"

> "…Resources should be decentralised because at the current pace it will take a long time and in Guatemala, all actions relevant to the communities take time…"

Participants from San Miguel Tucurú indicated:

> "…The municipality is the service provider and now the municipal administrators and I think that decentralisation should exist at all levels because we all have the same responsibility in respect to health for the population…"

> "…If all of the teams stay in one place they will not arrive where we are but if we work as 'ants' where everyone is gathered we will see that health will improve especially mortality levels, the indicators of morbidity will reduce if we decentralise…"

Participants were asked to comment on the services provided by the mobile physicians and assess them from their perspective and experience:

"…Some doctors who have their own clinics provide very expensive consultation and that service has to be used with the assistance of the doctor. But SIAS does not favour anyone and helps us a lot…"

Participants were asked about their views on giving resources to local administrators in order to undertake activities in each community:

"…People from different communities have a variety of illnesses and no money in the different centres and do not have medicine for the elderly. A Centre of Convergence should exist with a variety of medicine because when people arrive they are just told that medicine does not exist…"

Participants were asked for their views about the Centres of Convergence including the work of the MSPAS through SIAS in the communities and whether service charges should be applied for health provision:

"…We should not pay, the people in the communities do not have money and the husbands do not earn much. We are grateful for SIAS because we do not have money and through the project of FUNMMAYAN [SIAS] we can pay less…"

"…If people in community of San Marcos (located in San Miguel Tucurú) do not accept consultation and medicine when it is free of charge they are not going to accept it when they have to pay for it…"

Participants from both communities commented on traditional medicine as a way to reduce health expenditure:

"Doctor…says that there are arrangements within the SIAS. The medicines they give us at the centres are expired. What we can do is learn how to cure ourselves using plants. SIAS provides medicine for children and pregnant women…but we can plant achiote, samat, cilantro and hierbabuena (mint). Natural plants are very good for example, for common illnesses such as headaches and stomach aches. We can plant our own gardens with bougainvillaea and ocote for the throat."

Participants were asked about taxation and other tributary charges to increase provision of medicine:

"…As we have said we should not have to pay taxes because some have money or work and some do not so, why are we going to pay for it and there is not much to say, because the municipality gives us some money when we get our citizenship cards and they say they will help the community…"

Participants were asked to comment on the services provided by the doctor and whether they needed a doctor present in the community all of the time:

> "…The promoters do not have time because they work so, it is better to find someone [a doctor] who can be at the Centre of Convergence all of the time…"

> "…We should agree what should be the best organisation for the community and we should do this by region so that we do not have to go to the capital of the country…"

The economic condition of the communities is one that would make the application of service charges difficult for communities to manage. Participants did not consider further fee structures as being feasible. SIAS is viewed as less expensive and also as providing a quality service, however, resourcing is a major factor in the communities. The communities perceive themselves as having responsibility in deciding the most appropriate form of organisation of health services. All participants indicated the need for more financial resources especially for the expansion of coverage to include the elderly and to purchase more medicine. Value Added Tax (VAT), is considered unaffordable by participants. The real issue for participants is 'low' or 'no' income based on the patterns of work. Thus, participants acknowledge payment for medicine and accept that through traditional medicine, costs would be reduced. Traditional medicine was viewed as a way to keep costs down and was considered to be readily available in the communities.

7.11. Fieldwork Component 2 - Lines of Response on the Theme of 'Community Participation'

The next series of questions related to community participation. Participants were asked to comment on community participation and whether they considered community participation as an important element in RSS (regarding decentralisation policies). Participants from San Juan Chamelco commented:

> "…I am in agreement with community participation but it is necessary to strengthen some aspects in that some people from the community do not want to commit to the community. To achieve community participation it is important to involve committee leaders and other people in activities so that they are able to understand the work done and that they are a part of it. Some health monitors do not want to participate in the communities and think about training in different ways. The most important problem is close to home for example there was a lack of community participation and lack of

> collaboration for a woman who died a few days ago and only a few people participated in providing assistance and in this case participation failed. The health monitors should have broader knowledge with respect to the treatment of people who consult them so that they can provide the attention required…"

Participants from San Miguel Tucurú indicated:

> "…The organisation that exists now is good but it can be strengthened through the Improvement Committee because they are the main organisation responsible for the health of the community and to present they have been involved in community organisation especially in emergency cases. The responsibility is in the hands of the Health Monitors and Midwives in some cases and what we are lacking is strengthening the organisations…"

With regard to the issues around the form that community organisation should take, participants from San Miguel Tucurú suggested:

> "…Participation should be strengthened a little more and the Improvement Committee is not enough. I think that all is important and now we are beginning to make paulatine changes. Participation has cost us a lot because people speak Kekchí and although they dominate many languages, people see this as a barrier so it is important for people working in the areas to work in different languages so you do not have to say 'tell this woman about this medicine' because of the language. Language makes it difficult for people to participate and many times they do not trust or understand what is happening…"

Participants were asked for their views on how community participation could be used to achieve improvement in service provision and to improve the organisation of the SIAS. Participants also commented on whether or not they were satisfied with the way SIAS was currently functioning in the community. A participant from San Juan Chamelco suggested:

> "…I agree that community participation even though it is not working in the ideal way and in the way institutional personnel would prefer it to work, it is important to strengthen however there are no financial resources for extended coverage of health services…"

There is a need to strengthen the responsibilities of Health Monitors, as they are seen as having a role in community participation but it is not perceived to be adequately performed. There is recognition that community participation needs to be strengthened however, community participation is also linked to the need for further

resources. Communities do not consider that actions to improve levels of community participation would be achieved without adequate resources. Adequate resourcing at the community level is integral to RSS (decentralisation) models. Participants identified the need for co-ordination in the level of service provision. For instance, public works around increasing water supply were related to concerns for the communities' health. Also, the need to improve transportation and communication links were identified and related to health issues.

7.12. Fieldwork Component 2 - Lines of Response on the Theme of 'Incorporation of Traditional Medicine to Institutional Medicine'

The next series of questions relate to the incorporation of traditional medicine to the RSS process (decentralisation of services) at the municipal or community levels. Participants from San Juan Chamelco commented that:

> "…The Centres of Convergence should have a small garden for natural medicine and although in San Juan Chamelco traditional medicines have been used frequently it is important to increase knowledge on the quantity to take [dosage]. This type of medicine should be more accessible to the public and it should be incorporated into the process of dealing with community afflictions at the Centres of Convergence with the effect of reducing morbidity. A part of this process should be raising awareness among families to have their own botanical gardens according to the epidemiological profile of the communities. There is also a need for a seeds fund to provide medicines at moderate costs…."

Participants from San Miguel Tucurú suggested that:

> "…The community population manages traditional medicine in their own communities and the level of service is motivated more by caring for ones self, caring for the community. But I know some natural medicine and the way it should be used but some contradictions also exist for example, the dosage is not clear and not measured in terms of grams or kilograms and this is very important. Many times the community arrives with emergencies such as snake bites and poison and the healers know what to use and if they are not able to cure them they bring them here and many times it is because they do not know the dosage of the medicine to give. We try to encourage self-care, communities exist very far a part and one cannot come on a daily basis to the Health Centre and they also have other activities to perform but it is important to know more about traditional medicine and to train those who use it so that they can use the medicine adequately. But it is very important and it should be incorporated…"

Participants were asked about the incorporation of traditional agents and providers within the SIAS at the EBS level. Participant from San Juan Chamelco commented that:

> "…It is difficult to involve people who work in traditional medicine in the first place because they are protective of their knowledge and they see their knowledge as a form of work which represents an income for them…"

> "…It is not difficult to incorporate the [traditional] medicine because we can take the medicine to the Centres of Convergence. It would be good to have a provider there and also a Centre of Convergence where one does not exist in each community…"

> "…We need a small botanical garden like the one in Chicovan. We do not have anything so we need to see what is here so we can have it…()… In respect to decentralisation, which you asked us about this morning, and about community funds, any other place would have carried out the activities but they are difficult for us to do here. What we need is to improve training…"

Respondents were asked to comment on their knowledge of traditional medicine and the kinds of treatments they thought traditional medicine would be effectively used for according to their experience and based on the results obtained for themselves, their families, their friends and the community in general. This is a summary of the types of traditional medicine they used and what the medicine treated. It is written in summary form because respondents provided examples rather than speaking at length about types and usage. In cases where patients manifested with burns, calendula was suggested as the appropriate treatment. In cases of arthritis, turpentine was suggested and in the case of colic and abdominal pain, camomile or a medicinal herb called pericón was suggested. For parasites the common treatment was garlic or the medicinal plant called apasote. For acute respiratory infections, treatments of eucalyptus and bugambilia were suggested. For gastritis, a medicinal plant called achiote was suggested. Participants suggested that for the identification of common illnesses and their treatment using traditional medicine it was important to establish initial protocols for treatment under SIAS. Knowledge would be generated based on basic ailments and their cures and gradually expanded. Participants were asked about their priorities for the incorporation of traditional medicine to institutional medicine and how a system within the EBS for traditional medicine would be created as a part of the SIAS. Participants in San Juan Chamelco agreed that it was important to:

> "…train the EBS on traditional medicine and the mobile physicians should promote traditional medicine as an alternative. A strategy of training the trainers of the EBS should exist but one of the common problems is that there is no norm for the dosage of traditional medicine…"

When asked who they thought was responsible for the articulation and/or adoption of traditional medicine into institutional medicine, the main views expressed were:

> "…it is important that people who have knowledge are in charge of the process and those who value traditional medicine. It is also important that the MSPAS should invest effort to train doctors and EBS around this knowledge…"

> "…The Academy of Mayan Languages of Guatemala is also supporting us…()…FUNMMAYAN provides orientation, prepares [traditional] medicines for training and teaches other institutions how to prepare the medicine…."

Participants were asked to comment on the improvement they would like to see implemented around traditional medicine in order to improve the health conditions of the community. Participants from San Juan Chamelco suggested that:

> "…The laboratory should monitor the quality of medicine thus guaranteeing the quality of the product processed. Education should be provided to families on the use of natural and chemical medicine. Institutional personnel of the MSPAS should accompany the providers of traditional medicine to understand their work and agree protocols…"

Participants from San Miguel Tucurú suggested that:

> "…In the first place human resources are needed and they should know the themes and be trained, and the other thing is economic resources because as someone said, I can come to the Health Centre in half a day and lose Q20.00 just to come here and return to my community so it is not worth it. Economic and human resources would be important…"

Participants considered that:

> "…Education for families is important around traditional medicine and it is equally important to provide botanical gardens. Training and awareness for the EBS around traditional medicine is important through the district teams so that they can deliver the correct messages to families they work with. They should also maintain a botanical garden for emergency situations until

> families are able to have their own gardens and for this, financial assistance would be necessary…"

Participants were asked three questions about traditional medicine – (1) What is good about traditional medicine? (2) What can be practical about traditional medicine? (3) What can be bad about traditional medicine? The views of participants around these questions are summarised here because the themes were common across the board. Participants indicated that what they viewed as good about traditional medicine was accessibility to the medicine by the population because the plants are grown in the community; the low cost of the medicine; the medicine does not contain chemicals which are harmful; and, the medicine has been practiced for many generations so it is passed down within families and general knowledge is more easily shared across communities. Participants felt that traditional medicine belonged to the communities. Participants considered that what was practical about traditional medicine was that is was easy to use; it can be administered through drops once the preparations were made; people in the community plant their own seeds; and, it is fairly easy to dry plants and prepare them for use. Participants considered that the following aspects were bad or had to be improved: the lack of consistency in the use of the medicine as some providers use it badly; the lack of ethics governing its application; the lack of knowledge by some users on the correct dosage to administer; the dosage itself which is not prescribed; and, the lack of knowledge of secondary effects.

Issues around culture were important to explore in terms the incorporation of traditional medicine under RSS (decentralisation as a system). Participants were asked about how they thought the Mayan cosmovision should be articulated and adopted within the system of institutional medicine of the SIAS. Participants from San Juan Chamelco indicated:

> "…Provide knowledge on the customs of the communities and promote respect for Mayan culture so that all institutional personnel value Mayan customs..."

With regard to the healthcare levels (primary, secondary or tertiary) participants discussed the Mayan cosmovision and the medicine of the Kekchí with respect to ARIs, DPDs and pregnancy be articulated, adopted and developed. Participants from San Juan Chamelco indicated that:

"…It should be with the MSPAS which should value the customs and communities so that they are respected at all levels..."

Commercialisation is an important factor because for traditional medicine providers it is a form of income. There is a need at the institutional level to recognise the market value of traditional medicine and to provide adequate incentives for promotion and expansion. Communities value low cost provision and traditional medicine is viewed as low cost and easily accessible especially given the economic profiles of communities. Norms have to be established on application and dosage of traditional medicine. There was a fundamental need to train personnel working in institutional medicine on the basic practices of traditional medicine. The EBS was considered ideal for training trainers and expanding the use of traditional medicine.

Financial resources were also identified as important in order to ensure the expansion and sustainability of such a process. The organisations involved in health at the community level should improve co-ordination to explore the role of each provider within SIAS and traditional medicine. Baseline work already exists in the communities around the use of physiotherapy as part of traditional medicine. It was identified as one possible health area where protocols would be established. The communities identified the need for laboratories to continue to work with traditional medicine, expand its knowledge and undertake promotion work for the possible commercialisation of the medicine. Communities also identified the need to monitor the use of traditional medicine at the institutional level. This involves training and awareness activities for those institutional health providers working in the communities. The MSPAS has a role to play in all of the above activities to incorporate traditional medicine as part of institutional medicine.

7.13. Fieldwork Component 3 - Lines of Response from Traditional Birth Attendants and Traditional (Trained) Birth Attendants

This sub-group was asked to comment about their personal and professional objectives. All TBAs (including trained) were aware of the importance of their work and their role with the patients/users. The main comments were:

"…They should send us materials we need to do the job…"

"…To know more plants to help my people..."

"…So that the trained could help more, we need training…"

Although their main objective is to improve their job and their role in the community, both TBA groups identified the need for equipment and materials to treat and support pregnancies and deliveries, training and health promotion materials (especially for health education), and training in herbal medicines as part of traditional medicine (systematising local knowledge and practices). TBAs were asked to comment on their use and practice of traditional medicine. The main comments were:

"…They know me and that's why I visit them…"

"…I have been trained, they know the training I have had and they have confidence in that medicine…"

"…We have cured many illnesses using traditional medicine…"

The TBAs understand that patients/users have confidence in them and they value domiciliary healthcare. The TBAs indicate that part of this confidence building process is that the population is aware of the training they have had. There is no evidence of exclusivity and competition amongst this respondent group. They are willing to share their patients/users and knowledge with one another. The majority of the TBAs interviewed mentioned other traditional providers which they consider to be reliable from the perspective of the communities namely healers and herbalists with regard to the treatment of endemic and common illnesses including ARIs and DPDs:

"…I think that the herbalists I know are very good in their job. I look for them because I have confidence in their work…"

"…If it is the healer, they know what herbs to use…"

The TBAs do not overtly manifest their preference for either natural/traditional medicine or chemical/pharmacological medicine affirming that both are considered equally useful. Nevertheless, it is important to stress the TBAs' appreciation for the availability of and accessibility to the preparation and use of

traditional medicine. The mention of chemical/pharmacological medicine between the TBAs is less frequent than between the patients/users. The medicines that the TBAs described are usually traditional or combined with institutional medicine, which is easily accessible and accessed without medical prescription in the case of common illnesses. The use of the medicine is related to the preferences of the patients/users and the urgency for treatment in relation to financial realities. The main comments were:

> "…Both medicines are good…and people think the same way I do…it is easy to get natural medicine"

> "…People are accustomed to use natural medicine but they tell me what they want…"

All of the TBAs interviewed are able to provide domiciliary services with regard to attention to pregnancy and partum and they expressed pride in this service provision. Most of them considered that they were also able to efficiently treat common "illnesses" like diarrhoea, vomiting, fever, cold, and cough. However, they were aware that they would not cure all the illnesses and complications associated with their healthcare role. They understand that the population in their communities would contact them for the treatment of such illnesses over other healthcare options. The assistance provided is evidenced by the following quotes:

> "…I cure them when they take a bath in the river and they get a headache, sore throat and fever…"

> "…For weakness and when the foot is swollen because of the lack of vitamins…"

With regard to the patient's reference and counter-reference around pregnancy, partum and post-partum, the general tendency is to diagnose and cure patients at the household level. As the condition worsens, TBAs request assistance from institutional providers (institutional promoters and nurses) or for additional medicines. TBAs refer patients only if the household treatments have failed or if there are further complications out with their experience and knowledge. The majority agree with the intervention of the institutional health system in grave or complicated cases, but it is not clear what kind of symptoms compel them to make

the immediate reference to institutional health services. They agreed that the reference is particularly difficult in the case of pregnancies or delivery complications because the patients are resistant to treatment by male medical or paramedical personnel. In problematic situations the TBA is present in the health centre however institutional personnel do not welcome this. The main comments were:

> "…No because the patients don't want to go. They are used to being treated at home. If they go I have to go with them…"

> "…Pregnant women will not accept going. They are accustomed to other women assisting with pregnancies…"

> "…If the trained midwife can assist a pregnancy then she should but if she can't then you risk everything…"

With regard to self-medication or treatment in cases of pregnancy, partum and post-partum, the TBAs know that self-medication and self-prescription of pharmacological products during pregnancy and partum has serious side effects. They know that some patients use pharmacological medicine however, the majority of the TBAs affirmed that their role is limited in examining patients, referring problematic cases to the health post or acknowledging that only the doctor will know what to prescribe in such cases. The main comment was:

> "…You cannot give whatever medicine to a pregnant woman. Only the doctor can do that with a receipt…"

With regard to the treatments and practices during pregnancy, partum and post-partum, those most commonly applied referred to normal pregnancies and partum but mainly concentrated in the latter. The main comments were:

> "…When pregnant women have body pain I massage them…"

> "…I have the place and the materials I am going to use for good hygiene…"

> "…I prepare the patient. I don't have any materials for that. I only buy a new Gillette…"

"…I use the natural medicine called woyo' k'een…"

"…I look after the women, change her clothes. Change the child. I bathe them in warm water. I watch over the mother so that she does not faint…"

There were no references to steam baths as used by other ethnic groups. TBAs referred to massage and apply other practices associated with keeping the woman's body warm. The most important practice during partum is the hygiene of the delivery room and of the materials to be used. The described treatments included massage (using balsam or similar treatment), the use of the plant called woyo' k'een for the same purpose, and a beverage made from crushed and boiled black pepper. The TBAs did not explain the mode of preparation and dosage. Other treatments included boiled yeast administered through drops over five-weeks for abdominal pain, the cauterisation of the newborn's navel using a wax candle, and camomile tea to warm the stomach. All TBAs indicated that the patients should decide their position during partum based on their own customs and levels of comfort. Comments on this point included:

"…They should have their baby the way they want and the way that makes them comfortable…"

"…Whatever she says and how they learned from their mothers and what their customs say…"

TBAs were asked about treatments for ARIs. At least three of the TBAs interviewed did not know the term ARIs and thus, refrained from addressing questions around this theme although they were aware of cures for cough and flu. Four of the TBAs thought they had the ability to cure ARIs at the household level through the use of traditional medicine. Two used a combination of traditional and pharmaceutical medicine, and another two only used pharmaceutical medicine. However they indicated that the application of pharmaceutical medicine is limited to popular products, like Vick's balsamic, aspirins and flu syrups, which anyone can get without prescription. One of the TBAs asked for medicines from the health monitor when she needed to. The main comments were:

"…I know what it is. I suggest that we get more training to deal with them…"

"…I don't know what it is but I would like to learn something about them…"

In general, the patients' level of confidence in natural medicine is quite high, and only two of the TBAs interviewed referred patients immediately to institutional health services. The rest of the TBAs (except one) referred patients to institutional medicine only if the patients did not get better after the initial treatment (either applying natural or pharmaceutical medicine or both). One of the TBAs stated that she never refers her patient with ARIs as it was considered treatable. Comments such as the following were made:

"…Only a doctor can cure more complicated cases…"

"…If the illness is advanced and I can't do anything I'll send them to the health centre so that the nurse can cure them…"

TBAs were asked about treatments for DPDs. Amongst the group of TBAs interviewed, knowledge of DPDs was low. There were also more references to institutional medicine though there was consideration for the treatment of DPDs at home especially in cases of intestinal worms. The following comments were indicative:

"…I don't know anything about them and I would like to say that I need knowledge on them…"

"…I send them to the health promoter after I have tried something at home…"

The knowledge and dosage of the plants, teas and beverages are more known by the herbalist and the healers. The institutional provider that frequently sees these cases is the health monitor. If there are complications they refer cases to the health centres and hospitals. The medicines mentioned are: drink half a glass of water containing half a spoon of salt, sugar and lemon juice to cure vomiting and diarrhoea, or a boiled beverage (atol) made out of ripe plantain. A drink of half-a-glass per day of apazote and garlic for stomach worms, or the same amount of 'elder flower' and garlic.

TBAs made very little reference to cultural illnesses. However, in all the cases there was doubt about the effectiveness of institutional medicine for treating psychological disequilibria such as fright (post-stress syndrome) and evil eye (psychological or physical damage done to a child by an adult in close proximity). The main comments were:

> "…At the health post they are not sure of fright and evil eye…"

Two of the TBAs affirmed that they cure both illnesses. The curative practices include:

> "…I hold the hand of the ill child and pray to saints…"

> "…I bathe the child in *cacao* and *ruda* (a medicinal plant) and make the child inhale smoke…"

> "…In the case '*mollera caída'* (loss of skin elasticity around the head due to acute or severe dehydration), use physical treatments such as pulling the feet of a child suffering '*mollera caída'*…"

This group of respondents confirmed the incorporation of traditional medicine to institutional medicine. Curative practices involved both types of medicine and experience guided the decisions of the TBA. The preferences of the users were also considered important to the TBA. TBAs worked within the SIAS and independently. The concept of trust between themselves and the community, based on confidence building was important to how the relationships were developed. The TBAs were considered a source of knowledge and assistance and in most cases, were perceived as the preferred option. The SIAS network was used by the TBAs as required. TBAs also identified the need for more local resources under RSS to improve service provision.

7.14. Fieldwork Component 2 - Lines of Response from Healers and Herbalists

The objective of the traditional therapists or herbalists is to help others. This work, according to them requires a certain degree of secrecy therefore their knowledge is

kept secret. They also mentioned the importance of their work in terms of the recognition and incorporation to the institutional system and suggested space to hold their surgeries. However, this must be done under certain conditions. For instance they must be able to practice without discrimination, they must have space to express their opinions and views and they must be able to retain their patient caseloads. Respondents suggested that institutional providers were "…jealous of our knowledge…" The male healers and herbalists mentioned that they have accumulated between 25 to 50 years of experience while the female members seemed to be younger and less experienced. Comments included:

> "…I like to keep the health of my people good…"
>
> "…I would like a small local to improve my work…"
>
> "…I would like to have a meeting with the healers of all of the municipalities to see where we are all at…"
>
> "…Train others in my profession…"

With regard to the reasons why people consulted traditional health providers, all of the respondents stated the need for confidentiality in the healing process. The population is confident in their capacity, knowledge and experience. Only two of the respondents mentioned that eventually they referred patients to the institutional services. This was done in cases where the illness was not a part of their healthcare knowledge:

> "…A healer knows what they are doing and people go to healers because they have faith in their work…"
>
> "…All of the illnesses that I have treated I have cured. There are people who come to me in grave conditions and I cure them…"
>
> "…My Mayan knowledge makes me a good healer…"
>
> "…There have been illnesses that I have not been able to cure but these are rare. I send them to the hospitals…"

The healers frequently mentioned specific health problems as their health specialities. The 'specialisations' included fever, cramps, and muscle and bone pains, fright (post-trauma syndrome), evil eye, 'mollera caída', healing broken or curved bones, skin cancer, and weight loss due to various causes and associated with different illnesses.

The majority of healers interviewed support the use of natural medicine for the treatment of ARIs. Only two members of this group combine natural medicine with non-prescription pharmacological medicine. One member of the group does not treat ARIs and refers patients to the institutional health services. The conceptualisation of ARIs is that, they are infections caused by cold temperatures, which require 'hot treatments'. Despite the 'secrecy of their work' they talked about the kinds of treatments, dosage and expected results in the care of ARIs.

Respondents indicated that they mostly use traditional medicine to treat DPDs, especially diarrhoea and stomach worms. Only one healer in the group refers to institutional medicine in cases where the health of the patient worsens. Amongst the most common DPD treatments mentioned are:

> "…Drinking boiled leaves of Kag'irix or Pericón (both medicinal plants) to normalise the stomach's functions…"

> "…Boiling leaves of K'u'n iru over three days to expel stomach worms…"

The healers also treated pregnant women, described the medical practices during the partum process and considered what symptoms presented during pregnancy were not normal. In these cases women were referred to the institutional health system:

> "…People prefer treatment in their homes and I also prefer treating them in their homes so that they are closer to their families who can take care of them…"

"If they are sick because they are pregnant that is easier than other illnesses…"

Healers mentioned a less frequent use of medicines compared to the TBAs. This group did not stress the need for hygiene as much as the group of TBAs during pregnancy, delivery and post-delivery care problems. They agreed with the care of pregnancy and partum at home. They indicated the use of medicinal plants without reference to the use of pharmaceuticals. In general they were willing to refer any patient with health complications to the institutional health services. The main comments were:

"…If she is grave I don't give her anything. I refer her to the hospital…"

"…I massage when she has body pain before giving birth. The body needs massage when they are tired…"

"...Natural medicine only…never the pharmacy…"

In the areas where healers and herbalists specialise (including ARIs and DPDs), reference to institutional medicine is not made. Healers have experienced rejection from the medical and paramedical personnel of the institutional services. Discrimination is more associated to 'cultural illnesses' and not to pregnancy. They do not accompany pregnant women to the institutions. The main comment was:

"…I have never gone with them because the nurses don't want it. They say we don't know anything…"

With regard to the issues around the position during the partum, the group indicated that the vertical position for child delivery is considered the most adequate with the mother kneeling down, and some times with the assistance of the husband or the healer. This was considered the best position for delivery but they indicated that the woman had to choose what she considered the most comfortable position:

"…Vertical, with my help, embracing me around the waist. This is what we learned from our fathers and we cannot change it…"

With regard to cultural illnesses, there are differences, oppositions and antagonisms between both traditional and institutional health providers. The group of healers and herbalists are convinced that they can cure illnesses, which the institutional health services cannot:

> "…In the health centres, they do not cure these illnesses. Only the healers…"

> "…For fright, only I know the secret…"

> "…If the doctor wants to know how I work I will invite him to my house so that he can see with his own eyes what I do…"

Institutional medicine does not have an understanding of certain cultural illnesses experienced by the local population. However, the population consult healers in order to treat these kinds of illnesses. They require the patient's faith in their capacity to treat such illnesses and many of the treatments are kept secret (or rawasil as referred to in their language).

7.15. Fieldwork Component 2 - Lines of Response from Health Monitors and/or Health Promoters

The personal and professional objectives of this group are to assist and support neighbours in their communities and other areas when possible. This group identified the need for better provision of medicines in order to treat the most urgent cases. They mainly mentioned the need for training to improve professional and technical skills, followed by the need to work together with their communities. Professional needs were similar to those expressed by the other groups: equipment, space for treating patients and training and skills. Comparatively, this group stressed their economic issues more than any other group interviewed due mainly to the low salary they receive working with the NGOs that administer the SIAS at the community level.

The health monitors stated that they refer patients that they cannot treat to the institutional health services, however they know that the people can reject follow up treatment. There are a number of reasons for this, including the lack of

confidence in the institutional health system, lack of clear communication with medical and paramedical personnel, and difficulties to access institutional health services due to time, distance, and transportation. The main comments were:

> "…Because people are embarrassed to go to the health centres or they are nervous because they do not know the language…"

> "…Some like home remedies but more like pharmaceuticals because they don't want to waste their time preparing home remedies…"

> "…This is the medicine of our Mayan grandfathers and I have confidence in it. The pharmaceuticals are also good according to the people…"

The health monitors considered that the main reason why they refer patients to the institutional system is the lack of medicine. They feel capable of treating and curing many of the illnesses and have the knowledge but not the infra-structural support. They clearly distinguish between the illnesses treatable at home and the ones that have to be referred immediately to the institutional services, emphasising the need for treatment by the doctor. There were fewer statements for referring patients with common illnesses, except in cases in which their condition worsened. They are willing to test some of the natural medicines or to accept the treatment by traditional health providers if there are no pharmaceuticals or if there are many difficulties to access a health centre.

They indicated that ARIs can be cured with natural medicine or pharmaceutical medicine at home. Nonetheless, their opinion about healers is that they tend to generalise ARIs for instance, as common colds failing to recognise the different symptoms and the potential consequences of the illnesses:

> "They only know what their parents knew. They think ARIs is a common cold and they do not know how to recognise grave cases or how to cure them…"

The group also agreed that DPDs could be cured at home, especially using home remedies. However, they considered that it is better to refer patients to institutional medicine. The group of monitors thought that the healers need to know

about DPD symptoms and treat patients with such problems correctly. They indicated that:

> "…Healers do not know anything about heartburn as the beginning of gastritis…"

The health monitors usually do not treat pregnancies, partum and post-partum cases. Only two of the interviewees (both males) have treated pregnancies and post-partum situations, but not partum cases. All of them manifested absolute confidence in the training process. They are concerned about the lack of training amongst TBAs who are working directly with SIAS. Their main concern is that TBAs lack the adequate knowledge to identify pregnancy partum and post-partum warning signals for immediate reference to institutional health services. They also stated that TBAs do not know how to administer medicines to accelerate partum, for instance, in cases where the position of the foetus is compromised. There were few comments about the preferred position by women when delivering and the group indicated that this decision belongs to the mother or the TBA. There were ambiguous opinions on traditional vis-à-vis institutional practices. This group did not comment on cultural illnesses.

7.16. Fieldwork Component 2 - Lines of Response from Mobile Physicians

This group identified working with the community and treating the population as their primary concern. The work conditions at the local level and the forms of provision of health services are also important concerns for the group. Regarding the way in which health services are organised and the level of efficiency in provision:

> "…In the middle term, we would want to maintain the SIAS. Obtain a post-graduate degree. Reduce the rates of maternal-infant mortality, parasitic infections ARIs, malnutrition, skin diseases, and extend vaccination coverage…"

The Mobile Physicians attributed the tendency by the population to consult traditional health providers to the cultural beliefs and customs in the rural areas. Also, the use of traditional medicine is attributed to the lack of accessibility and health infrastructure. The main comment was:

> "…They treat themselves. They are accustomed to resolving their own problems. The healers would have had some effect on them because they use them so often, because of tradition and because medical services have not been available to these communities…"

The illnesses frequently treated by mobile physicians are parasitism, ARIs, malnutrition or anaemia, diarrhoeas, dermatitis and conjunctivitis. They considered that the population cure light diarrhoeas and common colds in their homes. None of the group referred patients to the traditional health providers with the exception of the TBAs. But only in cases where they trusted the skills of the TBA and where there was confidence in follow up procedures applied for treatment. If they were not able to treat or cure certain medical problems, they would refer their patients to medical specialists or to hospitals. The health problems that required reference to hospitals or specialists were cataracts, hypertension and miscarriage. They did not believe that 'cultural illnesses' existed or that only the traditional health providers would provide treatment and cure. Comments included:

> "…They don't have any foundation in science…they say they make the patient inhale smoke in the case of ARIs or they bathe the patient in warm baths with a eucalyptus leaf. This is not advisable…"

With regard to the treatment of ARIs, this group considered that ARIs could be treated at home, as long as the patients suffering did not get worse. In cases where the patient was worse off, they referred them to the health centre or the hospital. They thought that the healers are able to cure ARIs, but the traditional health providers have to recognise the symptoms and signs of gravity for immediate referral to the institutional system. They know that within the traditional beliefs of the population ARIs is included, but in general the population and the traditional providers do not consider them to be dangerous illnesses and do not use or apply the adequate medicine:

> "…In reality they can cure the illness…but they don't know when complications can occur. They give them teas but they don't know what teas…"

The group considered that the traditional health providers have more knowledge and experience dealing with DPDs. The traditional providers know more about DPD symptoms and the seasons in which these diseases spread to the population. However, they do not know about the causes that produce them (aetiology). The group of interviewees know that DPDs can be cured at home, but they do not approve of the use of garlic because it elevates blood pressure. They would prefer the reference to the institutional health facilities of patients suffering from DPDs, though the urgency to do so is not the same as with ARIs:

> "…They don't know about parasitic diseases. They have some knowledge but it is not scientific. They know that the diseases start when the rains come but they should know the causes…"

> "…Yes they know. They know the seasons when these diseases are more frequent, that the appetite decreases, that diarrhoea and vomiting can occur…They should refer to doctors…"

With regard to pregnancy, partum and post-partum, none of the group had assisted with pregnancy at the time of the interviews. They have a general negative opinion about the traditional practices and procedures of the TBAs in the communities, related to the healthcare given to pregnancies, partum and post-partum cases:

> "…They can assist the pregnancy. They know…what is happening but they do not know why…they don't have any foundation. They massage because the woman has pain around her waist or the region of her body. They don't know how to treat complications. They need more knowledge about the presentations…"

> "…Yes they can assist the pregnancy. They should clarify the month the woman is in. They don't know and can't detect complications…premature rupture of the membrane, and miscarriage because there are more facilities in the clinics to detect these…We don't know what techniques they use and we don't know if the techniques used by the TBAs are good…"

Mobile physicians think the TBAs do not have enough knowledge to care for complicated cases. They need to be monitored and evaluated more often in order to maintain strict control over the way the TBAs perform their work. Thus, these

procedures should avoid last minute complications and would increase the quality of the TBAs' interventions. With regard to the position during the partum, the group has a certain disposition to accept the vertical position at the moment of delivery, which is the preferred position recommended by the TBAs and most used by the patients in the communities. Nevertheless, they stressed that the decision to use this position for partum would be in the hands of the health providers rather than the patients.

7.17. Fieldwork Component 2 - Lines of Response from Graduate Nurses and Doctors of the Health Centres

The personal and professional objectives of this group of institutional medical and paramedical personnel were linked to the professional and institutional goals achieved under the SIAS. They are looking for a change of attitude in the way they are working, so that health personnel are more involved in resolving the health needs of the communities. This approach is better achieved little by little with newer and younger personnel being incorporated to SIAS. According to the group, this means that primary healthcare has three important elements in the development of medical practices: first, increasing knowledge of health problems at the rural level (more efficient primary healthcare and health education and promotion); second, increasing the interaction with the population being treated and therefore, more possibilities of knowing the population's customs and cultural practices in general and particularly in healthcare; and, third, real and concrete experience of these kind of practices in daily life at the local level. This is evidenced in the following comments:

> "…Obtain a good level of experience locally in all its aspects…"

> "…It is important at the local level…I need training generally and training in new ideas…"

> "…They know that I know the language and that I have been trained in health…"

According to this group, institutional approaches are close to organisational structures in the communities through the SIAS. Some levels of co-ordination have already been established with the communities with regard to the system of

reference of patients between the community, the traditional providers and the institutional personnel. There is a need to monitor how decisions are made, in order to reinforce the structure of reference by improving the quality of the health services overall. As part of this monitoring and evaluation procedure, the group considered the need for the integration of traditional medicine and its providers to SIAS, initially as a pilot plan in the townships of Chamelco and Tucurú. This can be achieved through exchanging knowledge and reducing mutual prejudices between both medical systems. The following comments were made to this regard:

> "…I don't know much about natural medicine. I apply what I have been taught or what I see in the pharmacies. The pharmaceuticals are good but they are expensive. I do have the desire to learn about natural medicine because it should be cheaper…"

> "…The healers know the plants and the amounts. They heal but they don't teach anybody. And some are expensive. You need to have both for the needs of the population but now you have nurses in different villages so the need is not that grave…"

The group stressed that the system of reference currently exist in an empirical way rather that in a systematic way. The reference system only works in the institutional health system in operational terms. The reason is because most of the time, the population consults the traditional health providers first. If they do not see or feel any improvement in their health status, the population or the traditional health providers refer or look for the SIAS. So, it is important to engage in communication between both health systems in egalitarian rather than in discriminatory ways, which usually happens:

> "…It is possible that there should be a certificate for nurses and for traditional providers…They say that people want them but there are very few resources. But the presence of the nurses has made them less popular. The people don't think about the big things. What they want is to be cured. So we nurses have to know both types of medicine…"

Communication should be established more frequently with the community leaders in order to promote a close working relationship with the shamans, healers, herbalists, masseurs and the TBAs. This working relationship could be established through visits, workshops, training sessions, negotiations and sensitisation

campaigns. In the case of the TBAs, who are in an intermediate level and function either between and within both health systems, it is necessary to constantly reinforce training activities in order to systematise their medical knowledge and exchange their own experiences to improve their healthcare skills and confidence at the local level. The main comment was:

> "…Even though we all use pharmaceuticals we all know that the population visits healers so that they can get traditional medicine. We would like to have more access to it and because it is cheaper. But we have confidence in pharmaceuticals and we have confidence in the doctors and nurses for reference. The assistant nurse who uses both medicines equally has confidence in the healer…"

The medical and paramedical personnel stated that they have had sporadic contacts with the traditional health providers who are geographically and professionally distanced from the institutional health system. However, they have very vague knowledge of their specialisations and treatments. From the comments above, this group for instance does not know how most of the traditional health providers use traditional medicine (medicinal plants and the rituals they perform or the combinations of popular and traditional medicine or pharmaceuticals they use) to cure their patients. Therefore, they consider it important to have access to more knowledge of traditional medicine practices. The group also recommended non-confrontational encounters with traditional health providers to recognise their professional work and to foment confidence amongst the professionals of both health systems:

> "…We should have training in traditional medicine and in exchange they should have some training in institutional medicine…"

The group thought that the Kekchí have their 'own knowledge' of ARIs and it would be important to know the vocabulary and elaborate a glossary of terms in both languages Kekchí and Spanish, which may be used to train both institutional and traditional health providers. Comments included:

> "…I think the healers can cure ARIs but the ones that are very well trained…in a few cases reference is made to the doctors and other traditional options are not considered…"

> "…Deficiencies in the traditional system are attributed to the lack of knowledge of this group of illnesses…they don't know the term…and the assistant nurses rely on training…they become very tense when they don't know the term even though they may know what the illness is…"

The group has used a combination of medicinal plants (like bougainvilleas for stomach worms) and pharmaceutical medicine in some DPD cases with successful results. They stressed that this kind of treatment is more frequently applied to patients with similar problems. However the treatments should be systematised with regard to popular conceptualisations and traditional knowledge and, scientific explanations and institutional knowledge. This systematisation in turn can work to foment confidence of the communities in the institutional health system. According to the group the systematisation of both types of knowledge can provide an appropriate framework for the population to seek institutional health services.

According to the statements of the group, close or frequent interaction between both health systems occurs in pre-natal healthcare actions. This may be utilised to educate mothers and TBAs about various pregnancy, partum and post-partum and lactancy aspects. Mothers and TBAs are valuable key human resources to increase the quality of health at the family and local levels:

> "…The midwife is not good for delivery because she has not been trained and she is not able to advise on this…"

> "…They are not very good at cutting the umbilical cord and sometimes they produce infections. Sometimes there are complications and the mother dies. They do not know too much about good hygiene but the great advantage they have is their experience…"

> "…When there are emergencies they can assist in the delivery but they need more knowledge…They can be trained and provide better advice…"

The group has a certain disposition to accept the vertical position for partum, which is preferred by the TBAs, shamans, healers and users in general. However, it is considered that the mothers should make the decision depending on the conditions (whether the partum is normal or complicated). Vertical partum should be

normatised and thereafter its inclusion should be operationalised, accepted and considered as common practice in the health centres and hospitals. The comments they made were not any different from those already stated above with regard to this question.

7.18. Fieldwork Component 2 - Lines of Response from Users of Both Types of Medicine

With regard to healing at home and self-medication, the group in general self-medicate without prescription (popular medicine). Only one respondent asked the pharmacist for information about what to take for common pains (headache, stomach ache, and toothache). The group has used some of the traditional treatments and remedies for the above problems for example: Apazote (medicinal plant) and garlic for stomach aches, guava for diarrhoea, and Cola de Caballo (medicinal herb) for urine problems. Typical comments included:

> "…I learned about which medicines to use…"

> "…We ourselves, thinking about our health, have bought medicines without consulting anybody…"

> "…For some things I can cure my family in my home without buying medicines…"

Institutional services are consulted where there is a high level of confidence in the health monitors (who usually refers patients) and in the doctors. The group mentioned the level of accessibility of the institutional facilities (health post or centre) as a secondary factor. The group is reserved when talking about the use of the traditional health providers, with the exception of the TBA. For instance, they mentioned the visits to traditional health providers such as shamans, healers and herbalists as the "business of others in the community" but not something that they themselves do or need. TBAs were accepted because home visitation was convenient and they performed specific healthcare skills and tasks. The comments were:

> "…Because the midwives are trained, they apply what they have learned…"

"…They have told me about traditional medicine for whatever illness but there is no one that I know who can teach me how to use it…"

"…I have confidence in the health centres so I go there…"

The prevalence of ARIs is very high amongst the population especially children according to the group's opinion. However, they indicated that they do not know how to cure these illnesses at home. Even if they use traditional medicine for certain symptoms associated to these illnesses, they indicated that the best option is the health centre and the doctor. They mentioned antibiotics although they do not know the side effects of the medicines prescribed by the institutional medical and paramedical personnel. The group mentioned some traditional treatments for ARIs such as steam baths with cypress seed, massage and balsamic. The main comments were:

"…Only the doctor knows how to cure these illnesses. They have given me prescriptions to buy medicine. I buy the medicine I know. Antibiotics to maintain microbes…"

"…I don't know what medicine to use for bronchitis. Tablets and injections they give us at the health centres. I don't know any natural medicine for this…"

The prevalence of DPDs is also very high in general and all the groups and ages are vulnerable to them. The group stated that most DPDs cannot be cured at home, with the exception of stomach worms and some stomach aches. They do not know the name of any medicine prescribed by the institutional health system to cure DPDs though they know that pills are prescribed with positive effects (to reduce stomach aches). The group mentioned some of the traditional medicines used at home for mild DPDs such as Baq'che leaf (medicinal plant) and the rubbing of a heated stone over the stomach wrapped in Xaq' obel leaf (medicinal plant) for stomach aches and a mixture of Apazote (medicinal plant) with garlic for parasites.

They prefer the TBAs at home for pre-partum, partum and post partum care. Most of the women in the community required the services of the TBAs although they used institutional health services. If the TBAs identify complications women

follow their recommendation to go to the institutional services with their husbands permission:

> "…When they cannot treat you in the home they send me to the hospitals. If the position is bad I go to the doctor…"

> "…The midwife provides advice and massage. They know where to touch the baby. Only they know what needs to be done…"

They did not mention any illness associated with pregnancy except for complications such as the transversal position of the foetus. Only one member of the group mentioned precautions to be taken when pregnant. Stomach massages are the general corrective treatment for these problems. They all mentioned that they were confident with the skills and knowledge of the TBAs. The respondent indicated that the vertical position when delivering the baby is the most adequate and comfortable position for the mother although they will follow-up on suggestions by the health provider who are supporting and helping them.

Chapter VIII
Analysis of Phase Two towards the Development of a Framework for Comprehensive Evaluation

8.1. Consideration of the Parameters for Analysis

This chapter provides examples on how evaluation of community participation in post conflict environments and decentralising policies could be done using qualitative methodology and a comprehensive epistemological framework. The assumptions and evidence is presented in contrast with the assumptions and the limitations of a mainstream evaluation framework like the one applied by the MSPAS/PMSS/UME for the Guatemalan case. As I have said, this evaluation framework (mainly structural functionalist) is limited in relevance and effectiveness because of the way its epistemological categories of analysis were designed and applied to assess the phenomena of decentralisation, participation, and heath sector reform. The analysis provided from Phase 2 illustrates how to critically understand and analyse some of the epistemological categories in a post-conflict environment like the Guatemalan one, at the national and sub-national levels and how the four methodologies which are part of the comprehensive framework can address the issues underlying intersectoral (the reform of the public sector) and sectoral decentralisation (the health sector reform) processes.

The first part of the analysis is based on responses from participants recorded in Chapter 7, Components 1 and 2 of the fieldwork. The responses are compared within each component that is, the groups interviewed under Component 1 are compared with each other and the groups interviewed under Component 2 are compared with each. Limited comparison is drawn across components. This is done for the following reasons: (1) the purpose was to establish, within groups, how variables are interpreted and understood in order to define the variables from each unique perspective; and, (2) the fieldwork was not designed to compare responses but rather to consider interpretations and visions within an alternative evaluation framework. An analysis based on direct comparison of responses would have limited their application within an alternative evaluation framework as considered under the epistemological approach of this thesis, that is, to bring knowledge together without placing any weight on the different perspectives presented. As such, the comparison across components, where it is done, is more for context-

setting purposes. In Guatemala, for instance, the visions of the community must co-exist with and in some aspects complement institutional and macro visions and *vice versa.* The framework itself is not definitive but rather an example of how an alternative evaluation framework can be elaborated within a given post-conflict environment.

The second part of the analysis brings together research from Phases 1 and 2 and analysis from the literature review to consider how an alternative evaluation framework might be constructed. In the section below, the variables and key words are identified and questions from Chapter 1 identified under the epistemological framework are stated in relation to each variable. The questions are not intended to be exclusively identified for that variable. It is appropriate to consider some of the questions for other variables. The themes covered are inter-related and complex and multiple links can be drawn between the variables, how they are derived, defined, interpreted and understood within the context of the thesis. Indicators are suggested to indicate how the variables can be measured within an evaluation framework, and some of the issues with regard to verification are also considered. This framework is an example only. It is not definitive in the sense that its universal application should be applied along the lines suggested. It is illustrative and demonstrative of a specific situation and within a given set of circumstances. This means that the process is evolutionary and unique to the environments it can be used to study.

8.2. Analysis of Component 1 on Decentralisation, Health Sector Reform, Community Participation and Ideas towards an Alternative Evaluation Framework

For Group 1, comprised of government officials and others involved in sectoral reform, the definition of decentralisation is shaped by the following: co-ordination of units responsible for reform, re-organisation of institutions (MSPAS), expansion and reorientation of Health Benefits and modernisation of provision. The process of decentralisation involves political administration, management and decision-making under a model of decentralised administration supported by community participation. While clear definitions of decentralisation do not emerge with Group 4 (officials or representatives from civil or academic sectors), this groups shares many of the views of Group 1.

Participants in Group 2 (advisors and consultants working inside or outside of government) agree with the definition of decentralisation as administrative decentralisation, however provide a comprehensive definition of democratic culture defined by pluralism and inclusion and safeguarded through audit and review functions at the municipal level. The concept of decentralisation is associated with ethics and values where decentralisation is viewed as a cultural shift in organisations and individuals and one which is defined by democracy. The concept of legitimacy is important to the way in which legislation is agreed and to policy development activity. Legal reform is important to the process of decentralisation overall. Therefore the experience of decentralisation is linked to the need to address culture (political, democratic, and social) and historical impacts which shape how a local community may behave or interact with institutions. Group 2 also discusses decentralisation as fiscal decentralisation, which is perceived as a further and necessary measure again linking it to municipal autonomy and democracy. Group 3 (officials from international agencies) identified administrative and fiscal decentralisation similarly to Group 2 as ideas around governance and local planning were suggested under the two forms of decentralisation.

With regard to health sector reform, Group 1 identified three key themes - (1) co-ordination at both the national and local levels to achieve health improvement; (2) modernisation of health services; and (3) expansion of coverage. Participants' views were consistent with health sector policy and programme initiatives under the framework of Health Sector Reform. While it was expected that Group 1 would echo government policy in the responses they gave, participants also discussed the concept of 'politics of health', which they defined as a way to improve accessibility and availability of health services (by achieving the key themes discussed above). Further, the concept was elaborated, and the issue of 'de-politicisation' of health policy, discussed. An example of this theme included ensuring that bi-lateral agreements were free from political pressures and were outwith the sphere of influence of the government of the day. At the macro-level, this represented improving relations between institutions responsible for policy review and development and decision-making. Examples of institutions were the MSPAS, which was considered to be over-politicised and through 'de-politicisation', reference is made to the MSPAS working with a network at primary and secondary levels of

attention and at national and local levels. Awareness-raising is also mentioned with direct reference to improving health indicators and inference is made to local action. For example, the group considered that there is a need for social education and sensitisation campaigns in schools and at the community level. Similar themes are discussed by Group 4. Group 4 identified the need for consistency in health policy discussing the role of different governments and how they manage health budgets. The focus is on resource investment and health priorities. The main reasons why responses from these two groups are similar are: (1) Group 4 often holds positions within government or has had party affiliations, and (2) Group 4 plays a significant role in Health Sector Reform policy through research with the MSPAS and other government institutions or as advisors on policy matters.

Group 2 links concepts of decentralisation to municipal autonomy. Through these two processes, the participants believed that the following could be achieved: local governability, administrative authority, sovereignty, management, development of information systems, representative and participatory democracy, and decentralisation of public administration. Municipal institutions are viewed as legitimising structures for decentralisation initiatives. The inference here is that they are close to the local community and better situated to achieve governance and participation. The idea of 'de-politicisation' as discussed by Group 1 is considered further by Group 2 in the form of municipal autonomy as a legitimising process in decision-making processes. The theme of co-ordination of institutions, which is discussed mostly at the national level by Group 1, is elaborated further by Group 2 as co-ordination at the municipal level through which local priorities can be identified, interpreted and understood.

The concept of municipal autonomy is shared by Group 3, which suggests the need to reform public administration through consensus. However, and perhaps given their unique position in the country as a part of the international network of officials and experts working in the country, this group refers to programmes in operation in the country. Nonetheless, there is high level of agreement on administrative and fiscal decentralisation linked to participation and governance as expressed by Group 2.

Group 1 mentions community participation under a model of administrative decentralisation. Community participation is not viewed solely or mainly as user participation but as participation of local providers. The participation of the former is viewed in terms of access to health services. The inference here is that community participation is defined and interpreted, in relation to the degree to which, the local population accesses health services, but not how the population may relate and interact with an array of health activities and providers. Therefore, little reference is made to impact on provision through decision-making.

The concept of participation is viewed by Group 2 as exchange and inclusion within health and with other sectors. The Peace Agreements are viewed as crucial to establishing decentralisation, Health Sector Reform and participation. Group 2 considers that the objective of decentralisation is participation. Participation is linked horizontally to creating the conditions for local democracy and governance and vertically through participatory democracy in decision-making processes in strategic development issues. The focus of Group 2 is clearly governance and participation, which is equated with municipal autonomy. These views are also shared by Group 3. Responses from Group 2 are comprehensive in making links between reform and participation among other processes. The interpretation applied by Group 2 to the Peace Agreements clearly identifies a process of participation as linked to other processes such as decentralisation and municipal autonomy.

In contrast to the views of officials, the groups of advisors and consultants and the academic sectors interviewed held views closer to the way the communities understood local governability and autonomy and linked these ideas to the Peace Agreements. Advisors and consultants and the academic sectors identified with key concepts such as participative democracy and active participation, which were close to the vision of decentralisation expressed by communities. There appears to be scope within health sector reform and decentralisation to discuss levels of involvement and also, how different levels of government interact with one another. The fieldwork findings for the two components suggest the need for more inclusive approaches to Health Sector Reform and decentralisation. The interviews with consultants and advisors did indicate the need for attitudinal scales in measuring Health Sector Reform in order to obtain different perspectives. This is in contrast to measurements suggested by high rank officials, which are mainly based on cost

assessments and analysis. While both examples are useful in measurement systems, Health Sector Reform and decentralisation is still not an idea that has evolved holistically encompassing different perspectives simultaneously.

With regard to views on an evaluation framework (mainstream and conventional or alternative and comprehensive), Group 1 discussed the theme of performance measures at length. Most importantly, Group 1 considered that participatory assessment is essential where political and social indicators are required to be developed with direct reference to the Peace Agreements' political and social indicators framework. While participants identified quantitative indicators such as one doctor per 10,000 inhabitants, comparative assessment of impact is also identified between themes such as health and nutrition. Assessments of impact are also mentioned in relation to resource allocation however these are essentially quantitative such as level of investment and amount spent, types of resources mobilised and type of met and unmet need. A comparative framework is mentioned including aggregated hard indicators (coverage, cost benefit and nutritional health). However, impact assessments in particular make little reference to the social, political and historical context of health situations in local communities. While trace (or basket) indicators are mentioned specifically linking the reality of the community to the health model, trend analysis is suggested for this measurement. Basket indicators can be important because grouped indicators can be locally defined and specifically related to the health situation of the community. Minimum selection of basket indicators is suggested. The inference is that such indicators may change constantly. In this regard, the interpretation of the Peace Agreements' political and social indicators framework is mainly through conventional evaluation apart from some degree of involvement of the local population. While this view is shared by Group 4 participants, very little mention is made by them about indicators apart from reducing infant mortality, reducing the prevalence of illnesses and diseases, and increasing nutritional health of children.

Group 2 considers that indicators should be shaped by a number of experiences including understanding the barriers of access to health services and impacts on users. While these are also identified by Groups 1 and 4, Group 2 participants are able to examine a more complex breakdown of measures perhaps because they contribute to evaluation and assessment activity directly as advisors

and consultants within Health Sector Reform. For example, 'accessibility' by the group is broken down as follows: (1) how services are supplied (local conditions and national response); (2) how services are received (culturally and socially); (3) the impact of the environment (physical such as transportation and distance); (4) costs associated with the supply-side and user-side of provision; (5) cultural inhibitors and opportunities (language); and, (6) awareness (socio-cultural history of the user and cultural manifestation of need). The focus is on the inter-relationship between the service and user in a more complex way such as user and access indicators, provision culture and cultural awareness indicators, and culture and need indicators. While the Group mentioned the need to assess cultural practices, the importance of traditional medicine in the group's responses can only be inferred and linked to ideas such as human dignity. Within an overall evaluation framework, participants consider the importance of the relationship between community participation and health coverage. Group 2 moves more towards a comprehensive and alternative evaluation framework than Groups 1 and 3.

Group 3, perhaps because of their links to international institutions, continue to argue from the perspective of conventional evaluations suggesting an existing framework for such studies to take place. Group 2, given their position as consultants and advisors, and length of experience in the thematic area, are able to look more broadly at the parameters of measurement and evaluation.

The groups interviewed under Component 1 were all based in the city and lent their services to the government in one capacity or another. The groups were knowledgeable about macro policy frameworks and thus discussed themes such as the need to develop the health infra-structure, effectiveness of functional relationships across and within institutions and sectors, and Health Sector Reform under administrative decentralisation. The majority of responses were influenced by a 'top-down' perspective shaped by policy development, health sector organisation and research activities. Terms such as community participation are associated with broader processes of democratisation. With the exception of one group, local experience is perceived as a relationship to provision rather than as integral to a social process of involvement. Given this perspective, for most groups, evaluation is viewed in conventional terms consistent with existing institutional evaluation frameworks such as the one discussed in Chapter 6 of this thesis.

8.3. Analysis of Component 2 on Health, Decentralisation, Community Participation and Traditional Medicine

The concept of health for the communities is defined and perceived locally – local environmental conditions, the health situation of the population and how local communities access and use health services. Local provision is also important to this vision because it is important for people to perceive that they are administering and controlling, to a degree determined by them, the health services that are available to them. Health also links to experience that is, people access and use health services where there is a level of trust and confidence in the system. A positive experience of health sector reform has a significant bearing on continued participation in the system and a positive experience for people, is shaped by the benefits they obtain for themselves and their community. An example of this view is expressed in relation to Health Sector Reform "…*should be at the rural level because that is the level I think at*…"

The idea of empowerment is evident in discussions about decentralisation with the communities. Decentralisation is viewed as "…*bringing resources to the community*…" in San Juan Chamelco and as a "…*process that will be organised step by step*…" and one that will provide "…*continuous support at the community level*…" in San Miguel Tucurú. Health Sector Reform and decentralisation are viewed as bringing benefits to the community. Decentralisation is viewed as the best way to achieve an effective and rapid response to address health problems, based on the decentralisation of resources, and in expanding the role of the municipalities. The following examples represent these views: "…*process of health should be an integral one, decentralisation should be generalised and everything should be decentralised*…" and "…*resources should be decentralised because at the current pace it will take a long time*…" Decentralisation is linked to the transfer of resources to the community. There is a clear understanding of the norms of the SIAS around resource transfers and the lack of resources at the community level is associated with the poor delivery of services under a decentralisation model. The idea of local action to resolve local problems is strongly expressed by participants, and it is associated with community identity and developing an understanding of the problem. The need to strengthen municipalities is also considered important again because the municipal level is viewed as being closer to communities and also

because of the nature of problems experienced by communities. Participants see a clear link between decision-making structures and the community itself. The community is considered instrumental in the reform process and in the process of decentralisation. The reform process is linked to the vision of reality of participants and their communities and viewed as practical in terms of securing access to health at the community level.

The idea of the municipality playing a central role is identified and linked to administrative decentralisation. This is exemplified by the following views: "…*each municipality is best placed to make decisions because…the municipality knows its problems and how to solve them*…", "…*all decisions relating to health should be taken there*…" and, "…*the process could be much more rapid at the municipal level*…" As expressed by Groups 2 and 3 under Component 1, the municipality is central to the idea of decentralisation as administrator for resources, development of policies and programmes and co-ordinating actions.

With regard to community participation, Health Sector Reform is linked to the direct participation of community leaders in decision-making. As mentioned above, the concepts of empowerment and decentralisation as a way to bring development to the community are indistinguishable. From the responses, it is clear that for the communities, Health Sector Reform is administered through decentralisation through which the community is able to participate in the process. Participants indicate the importance of articulating a role for community leaders, the involvement of community leaders in decision-making processes around Health Sector Reform, the need to improve the role of health monitors within the communities, to improve their profile through incentives, and the need to strengthen relationships between teams such as the technical team and health committees to oversee the work of the health monitors. Collaborative action is perceived as an outcome of community participation – "…*there was a lack of community participation and lack of collaboration for a woman who died…and only a few people participated in providing assistance and in this case participation failed*…".

Participation is also linked to strengthening community organisation – "…*the responsibility is in the hands of the health monitors and midwives in some cases and what we are lacking is strengthening the organisations*…" Participation in both

communities is perceived as involvement in the system of Health Sector Reform and from discussion about the role of municipalities, it is evident that communities view involvement at all levels of health provision from management of resources and to decision-making by their leaders in the policies and programmes that affect their lives directly. These also address issues with regard to exclusion, which is indicative of the experiences of many people in communities with previous government initiatives. The following examples express this view: "…*our community was in agreement…and…constructed the Centre of Convergence*…" and "…*met with people of the community and there were promoters…and this made the community happy*…" As mentioned above, it was also evident from comments that sustained involvement or use of health services is linked to the benefits for the community as a whole. The phrases - "…*better dialogue and more assistance*…" and "…*women were dying during delivery because assistance did not exist and now the health monitors are there*…" - exemplify this view. Community participation is seen as integral to reform at all levels but especially, in the health sector in terms of the delivery of services and decision-making. Community participation is also integral to how decentralisation policies are implemented. Where community participation does not exist then, the community does not view programmes as valid. Participation is not always seen as formal but in the everyday involvement in the community.

In comparing responses between the groups interviewed under components one and two, a number of different perspectives can be analysed. For the communities (Component two), a holistic understanding of health problems tends to emerge from the focus groups which link socio-economic issues to health issues. Therefore the role of the municipality in addressing local problems is viewed as important. There also tends to be an emphasis on local community involvement. The communities clearly identify with a two-tier structure under Health Sector Reform – the municipal level and the community level. This contrasts sharply with the perspective of high rank officials, which tend to provide a strategic overview of Health Sector Reform and argue from the institutional perspective. For instance, the role of the community is that of receptors of services rather than active participants in the decision-making processes. High rank officials also tend to discuss partnership formation and building alliances between international and national organisations (of varying kinds) rather than thinking about the community as an equal partner in the Health Sector Reform process.

Despite the communities' views about involvement in the decision-making processes, communities are clearly not involved in negotiating bilateral agreements with health providers or influencing resource allocation at the national level to municipalities. It would appear from the focus group evidence that communities are reflecting greater involvement in the process but not complete involvement. In comparing views about involvement to the history of participation of communities, it would appear that the experience of involvement is different from the way it had been and Health Sector Reform provides communities with an opportunity to organise and strengthen local levels of participation. However, from interview with high rank officials, the role of the community as active participants in the process seems limited. The idea of the 'politics of health' is mentioned by high rank officials but even with this idea, officials did not identify the role the community would play in achieving continuity of health policies and services. Officials tend to discuss this idea as a way to generate education and awareness through institutional strengthening beginning with national institutions such as the Ministry of Public Health and Social Welfare. While there is a need to undertake this work, the need for synergy that is, building up institutions and organisations simultaneously and on different fronts (national and local) is not adequately addressed. There is a gap in how Health Sector Reform is perceived by high rank officials and although the communities themselves are clearly interested in the local situation (which they were closer to), at the strategic and operational levels, the factor of community involvement is not sufficiently discussed.

With regard to traditional medicine, there are common views from both communities on traditional medicine and its incorporation under Health Sector Reform. Traditional medicine is linked to the well-being of the community – "…*the community population manages traditional medicine in their own communities and the level of service is motivated by…caring for the community*…" however the issue raised by the communities relates to the systematisation of knowledge – "…*they do not know the dosage of the medicine to give*…" This view is shared by providers of institutional medicine, the user groups and by groups interviewed under Component 1. The providers of traditional medicine do not hold this view and provide examples of knowledge, which is shared with the population and with other providers. For the communities, traditional medicine is a part of healthcare – "…*we try to encourage*

self care, communities exist very far a part and one cannot come on a daily basis to the Health Centre…" There are a number of factors influencing this view including confidence in the benefits of traditional medicine, the link between culture and traditional practice that the medicine represents for people and access, whether this is economic or locality. The concept of the quality of life or well-being is linked to addressing the community's health situation – "…*should be incorporated into the process of dealing with community afflictions*…".

While there is general consensus on the value of traditional medicine, two views emerge about its incorporation. The first view suggests that much of the knowledge of traditional medicine is protected and therefore, impossible to incorporate. The second view suggests that the Centres of Convergence can be used to incorporate traditional medicine. The second view recognises that there is a process of systematisation because some plants are known and used for common ailments. Several examples were provided in Chapter 7. The communities are clear that those with knowledge of traditional medicine should have direct involvement in its incorporation under the SIAS and those who practice traditional medicine should be respected within the system of provision. The communities hold clear views about how traditional medicine can and cannot be incorporated under the SIAS and who should be involved in this incorporation – "…*it is important that people who have knowledge are included in the process and those who value traditional medicine*…" On the latter point, value of Mayan culture cannot be separated from such views. Traditional medicine, for the communities, is a part of the cultural vision and respect of culture is important to the practice of health. In part, such comments reflect a number of variables in this thesis such as prejudice, assimilation, segregation and exclusion. The importance of cultural values and respect of Mayan customs by institutional personnel reflects this view.

While Health Sector Reform should include traditional medicine, the communities themselves do not choose one medicine over another. The choices made about medicine are likely to be affected by how effective the treatment is in their cure. The following example is indicative of this view: "…*many times the community arrives with emergencies…and healers know what to use and if they are not able to cure them they bring them here*…".

For the birth attendants, the objective of traditional medicine under Health Sector Reform is to improve provision and the role of health in the community. There is an element of confidence that cannot be downplayed. TBAs for instance know traditional healers and are familiar with their experience and skills. This makes it more likely for them to use traditional healers. While they consider that more knowledge is needed, they also recognise a strong knowledge base in communities, which they use. Cultural illnesses in particular are considered to be best understood and cured through traditional medicine. Healers and herbalists share these views. They consider that incorporation must be done through respect of traditional health providers, that traditional healers must have a voice in health provision and should be allowed to maintain contact with patients even after patients have gone to institutional providers. Both groups have experienced prejudice in the way institutional health providers view traditional medicine. There were many common practices between this group and the TBAs however this group referred patients to institutional medicine to a lesser degree. This group was careful about which patients to treat and which ailments were treatable by them. Illnesses not considered treatable were referred to institutional medicine. The work conducted by traditional providers was also considered secret therefore making the process of incorporation difficult in terms of systematisation of norms and practices. The services of the institutional health sector were not always considered compatible with traditional medicine although there was scope for incorporation based on three principle rules (respect, participation and continuity). The group made less frequent references to institutional personnel and to the network of health services unlike the group of TBAs interviewed for this research.

Health Monitors and Health Promoters consider that access to institutional medicine makes it more feasible to use traditional medicine; however, the tendency among this group is to use institutional medicine when it is available especially in cases of pregnancy, ARIs and DPDs. The findings for this group of respondents differed from traditional providers and TBAs. There was very little opinion around the incorporation of traditional medicine to institutional medicine. High levels of mistrust of traditional medicine were indicated especially in the areas of knowledge and skills. Illnesses such as ARIs and DPDs, which were considered common by traditional providers, were often referred to institutional medicine by this group. Cultural issues were also identified by this group in making reference to institutional

medicine expressed mainly in the lack of confidence by users but also in terms of access to transport and other resources. This group is a part of Health Sector Reform and works within the SIAS to deliver decentralised health services to the population however rely mainly on institutional support although this is lacking. Respondents did identify traditional medicine as an option in cases where institutional support was not forthcoming but in limited cases.

The objective of mobile physicians is to work with the communities. However, the group of mobile physicians interviewed for this research has little knowledge of cultural practices of traditional medicine. This group attributed the preference of patients for traditional medicine and providers, to the customs and beliefs in local communities. Traditional medicine is considered to be the medicine of last resort where institutional medicine is not available or accessible by the local population. For instance, mild cases of ARIs and DPDs are considered treatable by traditional medicine and some value is placed on local knowledge about the spread of diseases and local conditions. Nevertheless, the mobile physicians consider very little complementarity between the two types of medicine. This is especially noted in discussion about the skills and knowledge of TBAs.

The objectives for nurses and doctors at Health Centres with regard to traditional medicine is to ensure incorporation under the SIAS in order to become more aware of local health problems and to increase levels of interaction with the population by gaining knowledge of the cultural illnesses which afflict them. This is considered important in confidence building, working closely with communities, gaining new knowledge about the communities and in obtaining new training. This group suggests a tri-partite link between the community, traditional medicine and institutional providers. Users who felt that confidence building is an important part of the process also share these views.

Overall, there were a number of perspectives on health in general and about institutional and traditional medicine in particular. There is a general difference in opinion on the value and use of traditional medicine and how it can be incorporated to institutional medicine. The idea of knowledge of natural medicines is very important because this knowledge appears to be guarded, passed down inter-

generationally and mainly the domain of men. There appears to be little acceptance by institutional providers especially mobile physicians of the use and importance of traditional medicine although those providers closer to the communities maintain a better understanding of its use and application.

In general, there have been many benefits of Health Sector Reform at the local level however a number of obstacles remain including: (a) traditional providers continue to experience prejudice and isolation from the institutional system; (b) training is a key factor however training tends to take little notice of cultural beliefs and practices; (c) concerns by traditional providers of their knowledge becoming lost within an institutionalised system of norms are real and inhibit many from sharing their knowledge openly; (d) institutional providers offer very little space for traditional medicine and this is especially noticeable in comments from mobile physicians; and, (e) two systems appear to operate at the local level with very little convergence, at the present moment. While reform is taking place at the institutional level in terms of improving access, quality and coverage, the local community and its practices are not easily incorporated to the reform process. However, with the availability of both types of medicines, and from interview with users, it is apparent that choice has been extended to the communities. Although in most instances choice may be directed by access to financial resources, users tend to use both systems as required and needed. While mobile physicians, high rank officials and healers and herbalists tend to support their respective systems, those interacting at both levels (TBAs, assistant nurses, academics and NGOs and organisations) tend to see the advantages, valuing both systems of provision and seeking to understand how best to use the systems (in terms of access, resourcing and understanding of the medical problem). This is perhaps where Health Sector Reform is most noticeable and effective and where ideas about decentralisation have had most impact.

8.4. Fieldwork Consideration of the Particularities of Health in a Post-Conflict Environment

Health issues that are specific to the post conflict environment are not identified as such by any of the groups participating in the research. From my own discussions with participants, off the record, and from personal experience living in the conflict and post-conflict environment of Guatemala, it is not convenient for people to identify a situation in this context. There are a number of reasons why people do not

make such references. First, people have a tendency to disassociate themselves from the conflict and what it represents in terms of the destruction to life, disruption of community and continuity, and risks to health and personal safety. Second, to be associated with the conflict during the time of the second Rios Montt government, as discussed earlier, could mean certain retaliation and retribution. It must be remembered that people continue to live with the fear and paranoia in the post-conflict environment that was present in the conflict period. And third, people do not describe their situations as one with characteristics particular to a post-conflict environment. The research instruments were designed in ways to avoid direct and explicit reference to a post-conflict environment. This was done to ensure that a trust-building process was taking place with people through exchange and dialogue.

Apart from the three reasons discussed above, another important reason and perhaps the reason which justifies the need for this present research is the lack of a conceptual framework which would enable a profound understanding of health issues within a post-conflict environment, how and when these are identified, and what issues are relevant and why. The discussion of health problems within a framework as provided by the Peace Agreements is a relatively new phenomenon. The groups under Component 1 of the research make clear reference to the Peace Agreements framework however offer slightly different interpretations of Health Sector Reform, participation and the conceptualisation of social and political indicators. There are many health problems in the country; however, it is difficult to make distinctions, considering the array of health issues that should be addressed under Health Sector Reform, of the particularities of health in a post-conflict environment. In part, this can be defined has the worsening of the general health situation for sectors of the population due to government neglect, corruption and abuse of human rights. However, evaluation frameworks, such as the MSPAS institutional evaluation discussed in Chapter 6 make little reference to the health situation in a post-conflict environment apart from describing the general situation of health.

The research reported in Chapter 7 identifies terms such as cultural health and human dignity. Through inference, links can be drawn to broader analysis. However, without the conceptual framework, and due to the limitations of existing conventional evaluation frameworks, the context for analysis is missing. An

alternative evaluation framework would aim to address this by providing a conceptual framework within which to consider such health issues. The different perspectives as identified here add to the understanding and interpretation of key concepts that should serve as definitive sources, consistent with the epistemological framework for this thesis. Through this exercise, the following is achieved: local interpretation of key concepts, institutional interpretations of key frameworks (Peace Agreements) as translated into policy, interpretation of experience identified as key concepts for further analysis, development of a conceptual framework based on interpretations and applied definitions for application in specific situations, and an emergence of an alternative way to consider and weigh the constructs of reality in a given moment in time.

8.5. Selection and Analysis of Variables from Phase 2

The examples presented below identify which variables participants from Components 1 and 2 identified and discussed. CCA is applied to analyse the meaning, content and context of their discourse (collective thematic discussion based on a question guide validated with all the groups). This critical analysis is complemented with a historical political analysis and a literature review related to the categories of analysis obtained from the focus group sessions. Respondents were not asked directly about the variables however they were asked to respond to the analytical questions of the guide. The questions were designed to construct and identify variables in relation to community participation, democratisation, Health Sector Reform and peace building process (post-conflict environment). Policy directives define some of the variables. The tables below identify and provide examples of the epistemological variables and how participants discuss them. These are used further in the design of an alternation evaluation framework.

8.6. Component 1 – Selection and Analysis of Variables

Variable	Interpretation and Meaning
Health	Most of the focus groups agree that the health sector is highly politicised. The term 'politics of health' is used to associate health policies with government politics and to concepts such as the need for 'consistency', the need to identify 'priority areas at the national level', and the need to avoid 'discarding initiatives and projects during periods of national political change' (Group 1, Component 1). The findings suggest change towards a 'politics of being' or an emergent culture of health, adopting the definitions under the Peace Agreements

	and other international conventions where the importance of health as a factor in development is critical to the life of the individual and community. Group 1 under Component 1 mentions the Peace Agreements social and political framework indicators. Groups 2 and 3 under Component 1 mention the Peace Agreements' principle of autonomy, to be re-considered within the new political reality of the country. The concept of health is all encompassing and includes physical, mental, emotional and general wellbeing. However the definitions applied are institutional definitions of the health although a more comprehensive concept of health emerges from groups of respondents, which interpret health as a policy issue. The best example of this is mention of the rationalisation of policies, programmes and projects of public administration under the objective of sustainability (Group 2, Component 1). As mentioned, health is not linked to post-conflict environments by any of the groups of respondents. The understanding of health within the context of post-conflict environments is missing. Health is associated with the broader well being of the community but not related to the features and trends of post-conflict and peace building in the country. Although the Peace Agreements are mentioned for definitive purposes, at the institutional level the categories are used to shape a programme of reform under decentralisation. Group 2 under Component 1 makes reference to the Social Funds and Development Councils as a way to promote institutional arrangements and co-ordination. Group 3 under Component 1 makes reference to an array of programmes dealing with municipal development, taxation and fiscal policy and issues with regard to equity. Multi-sectoral and sectoral policy issues are addressed indirectly as 'politics of health' issues.
Indirect Participation	Under a process of decentralisation this is described as different levels of participation in health actions. Participation is identified as representation at the local level through organised groups and the recognition of the need for debate around the incorporation of traditional medicine to institutional medicine based on the systematisation of knowledge and practice. Group 1 under Component 1 discuss this concept as 'analysis, monitoring and open discussion with communities to review norms'. Motivational stimuli and health incentives to encourage ownership of the health model is also mentioned as a way to improve health services through local involvement. Group 2 under Component 1 mention the concept 'cultural plurality' which is elaborated as inter-cultural exchange and local participation. The distinction between practical services and cultural conceptions of users is understood not solely in provision but also in evaluation of services. Traditional medicine is not mentioned explicitly however there is a notion of indirect participation through exchange between users and suppliers.
Democracy	This term is discussed in the form of representative democracy or the involvement of health administrators and the

	implementation of health actions through groups at the community level identifying and organising health priorities. The Peace Agreements especially around the recognition of rights is central to the discussion of democracy. Group 2 under Component 1 suggest the political development of citizenship with an inference here to rights and obligations, political democratic culture meaning consensus and consultation, and participatory democracy meaning a vision of pluralism and inclusion. Linked to policy, reference is made to legitimising functions including providing cultural, social and political legitimacy to the acts of government as those in a representative role. Group 3 under Component 1 suggests electoral reform, institutional strengthening, and participation initiatives, and as mentioned above, consensus building processes. Constitutional reform is linked to consultation, the inference being that people have a voice in shaping and determining such processes.
Administrative Decentralisation	This concept relates to attempts to unify efforts and create synergies among different providers. All groups under Component 1 identified a critical need for the institutional re-organisation of the MSPAS, provision through sectoral personnel at the local level, and through a diverse range of organisations such as NGOs. The decentralisation model discussed was the TBSA identified through the role of experts to deliver the SIAS through bilateral agreements. Allocation of resources to the communities through participative action was another theme relevant to this variable. Health decentralisation assists this process through the formation of basic health teams, institutional personnel and the Centre of Convergence or the Community Centre. Key words for Group 1 under Component 1 are: co-ordination, re-organisation, expansion, re-orientation and modernisation of the health sector. Key words for Group 2 under Component 1 are: active community participation, local need, municipal strengthening, governance and administrative authority. Key words for Group 3 under Component 1 are: de-bureaucratisation, institutional strengthening, systematisation and regulation. Key words for Group 4 under Component 1 are: continuity and continuation.
Fiscal Decentralisation	This term is linked to administrative decentralisation and municipal autonomy. It is used to address priority local needs through evaluation at the local level in Situation Rooms, feeding information back to the institutional levels for the provision and allocation of resources. Groups 2 and 3 under Component 1 suggest evaluation of deconcentration initiatives, introduction of financial modernisation programmes, formation of technical teams for financial administration, and accounting and systematisation of financial administration among other issues.
Socio-economic Inequality	This term is discussed in relation to the socio-economic situation in communities, levels of poverty and exclusion experienced by communities in relation to poor quality provision of basic services, lack of choice and

	disempowerment. Group 2 under Component 1 discussed indicators of economic accessibility to health services defined in terms of costs for initial treatment, costs for follow-up or subsequent treatments, availability and viability of supplies and revenue generation capacity. Group 3 under Component 1 discusses the term in relation to economic activity and opportunities for development and equality in health service provision. Evaluation of internal market indicators linked to quality of life and poverty in local communities is also associated to the theme. The concept of health disparity also emerges in discussion with this group specifically related to investment in curative versus preventative medicine.

8.7. Component 2 – Selection and Analysis of Variables

Variable	Interpretation and Meaning
Health	Health is viewed from a number of perspectives including appropriate healthcare for women and children, having an impact on the health profile of the community and improving access under the SIAS. The variable health is also perceived multi-dimensionally because the respondent group identified health related issues as part of the community health profile such as clean water and improved infrastructure. There is some link to the social and economic conditions of the community as presenting barriers to good quality health care, which is a challenge under decentralisation. This variable is understood in individual and collective form as some traditional health providers were also community leaders and consulted on a range of issues, and not just health. Health is also perceived as community well-being, which comes under the multi-faceted role of traditional health providers. The individual is important however community well-being is integral to provision and reform of the system and incorporation of traditional medicine to institutional medicine. Two examples illustrate definitions and descriptions of this variable: (1) "…*I consider health to be very important and attention in provision and administration in each community because it is important to have attention frequently and now the administrators and providers are giving us a better quality service and more people are accepting the service*…" (2) "…*My community started in 1997, in May or April, I forget now, it was reinitiated…met with the people of the community and there were promoters and then seven health monitors were selected with the help of FUNMMAYAN and this made the community happy. Now I see that the health monitors come to the community each week*…"
Participation	Traditional health providers and users mainly addressed this variable. Choice was critical in the provision of health services and most traditional providers acknowledged the role of the user in determining what was best for them and their families. Further, Health Sector Reform, decentralisation and participation are linked. Communities view participation as necessary to reform and reform is viewed through

	decentralisation. An example of participation is "…*I consider health to be very important and attention in provision and administration in each community because it is important to have attention frequently and now the administrators and providers are giving us a better quality service and more people are accepting the service. I consider the municipality of Tucurú will be better organised because the only thing that is lacking is more trained people*…"
Direct Participation	This variable is linked to representative democracy and political systems and is discussed in relation to the importance of articulating a role for community leaders, the involvement of community leaders in decision-making processes around health sector reform, the need to improve the role of health monitors within the communities, and the need to strengthen relationships between the technical teams and health committees to oversee the work of the health monitors. The idea that local actions for local problems are associated with participation, the identity of the community (the variable ethnic identity) and understanding and interpretations of local problems. The examples here are: (1) "…*To achieve community participation it is important to involve committee leaders and other people in activities so that they are able to understand the work done and that they are a part of it*… (2) "…*It is important that people who have knowledge are in charge of the process and those who value traditional medicine*…"
Social Participation	Participation is seen as integral to how decentralisation policies are implemented. Where community participation does not exist then programmes lose legitimacy. Improved community participation is linked to resources from central government. This is closely linked to the DPA with elements of the TBSA. The examples include: (1) "…*I agree that community participation even though it is not working in the ideal way and in the way institutional personnel would prefer it to work, it is important to strengthen however there are no financial resources for extended coverage of health services*…" (2) "…*The organisation that exists now is good but it can be strengthened through the Improvement Committee because they are the main organisation responsible for the health of the community and to present they have been involved in community organisation especially in emergency cases. The responsibility is in the hands of the Health Monitors and midwives in some cases and what we are lacking is strengthening the organisations…*"
Decentralisation	The variable decentralisation is further explored through incorporation of traditional medicine with institutional medicine. There is a cost element associated to this because the use of traditional medicine is considered financially less taxing for communities and easily accessible. The issue of incorporation also identifies the factor of commercialisation of traditional medicine and thus, the variable market or economic decentralisation is relevant to the discussion especially in

	terms of market value of traditional medicine. The example includes: "…*Decentralisation of resources and responsibilities should involve all actors, the process of health should be an integral one, decentralisation should be generalised and everything should be decentralised and the municipality should be a part of the decentralisation process*…"
Administrative Decentralisation	This group of respondents links the variables participation and administrative decentralisation. The examples here are (1)"…*Municipalisation is the key to decision-making at the municipal level and everything should be done at the municipality and that all decisions relating to health should be taken there because it is not a departmental thing, the municipality knows the health issues, the diagnostics and the economic problems that exist…"* (2) "…*I prefer that the transfer of responsibility and resources from the Ministry of Health to health providers and administrators was rapid and effective and on occasions I have waited for responses to questions however they have taken a great deal of time to answer and the response has also come back negative….*"
Fiscal Decentralisation	Decentralisation (also fiscal decentralisation) was linked to the transfer of resources to the community based on indicators of service provision. The need to strengthen municipalities was also considered important because the municipal level is viewed as being closer to communities (administrative decentralisation) and linked to decision-making structures. The community was considered instrumental in the reform process and in the process of decentralisation. Examples here include: (1) "…*A study of municipalities found that they were capable of confronting their problems, become more capable than the Ministry of Health at certain times. Each municipality is best placed to make decisions because as it has been said already the municipality knows its problems and how to solve them from the perspective of health, what influences these problems is the economic situation and financial problems*…" (2) "…*A study on the municipality suggested that the process could be much more rapid at the municipal level than the rural level because the municipality knows its problems and can react quickly to resolve them because with health you cannot wait for years. We should not pay, the people in the communities do not have money and the husbands do not earn much. We are grateful for SIAS because we do not have money and through the project of FUNMMAYAN and SIAS we can pay less…"*
Socio-economic Inequality	This variable is identified through the discussion of the benefits under the SIAS namely, breaking down the isolation of communities from municipal services but also in relation to the condition of poverty in which the communities exist. The socio-economic profile is again directed to the variable administrative decentralisation or targeting resources to priority health actions. The example is (1) *"…As we have said we should not have to pay taxes because some have money or work and some do not so why are we going to pay for it and there is not*

	much to say because the municipality gives us some money when we get our citizenship cards and they say they will help the community…" (2) "…*In the first place human resources are needed and they should know the themes and be trained and the other thing is economic resources because as someone said, I can come to the Health Centre in half a day and lose Q20.00 just to come here and return to my community so it is not worth it. Economic and human resources would be important…"*
Exclusion	The variable exclusion is linked to ethnic and social exclusion and expressed in terms of geographic isolation, poor access or development of infra-structure and the lack of incorporation of traditional medicine to institutional medicine. The culture in the two communities from the institutional perspective is perceived in terms of 'otherness'. Some institutional personnel expressed the need to breakdown barriers between cultures and the types of medicine, and to 'build bridges'. These personnel identified the need to transform perspectives in order to understand how the community assessed its own problems, identified priorities, used the services available to it and made choices about medical treatment. Often, traditional medicine was the first port of call for community members and relationships with traditional health providers were based on previous knowledge, confidence and to some extent, their record in dealing with problems. These factors were often under-estimated by institutional personnel working in the communities. Examples are (1) "…*Provide knowledge on the customs of the communities and promote respect for Mayan culture so that all institutional personnel value Mayan customs...*" (2) "…*Training and awareness for basic health teams around traditional medicine is important through the district teams so that they can deliver the correct messages to families they work with…*" (3) "…*Institutional personnel of the Ministry of Health should accompany the providers of traditional medicine to understand their work and agree protocols…"*
Prejudice by Anger Assimilation Segregation	These variables were identified when examining the levels of understanding that different providers had about the health services they provided. These variables were mainly identified in discussion about the purpose, use and value of traditional medicine. Some institutional personnel expressed the lack of understanding of the effectiveness of traditional medicine and its significance for people even though some traditional health providers understood how the medicine is used and what its limitations were in that, they knew when to make a reference to institutional medicine. Some institutional personnel, who were ignorant of traditional medicine, manifested this ignorance by raising doubts about the validity of traditional medicine and about traditional medicine practitioners. The attitudes were paternalistic and dismissive. The main oversight by some institutional personnel was the process of choice or decision-making applied by members of the communities

	based on what was best, from their own perspectives, for themselves and their families. Attitudes of paternalism were also evident when institutional providers viewed institutional medicine as a service brought to the communities but not as a service that can co-exist with the existing practices of medicine. Some institutional personnel also interpreted choice for traditional medicine by members of the communities as an economic imperative driven by the lack of financial resources and failed to value the relationships of mutual exchange within the community structures themselves. The users of institutional services were perceived by some institutional personnel as patients referred for treatment but not as participants of a health service. The examples here are: (1) "…*Deficiencies in the traditional system are attributed to the lack of knowledge of this group of illnesses…they don't know the term…and the assistant nurses rely on training…they become very tense when they don't know the term even though they may know what the illness is*…" (2) "…*They don't know about parasitic diseases. They have some knowledge but it is not scientific. They know that the diseases start when the rains come but they should know the causes*…" (3) "…*In reality they can cure the illness…but they don't know when complications can occur. They give them teas but they don't know what teas…*" (4) "…*They only know what their parents knew. They think ARIs is a common cold and they do not know how to recognise grave cases or how to cure them*…"

Chapter IX
Conclusions

9.1. The Context for Conclusions

As I indicated in Chapter 1, in undertaking this study of Guatemala, I had to come to an understanding and interpretation of the history of the country as relevant to a post-conflict environment. I designed questions and methodologies which would enable me to undertake a comprehensive analysis to address the objectives and aims of this thesis. The questions were designed to address the main planned contribution of my research – the development of an epistemological and conceptual framework important to developing the foundations for critique of mainstream evaluation methodologies.

In constructing my analysis for this final chapter, I grouped the key questions, as identified in Chapter 1, under the three objectives of the thesis. Some of the questions fall under two or all three of the objectives and this is clearly indicated in Chapter 1. I answer the questions that are most relevant to that objective using the evidence stated in the previous chapters. I use key findings from the previous chapters to build my analysis using both the primary and secondary research.

9.2. Approaches towards Decentralisation in Health Sector Reform

The first objective of the thesis was to examine and compare the philosophical-ideological approaches towards decentralisation policies (as mechanisms, systems, and processes) underlying health sector reform policies and actions, conceptual planning and procedures, and implementation guidelines and practices at the international and national levels as presented in the Guatemalan case. My research found that the International Financial Institutions (IFIs) and the last Guatemalan government administrations had not thoroughly assessed the structural constraints, possibilities and outcomes of the multi-sectoral and sectoral decentralisation policies applied in the last ten years. I found that social policies occupied a residual role under the framework of the transitional safety networks because the main driver was free market ideology, central to Structural Adjustment Policies –SAPs- (within which Public Sector Reform –RSP- was integral). Words such as ‘economic efficiency’ and ‘economic expansion’ became more important in public sector service provision.

I outlined in Chapter 4, the evolution of the historical profile and socio-economic patterns of development of the Guatemalan exclusion model. The policies designed by the IFIs, in conception, and implementation had little significance within the social, economic, political and cultural reality of Guatemala. I also explored the contradictions of the social agenda in terms of the contents and outcomes of the Peace Agreements (PAs) and the Macro-Economic Agenda (MEA) to reduce and transform the state apparatus (both the Reform of the Public Sector -RSP- and the Health Sectoral Reform –RSS-). Because decentralisation policies were conceptualised and implemented without clear articulation, the AME was prioritised over the PAs.

The WB's decentralisation framework (types and approaches of decentralisation) was implemented in most developing countries, as an overall generic and conceptual framework. I questioned the WB's framework on the basis that it did not consider post-conflict situations. Yet, the framework was being evaluated within the context of the post-conflict environment. I identified that the framework did not mention fundamental categories like recovery, peace-building and post-conflict settings (analysed in Chapters 3 and 4) in order to comprehend reality like the Guatemala one.

My research identified that the decentralisation process for the Guatemalan case (directed by WB and other IFIs), was initially developed in the following way: (a) market oriented policies under a neo-liberal vision; (b) authoritative and bureaucratic policy management mechanisms; (c) justification of policies under the democratic rhetoric of 'open participative pluralism, egalitarian citizenship rights and active social inclusion' under the PAs framework; (d) implementation benefiting vested interests; (e) unaligned policy objectives and outcomes (as discussed in Chapters 3, 4, and 5); and, (f) lack of evaluation on the structural constraints and possibilities confronting decentralisation policies in conflict and post-conflict environments.

I found that a number of factors negatively impacted upon the implementation of decentralisation policies – (a) historical power imbalances which continued to dominate political development, (b) a socio-economic model based on an unproductive landholding of property and an exhausted agro-export system, and,

(c) a socio-political model based on repression, exclusion and inequity. I argued that there is an inherent contradiction in the actions of the state to transform itself by adopting social and economic development initiatives without radically altering the power bases that sustain it. Thus, the rural communities have hardly been involved (through direct participation) because the aim of the state has been to limit involvement and continue to exert control over the population. Decentralisation where such positions are maintained meant that (a) the interest groups continue to come from the same elitist traditional structures of the society; (b) dominant western values of the elite culture are integrated into the dominant strata of Guatemalan society; and, (c) elitist groups have not been inhibited from participation in the transitional phase from military to civilian rule nor have the emergence of new elitist groups been prevented from becoming involved in the tiers of government.

My view is that ideological discourses could influence change, however, such changes could occur only if there is a process of transformation of the state apparatus, its institutions, and the rule of law and the values of the entire society. Social and cultural values have to become common practice in institutional and social interactions. An educational process promoting new social and cultural values between population and sectoral institutions must be developed. There should be political negotiations about these interactions, to depolarise the different social sectors of Guatemalan society, and arrive at public consensus and to enact an effective democratisation and participation plan for the majority of the population. A participative democratic process depends heavily on horizontal decision-making therefore, it would be very important for the IFIs to expand their approach and address the degree and extension of practices of power by political groups within local social systems and processes in the post-conflict environment.

As discussed in Chapter 3, I suggest that deconcentration, delegation and privatisation policies were market mechanisms strategically imposed to build-up the necessary space(s) for the market forces through the des-incorporation (privatisation) of state enterprises at the end of the 1990s in the country. I also discussed that, decentralisation policies through techno-bureaucratic control focused on delegated authority and responsibilities rather than devolved powers or the generation of self-reliance in the local communities. I considered that that a participative approach had been conceptually designed as a series of ‘prescriptive

procedures', for instance, to create capacity building processes in order to address problems of poverty, inequality and exclusion. However as I argued, such processes were not implemented in the rural communities even though they were introduced under the PAs. I found that the concept of decentralisation is associated to ethics and values. It is viewed as a cultural shift in organisation and individuals. Under the PAs, decentralisation was perceived as an opportunity for democratisation. Development policies related to multi-sectoral and sectoral policies (including decentralisation) have often served authoritarian and military aims in the past. The PAs are also viewed as crucial to establishing decentralisation, health sector reform and participation. At the macro-level, this means improving relations between institutions responsible for policy review and development, and decision-making. For example, a process of 'de-politicisation' would enable more effective working of the MSPAS at primary and secondary healthcare levels countrywide.

I also found, through the review of literature, discussion with communities and community health providers, that decentralisation was linked to municipal autonomy (local governability, administrative authority, sovereignty, management, development of information systems, representative and participatory democracy, and decentralisation of public administration). My research evidenced that discussion on the concept of municipal autonomy is linked to the need to reform public administration through pluralist consensus. I found that there is a high level of agreement on administrative and fiscal decentralisation linked to participation and governance.

My research found that the decentralisation process of a purely technical approach, scope and framework has not been working at the local levels. Positive results have been few and insignificant to be able to effectively and satisfactorily produce changes in the structure of the SIAS. In my research I suggested that an important example of community participation is the incorporation of some elements of traditional medicine into the primary healthcare system. These elements would include: traditional healers, use of medicinal plants, traditional treatments, and the establishment or support of health community networks according to the PAs' agenda. While some progress is noteworthy, further action is needed on confronting opposing views and institutional attitudes in this regard.

At the national and sub-national levels the imbalance of power between the structures of government and the indigenous minorities has produced a vacuum in the existence of a strong counter-discourse against the negative outcomes related to development policies (including health decentralisation). The counter-discourse and social mobilisation can change the authoritarian way, in which policy is implemented. Social mobilisation could create political and social pressure to counter the IFIs' structural adjustment and decentralisation policies. Also, social mobilisation could progressively change how these policies are carried out in developing countries within complex post-conflict environments like Guatemala.

I consider that the hegemony of the discourse on decentralisation in Guatemala has been exerted within a techno-bureaucratic conceptual model (TBSA), which is justified in the power-knowledge of high technical expertise. For instance, the TBSA has been based on a theoretical and technical rationale. This rationale includes cultural development through policy values and organisational practices from the state institutions, which discriminate against the community's potential. These factors have reinforced the authoritarian character of the state and governments in Guatemala. Therefore, the RSS planning and execution is directed without objections from these organisations of institutional and formal knowledge at the international and national levels with the subordination of the latter to the former.

9.3. Community Participation within Health Sector Reform in a Post Conflict Environment

The second objective is - to define and analyse the achievements and limitations of community participation within the RSS programmes, linked to the approaches towards decentralisation and pluralistic democratisation practices within post-conflict environments. Using examples of the institutional attempts to integrate traditional medicine into the primary healthcare level, of two municipalities in the countryside of Guatemala, my research found that within the RSS process, the strategic alliance established by the MSPAS with NGOs and CBOs in the health areas and other social institutions is based on the principle of sustainability. Thus, the RSS process has been one of decentralisation through delegation between governmental and non-governmental partnership. However, the incorporation of community voluntary personnel by the MSPAS has not been sufficient to guarantee strong commitment and agreement with all social actors either directly or indirectly involved in the RSS

process. The incorporation of different NGOs and CBOs to the SIAS model as main sources and actors has been part of the main aim, but there have not been adequate mechanisms to supervise and evaluate them over time. Also, within the RSS legal framework, there is a need for more flexibility and creativity to allow for profound changes amongst NGOs and CBOs in the administration and provision of health services under the SIAS. The main concern has been inappropriate and rigid decision-making, constraints in the implementation procedures of RSS policy and limitation in the outcomes of such policies at the local level.

The MSPAS evaluation carried out in this research (in Chapter 6) identified issues regarding the limited impacts and outcomes of the RSS process through the implementation of SIAS, which included: (a) an authoritarian decentralisation process imposed vertically; (b) lack of operation of health committees responsible for the management of SIAS at the grassroots level; (c) where committees exist, lack of agreement with the local population on how they are set up; (d) where committees exist, lack of knowledge about roles and remits; (e) lack of involvement by the people in decision making, and, (f) lack of financial resources.

Critical issues or themes were transformed into variables and their indicators to comprehend the characteristics of the three approaches towards decentralisation (MMA, TBSA and DPA, presented in Chapter 3). Amongst the most important issues determined by the comprehensive evaluation through this thesis were: political decentralisation, fiscal decentralisation, economic or market decentralisation, administrative decentralisation and sectoral health decentralisation. Their sub-categories of analysis were: deconcentration, delegation, devolution related to administrative and fiscal decentralisation, and privatisation and deregulation related to economic or market decentralisation. Assessing macro-economic problems to understand the IFIs political agenda related to financial and administrative reforms (decentralisation), the issues were: the economic problems and compensation related to poverty assessment, equity, effectiveness, efficiency and accountability.

Rethinking decentralisation beyond the mainstream macroeconomic terms in order to enable a comprehensive evaluation of the Guatemalan post-conflict reality, complementary critical categories of analysis were used to carry out the evaluation of the approaches towards decentralisation in the Guatemalan case. These

included: (a) health and its meaning, (b) the exclusion model and supra-structure of the state, (c) participation and methods of community participation, (d) the conceptualisation of democracy and the democratisation process, (e) concepts of citizen and human rights (and limitations in the Guatemalan context) and, nationality (f) racism, oppression and discrimination addressed as the intrinsic features of the historical formation of the state and the supra-structure of the state institutions and society in the country, (g) ethnicity (an important element of Guatemalan society and one of the most important problems to be resolved in terms of citizen and human rights) (h) prejudice, related to the racism, and the oppressive and discriminative socio-economic and socio-political exclusionary model of Guatemala, (i) pluralism, the necessary step forward to change the exclusionary model and improve access to power and services amongst other important issues, (j) assimilation and segregation related to state policies to incorporate, in a selective and particular way, the ethnic minorities without taking into account ethnicity and socio-cultural diversity, and (k) genocide, a category of analysis applied to the Guatemalan case, due to the characteristics of the counter-insurgency strategies against the indigenous population in the conflict areas. A proposal for a comprehensive and alternative evaluation framework is presented in a matrix in Appendix 7 which identifies these variables, defines them within the context of the thesis and suggests indicators for their development.

I found that it was strategically important to create local consensus through negotiation in order to gain local support and confidence rather than responding through passive or active resistance from the local population sectors. In the post-conflict environment of Guatemala, the local population was also suspicious of participation initiatives because of the experience of repression. There is a lack of local level information in the literature on decentralisation especially on the co-ordination of services under decentralisation, conflict resolution strategies adopted by the population, the means of negotiation employed by the population and the relationship of the population to organised and formal power structures.

In post-conflict environments, some problems associated with decentralisation have included the development and implementation of projects and policies, which cannot be adapted to local realities, delays in support aid, and under-utilisation and sustainability of local resources. The priorities of the local

communities have differed from those considered to be important under the IFIs policies, donor countries and the national government programmes. Another factor is that after living for many years under conditions of violence and war, the local Guatemalan population is concerned with satisfying immediate economic and consumption needs in order to survive than with the provision of social services. On the one hand, policies and programmes are implemented from above with little relevance to the local environment and on the other hand, the needs of the local population are immediate and complex and speedy resolutions are required.

My research with the communities found high levels of dissatisfaction with how health sector reform has been administered by the government. I found that there should be a series of collective agreements with community representatives. These institutional and social agreements in which the above processes are carried out would consolidate the organisational process towards a DPA approach towards decentralisation. I suggest that this approach would allow the appropriation and ownership of the decentralised local health initiatives in the rural communities in Guatemala in the middle- and long-terms. It is important to advocate this conceptual framework of interaction with the communities based on simplified strategic knowledge but nonetheless, more practical and concrete solutions for resolving local health problems, is sought. The conceptual framework would be developed with an understanding of the phenomenological aspects of common local experiences, which have become systematised in daily practice. This decentralisation approach would be one of the best means of constructing mutual confidence and contributing to true pluri-culturalism in practice including the existing pluri-ethnic background of the country. The potential outcomes of this approach can be promotion of cultural equity in local space, more accurate reflection of expectations and avoiding false expectations, and creation of a collective conscience to look for a more peaceful way to solve problems and satisfy needs. From this perspective, constant feedback would make it possible to generate in the medium-term an authentic process of self-management in the search for solutions to immediate problems in collective/individual form.

According to my research analysis, the IFIs, MSPAS and organisations involved in SIAS should pay attention to (a) the over-rationalisation of capacity issues from the purely technical paradigms rather than from the phenomenological vision of the daily experience of the Guatemalan communities; (b) evaluations that

determine capacity building amongst the counterparts are motivated by policy preoccupations and the corporate-institutional interests of the IFIs and central government agendas; and, (c) variables that can potentially or concretely include the 'building of local capacity' according to the cognitive frameworks of the communities are required. The need for another set of policy values is crucial in transforming the prevalent vision towards decentralisation in the future.

From my fieldwork in the health districts of San Juan Chamelco and San Miguel Tucurú, I found that communities have been actively involved in dialogue and identified health problems and needs for their areas. However, they have been struggling to secure opportunities for local self-management to enable them to 'systematise community information generated by the community itself'. This research recommends that with regard to further progress of initiatives around community participation, any new development of SIAS should include discussion and consensus and gradually involve the population in the continuous validation of the health system based on routine and everyday experiences, the real and concrete context of their lives, and the anticipated, perceived and defined context of development for the community. These exercises can be part of the training sessions to create leadership and community management directed to persons that the community has selected. The training of these future trainers would be achieved in a short time. This new leadership together with collective community control in the generation, discussion and systematisation of information for collective actions will facilitate the process of identifying problems integrally. Levels of social and cultural polarisation in the communities would be taken into account so that sessions on community mental health and conflict resolution strategies can be included as a part of a basic package established through SIAS (this is supported by the Health Code and the PAs) with heterogeneous and homogeneous community groups (institutional, public sector and civil society of the locality among others).

The indigenous Mayan communities are in a situation of great disadvantage because of the level of polarisation they are suffering as a product of the conflict period (social and economic divisionism, institutional clientelism, religious sectarianism and political factionalism). In relation to this, there has been a proliferation of some forms of organised expressions of 'collective solidarity'. These 'organised expressions of solidarity' have mainly been established under the

influence of both churches (Catholic and Protestant), NGOs and development cooperation, however this kind of participation process has not been free of manipulation and some of the intermediaries seek to subordinate communities to their own vested interests and agendas. Some leaders and social groups have taken distance from the ex-guerrilla while others continue to be subordinated and dependent on them. Inter-group division is common especially among the leaders and their social bases because some leaders propose changes and prioritise dialogue on issues far too abstract or difficult to visualise with regard to the immediate realities of the communities. Other leaders experience a conflict of interest in the administration of resources and policies and desire to exercise authority and control over the rest of the population to their own advantage. These social problems contribute to the creation of 'insecure or illegitimate leaderships' that have inhibited alliances and propitiate weaknesses in the social fabric of the communities. Other multiple socio-economic, socio-political and socio-cultural factors of identity formation and practice, such as sex, religion, economic activity, access to property, culture, language and military and paramilitary affiliation or membership, have made the process of participation more complex and difficult.

In Guatemala, small-scale regional, sub-regional or local economies cannot sustain net fiscal benefits of sub-national and local government activities. Many regions, areas, and communities are impoverished and marginalised from 'national mainstream development'. According to the IFIs, co-participation funds could generate unconditional financial transferences for the respective local contributions although these transferences are assignations defined at the central level with political, financial and administrative implication for the recipients. These systems, which have reduced the historical tendency to concentrate public costs, do not reduce the differences generated by decentralising the decision-making processes (with independent decisions on expenditure and income taken at the sub-national level). This does not induce citizen participation and does not activate the democratic mechanisms that favour efficiency and social equity issues. If citizen participation is analysed in the process, it can be said that in general, elected representatives and local executives are reduced to instruments for receiving orders and tasks from central authority under a set of conditions in order to have access to financial resources.

Small communities are not able nor have the capacity to manage complex problems where the superiority of central provision is evident under authoritarian rule. For instance, the concept of regionalisation (decentralisation through deconcentration and delegation of authority under military control by region) provided a strategic and critical revision of the counter-insurgency policies to defeat the guerrilla movement in the ‘conflict areas’. The traditional divisions created by departmentalism since the nineteenth century were perceived as 'obsolete and arbitrary' for military surveillance and population control purposes by the central government. Regionalisation as a decentralisation process reinforced the authoritarian and verticalist presence of the state and central government in the rural areas without allowing local communities to have any decision about these strategies. Municipalities in the rural areas have continued as minor and subordinate parts of central government without a significant role at the local level despite their constitutional autonomy and direct representative elected authorities. Central government institutions made the decisions and they were implemented in the regions by the inter-institutional co-ordination bodies as part of the ‘network of the state apparatus’. Thus, inter-institutional co-ordination bodies (administrative and managerial regional centres managed by the military intelligence) constituted the first practical experience of administrative deconcentration and delegation of authority in the recent history of the country.

The problem in Guatemala has not been just the transfer of resources and the ‘principle of subsidisation to propitiate ‘spill over effects’ at the local level in order to generate economic and fiscal growth. It is also difficult to promote change in the socio-political relationships between population, institutions and authorities because of the political history of the country. These changes could be embedded in institutional and social interactions between population and sectoral institutions. These interactions could include political discussion about how to effectively plan, manage and monitor economic and fiscal resources and produce socio-economic transformations for the majority of the population in the middle and long-terms. The intentions of the IFIs have been to generate economic growth opportunities and assets, social and infrastructure investment, and sustainable production and productivity as a planning development rationale to ‘equalise’ per capita sub-national and local level economic and fiscal capacities. However, a practical solution has been unrealistic in political, social and cultural terms due to the dominant political

and cultural values in place. The participative democratic process depends heavily on horizontal decision-making therefore, it would be very important for the IFIs to expand their approach and address the degree and extension of practices of power by political and social groups within local social systems and processes in the post-conflict environment.

Ideas about equity and justice under the Health Code cover integrated health care for families, health care for the Mayan, Garifuna, and Xinca peoples, with emphasis on women, health care for the migrant population and strengthening of integrated health care for other groups, and broader basic health service coverage based on quality and sustainability. Under Health Sector Reform (RSS), emphasis is placed on the organisation of publicly financed services to extend coverage to the rural population that currently has no access to health care. Again, there are formal and institutional mechanisms covering equity and justice and the distribution of resources however enforcement and legitimising mechanisms are missing.

My research discussed that Health Sector Reform (RSS) was implemented nationwide after it started with a pilot phase (discussed in Chapter 6). RSS (decentralisation) reached the former conflict areas, where the indigenous ethnic groups have participated in the process. However, in many cases, as evidenced in this thesis in Chapters 6 and 7, the impact and outcome of the RSS has been weak and poor, limited and restricted. Worst, the RSS process is becoming weaker over time, and in the last two government administrations there have even been significant setbacks in terms of coverage and resources. Also, despite some promising initial socio-demographic and epidemiological statistics related to the improvement in the first healthcare level of the services provision under SIAS, significant improvements in the health status of most of the communities affected by the civil conflict are pending.

Furthermore, the concept of effectiveness for most of the members of the communities that formed part of the mainstream evaluation (analysed in Chapters 6 and 7), is conceptualised as an integral process of improvement in their daily lives as well as a series of actions that have improved their standard of living. For instance, better health status in the community, more active rather than passive participation in the resolution of health and other problems in the communities, and

increasing access to public services in general and not only to health services through SIAS. Thus, effectiveness encompasses a series of perceived and felt changes in the economic, social and cultural realms of life. These interrelated and comprehensive conceptualisations about the meaning of effectiveness are dissimilar with the technical concept of effectiveness, which, depending on its field application, mainly refers to a particular purpose of improvement but it is lacking the sense of integrality to development.

The data presented in the analysis of the institutional evaluation found that the communities partially participated in the assessment of health problems and the identification of needs. There was no community participation in activities that established priorities and goals or in the programming of health services and activities related to local implementation. The methodological observations to establishing a more comprehensive set of variables and indicators in order to have a deeper and broader understanding of the status of community organisations, could have addressed the following issues: (a) the meaning of health, need, problem and solution from the perspective of community members; (b) the community's point of view, on needs, problems and solutions prioritised; (c) the similarities on the needs and views of all the community sectors depending on its location and ethno-demographic composition; (d) the coherence of views and conceptualisations with the priorities of health decentralisation policies of SIAS; (e) the need for a historical comparative analysis about the evolution of community organisation structures related to the nature of the leadership formation (traditional and non-traditional structures, religious structures, and civil-military structures); (f) the way the community is compelled to organise (mobilise) itself to face problems and needs; and, (g) the way the community understands and practices management including the level of capacity building the community members have or need to develop under the SIAS and other inter-sectoral areas.

I found that the communities had very little impact on supervision and evaluation activities, which referred to the level of direct community participation. It appeared that the communities attempted to promote leadership features in the mobilisation of health resources and in the management of services. However, this was not entirely achieved because of the lack of a strong organisation process and the absence of more empowering mechanisms for local participation. In general

terms, according to the above information, community participation in health activities was limited. In many aspects the questions for this component referred to the communities' potential and their possible role rather than what they were doing with regard to health and local development.

Further, the methodological observations to establish a more comprehensive set of variables and indicators were the following: first, each of the above managerial categories encompassed specific activities that were inter-related. Nonetheless, this component provided important information (although incomplete) for identifying which activities and stages of healthcare provision involved individual institutional actors and features of community participation. The set of indicators were insufficient to measure the variables that intervened or determined the answer to these questions in any depth and breadth. As I mentioned, the evaluative model was functional, a-temporal, not contextualised amongst the communities studied and unable to identify the role of the actors. The socio-economic, socio-political, and socio-cultural problems were not confronted. Second, the evaluation could have included and inter-related the key issues with the critical and analytical aspects of the methodological inquiry. For instance, (a) the kinds of factors (variables) intervening in preventing organisational and managerial skills from developing in the community and therefore, directly or indirectly affecting the implementation of SIAS; (b) the meaning of power, decentralisation, democracy, participation, inclusion, equality and empowerment among other conceptual categories related to community organisation. These issues would have been asked of SIAS members, the community, and the PRSS staff and related to the national and sub-national situation in the country; (c) before or after the implementation of SIAS, the kind of community skills that existed; (d) the development process of those skills that already existed before the SIAS implementation; (e) the degree to which the community's skills were disrupted, diminished or destroyed during the civil war; (f) the potentials of community resurgence (re-organisation) in the short, middle and long terms; and, (g) the promotion and support of community resurgence (re-organisation) in those communities affected. The methodology of this evaluation did not present enough information to establish an evidence-base.

With regard to the stages in the service administration process and how the communities chosen participated in the four managerial stages of the SIAS:

planning, implementation, monitoring and evaluation, the implementation stage was where the community had the greatest level of 'indirect participation' (limited decision-making power). This was not only valid for community members but also for the Basic Health Teams (EBS). The communities through their health committees did not undertake health service administration as part of the four-implementation activities designated by SIAS. There were a number of activities that should have been administered by the committees to maintain the community centres according to the norms of the HC. There was an acceptable trend in participation in terms of health promotion. However, participation would have been reinforced within the SIAS policies, extending participation to planning, monitoring and evaluation activities at the community level. The model defined by healthcare provision was acceptable in terms of encouraging community participation according to the information of this evaluation. Nonetheless, expanding participation of individual community actors in planning, monitoring and evaluation would have clearly strengthened it. All the local actors either institutional or community would have been strengthened to undertake evaluation activities, which appeared to be weak. The low percentage of monitoring and evaluation activities indicated that the communities were not performing their key accountability functions.

9.4. Application of Variables in a Post-Conflict Environment to Analyse Community Participation

The third objective of the thesis is to determine and apply complementary variables over the historical, political, social, economic and cultural characteristics of a post-conflict environment, - macro and micro in scope - in order to analyse community participation within a health sector reform process and decentralisation policies aimed at the primary healthcare level, through a comprehensive evaluation framework. I have suggested that decentralisation policies within the content of the PAs and the MEA have been based on a number of wrong assumptions, which have been criticised in this thesis. These include: (a) the presence of dynamic social and economic sectors within country, (b) that such sectors participate in society in inclusive and democratic ways, (c) that the Guatemalan political system is efficient and well managed (d) that democracy is well established, (e) that the historical relationships of the diverse sectors of the population in Guatemala pursue similar socio-economic objectives and that there is general consensus since the signing up of the PAs.

After reviewing the results of the MSPAS/PMSS/UME evaluation and the questions asked by the evaluation of this research, the following contradictions are important to take into account in order to shape the way participative evaluations could be implemented: (a) there is no equal participation in the decision-making and accountability processes; and, (b) institutional rationale and sectoral practices have been dominant over community beliefs and tasks assigned under SIAS norms to the committees and communities. This contrasts notably with the valorisations of the health committees and the users (Chapter 6) in that (a) community organisation is viewed as the best way to promote the interests of the population and value the potential of the communities' human rights as health rights; and, (b) the positive perception of participating in the resolution of problems and management of the local units for development, which are more significant for the well being of the communities. I suggested throughout my thesis that local democratic participative and organisational initiatives, possibilities and potentialities have to be directly negotiated with the communities in egalitarian terms. In examining the contents of the MSPAS' evaluation protocol, the idea of community participation is subordinate to the predetermined model as an 'ideal and closed framework and effective functional structure' (addressed in Chapters 6 and 7).

However research in public health demonstrated that minimum performance had been achieved. An evaluation of the primary healthcare services found that the performance of several NGOs, which were contracted to provide primary healthcare under the SIAS was unsatisfactory because performance measures relating to service provision had not been adequately defined (MSPAS/OPS/OMS, 2001). My participation in the MSPAS evaluation on community participation in health also provides further insight to this (discussed in Chapter 6). The main characteristics of the redefined healthcare model have been the explicit development of basic service plans and contracting of private entities (mostly NGOs) for the delivery of publicly financed health services. In the communities that now have services provided by the SIAS, community centres have been established. The goal has been to increase coverage and reduce the incidence of certain diseases. The MSPAS has also begun efforts to improve its capacity to regulate and control private agents. The MSPAS central administration has set up an evaluation and monitoring system that has led to the termination of several agreements with NGOs for non-compliance. However this system has been inefficient because it is based mostly on quotas and supply

needs. The system should be more comprehensive in its indicator composition and variables for quality assurance and should include assessments of views on health by the population, patterns of active participation and decision-making behaviour.

Therefore, there has been no evidence to demonstrate that RSS has introduced an acceptable standard of performance into local health services. The following reasons have been identified for this inadequacy: first, the actual target population has been smaller than the number declared by some NGOs. Thus, some NGOs have been operating with undeclared surpluses. Second, there have been a lack of incentives to progress from the data collection and service mapping phase to the actual delivery of health benefits at the local levels because the resources allocated for the two phases have been insufficient and costs for the service delivery phase are actually higher. Third, there has been a lack of formal accreditation of some of the NGOs, which were contracted, and many lack basic competencies for service delivery. And fourth, the SIAS has been attempting to provide health services to populations that have hardly received any public healthcare or that have not approached such services before. There have been many concerns from the IDB and WB about the way in which the MSPAS signed agreements with NGOs. Within the framework of the SIAS, some responsibilities and resources have been decentralised to Health Area Authorities. Increasingly, Health Areas where the SIAS has been implemented have been signing agreements with local and international NGOs working at the community levels for service delivery.

I need to consider the above within the context of a comprehensive evaluation framework therefore relating the present (decentralisation policies) to the past in order to identify variables that could be used and cross-referenced. Like prejudice, discrimination can be either positive (providing special advantages) or negative (placing obstacles in front of particular categories of people). Throughout Guatemala's history, negative discrimination has been constructed (ideologically conceptualised), and applied (behaviourally practiced) against the majority of the population. This psychosocial pattern has reinforced the application of an exclusionary socio-economic model of development. The research found that discrimination in Guatemala has been part of social perceptions, attitudes and actions. Discrimination has operated within the state's institutions including health facilities. Further, and as I have pointed out, in Guatemala, race and ethnicity

overlap and the non-indigenous sectors of population do not have a clear sense of biological differences. Ethnicity in ideological terms has relied on the understanding of the cultural heritage in folkloric terms (as an attraction of the 'otherness' to be culturally and socially different) and not in socio-political terms (as a pluralist differentiation with similar needs, aspirations and fulfilment of potentials). In the country's context of violence, the level of negative connotation towards ethnic differentiation has meant that people have hidden or denied their membership to a determined ethnic group. This behaviour has changed according to the levels of oppression and repression affecting the ethnic groups over time. Indigenous and non-indigenous Guatemalans have grown without knowing each other, and worst of all, not having the capacity to organise and empower themselves. The historical divisions have had a negative impact on the degree of social organisation and mobilisation against the political system and its oppressive state. For instance, Mayan, workers and peasant movements have lacked a cohesive agenda and have been unable to counter-balance the vested interests of the elites under the shadow of the state.

There are a number of reasons why this situation continues. First, the state has been characterised as dominant, exclusionary, classist and racist. Historically, it has restricted and repressed citizen participation using violence and coercion as institutional mechanisms to achieve its goals. Thus, the population has been deprived of knowledge, practices and, in general, of a democratic political culture. I referred to the Constitution (1985) and the Peace Agreements where, an operational and participatory democracy, modernisation of the state through democratic forms of decentralisation and promotion of citizen participation are clearly stated. However, in reality, rural citizens have not perceived themselves as part of a nation-state, and the state's apparatus has not reached the whole of the territory except in instances of repression. The transitional democratic process has hardly provided opportunities for participation in the political life of the country. The political system has continued to block the development of political institutions, excluding the majority of the population from exerting political power even within the traditional political party structures. Despite the existence of civil organisations, the general tendency has been to discourage the formation, foundation and functioning of civic associations and committees, municipal committees, co-operatives, and associative enterprises.

The ones that exist have been limited in development to prevent their independent and autonomous growth away from the centralising state apparatus.

Second, the mechanisms and the effects of the exclusion model -particularly in the rural areas- have been the key determinants to discourage (and in historical periods to encourage) people to participate in politics and development. I provided many examples illustrating that the psychological, social and economic impacts (sensation of alienation, hopelessness and powerlessness produced through marginalisation, poverty and racism) over the poor and indigenous population have been decisive to maintain the status quo. Nonetheless, under such an undemocratic political system the government institutions have been centrally involved in the regulation and provision of social policies. The implementation of the PAs has been weakened particularly since the time of the referendum (popular consultation) in 1998. The consultation failed to gain political and social approval to reform the Constitution according to PAs contents in order to legally reinforce more democratic structural changes in the political system and the socio-economic model of the country. This historical factor is very important in order to understand the reasons for the failure of the entire peace-building process. Other major factors in respect to social organisation and participation have been the lack of representation of multi-sectoral social interests, low level of integration and the inability to present collective proposals. Nonetheless, it is important to consider that violence and intimidation has been continued against several organisations for many years and this has weakened their capacity for social action against the state. For instance, the levels of violence, public insecurity, corruption and loss of credibility in the government hindered the implementation of the 'Governance Pacts' (negotiated in 1997 and re-negotiated in 2001 with the last two government administrations). Through these Governance Pacts, grassroots community organisations, popular organisations, NGOs and municipal governments could had been organisationally and collectively strengthened and empowered through networks, alliances and co-ordinating entities at the municipal, departmental and national levels. Civil organisations would have been able to participate in the implementations of the PAs and to make demands to the state institutions. These demands would have been directly related to the democratisation of the country especially through the peace agreements on 'Socio-economic Issues and Agrarian Reform', the 'Identity and Rights of the Indigenous

People' and the 'Strengthening of Civilian Power and the Role of the Army in a Democratic Society'.

Third, under the PAs, the need to deconcentrate and delegate powers, responsibilities and resources of central government has been emphasised. Democratic forms of decentralisation could have guaranteed the transfer of decision-making powers and adequate resources at the local, municipal, departmental and regional levels. On one hand, citizen participation has not been extended beyond the casting of votes. It has not implied exerting social control (accountability) on the way in which local and national authorities have managed public resources and control public institutions. There have not been direct empowering mechanisms to force governments to respond to the actual needs of the population. Thus, the majority of the population in Guatemala have demonstrated poor citizen participation due to the lack of a democratic and political culture that prevents them from exercising their political rights. On the other hand, local civil society organisations have not developed skills and capacity for democratic participation. They have been unable to develop knowledge and manage information on the problems that affect the population. They have been disorganised, their leadership has reproduced the traditional vertical nature of the institutional structures of the state, and confrontation with the state institutions has continued. Civil organisations have not concentrated political power or created the spaces to articulate demands in any systematic or effective way. Likewise, local governments have also not established mechanisms for consistent and transparent communication with the population.

I suggest that decentralisation has not contributed to the demilitarisation of minds in the country so far. Pitifully, decentralisation has been used to reinforce militarisation. In the past, decentralisation was applied as part of the counter-insurgency strategies for the militarisation and control of the population in the rural areas. Decentralisation has not gone beyond deconcentration and delegation stages within the public sector. However, decentralisation has been used to achieve devolution and deregulation within the private sector. Reflecting the true intentions of the decentralisation policies and the imbalances of power allowed to the different socio-economic sectors by the state apparatus. Political decentralisation has not happened yet in Guatemala in terms of multisectoral or sectoral institutional reform.

Most of the development policies and decentralisation efforts are authoritarian, centralised and verticalist, where power-authority and decision-making are mainly exerted from central executive power. There has not been any significant contribution under such processes, to transform the authoritarian attitudes and practices as well as the culture of violence, which is still rampant in the country.

The legitimisation of the state, political parties and political groups, has not been achieved through the implementation of the some of the contents of the PAs. Where an organised group has low levels of legitimacy it is conceivable that it will take quite some time before the democratisation process takes-off. The above definition depends on the 'institutionalisation' of representative groups to a certain degree. Where adequate representation does not exist, the process of decentralisation has been owned by more formal organisations that already exist. Nonetheless, they do not represent the population to any great extent. The selection of representatives by the local population must therefore exist at the same time or shortly after a decentralisation process has been launched. Nevertheless, examining the process in Guatemala, the selection of representatives at the beginning of the process has not meant they had neither the power nor a pivotal role in such a process. Thus, the above definition considered within its scope the authoritarian and developmentalist nature of the Guatemalan state but recognised the need for representative and formal processes within certain limits to generate ‘some degree of legitimacy’.

In addition, the different levels of government are not defined (central, departmental and local) in terms of which level will address the needs of the population (Development Councils, civil associations, and non-government organisations). Thus, the legal administrative framework of the decentralisation policies in the country should be reformed in order to respond to a broader concept of decentralisation by consensus. This means the redefinition of the role of the state and the responsibilities of each actor. It is important then to reform the state’s normative laws. It is important that the ministries of Education and Health retake their position of sectoral leadership in order to have a system of financial and administrative accountability. These ministries should have a law of public investment and a system of evaluation and monitoring to assess the results of decentralisation and social policies. Thus, it is important to continue with the

decentralisation process using resources more efficiently and under citizenship control.

According to the analysis presented in chapters 4 and 6, the decentralisation model has hardly taken in account the most vulnerable sectors of population to actively participate in the Public Sector Reform (RSP) and within it Health Sector Reform (RSS). Additionally, as the thesis has shown, the decisions with regard to policy design and implementation procedures, dispositions and initiatives have mostly been taken far and away from the realities of the recipient countries of these policies. If, as in the Guatemalan case, a historical model of exclusion and a weak PAs implementation process and post-conflict scenario is considered, then the outcome is that participation of the most vulnerable groups has not been achieved. All the limitations described previously do no allow for the participation of the most vulnerable groups in the different stages of the decentralisation process.

Social action in Guatemala has been related to collective measures, acts, initiatives, stands, and developed agendas, which combine an array of social sectors. Social action has been employed by Guatemalan groups and organisations seeking to alter institutional policies or to make changes in the distribution of power in a society throughout time. Guerrilla movements, civil rights groups, NGOs, CBOs, Unions, the Church of various denominations, and other social and religious movements have been common examples of social action in the Guatemalan context. However, in the country's post-conflict environment, social action pursued by the civil sectors has hardly challenged traditional and conventional elitist or sectarian leaderships. Nor have they produced profound changes in the political agenda of the state institutions in the hands of the economic and social elite and the military. Currently, although these kinds of political civil organisations have been quite active in Guatemala since the signing of the Peace Agreements, their level of power through social action vis-à-vis the power of the state apparatus has been very limited in political decision making.

9.5. Achieving the Aim of an Alternative and Comprehensive Evaluation Framework

I developed the thesis paying attention to the elements that I had to gather and present as examples of a critical and comprehensive evaluation. I also addressed

four main epistemological categories of analysis for this exercise according to the methodological approaches I applied: the limitations and potentials of the decentralisation process throughout the history of the country (with emphasis on the current health sector reform process since formal peace was signed), the degree of democratisation of the state and social institutions throughout time, the process of social participation (with emphasis on community participation), and the characteristics of the post-conflict environment prevalent in the country.

I aimed to contribute to further analysis and studies on why, how, and when to evaluate, in an in-depth way, decentralisation (mainly sectoral decentralisation) within a post-conflict environment, which has hardly been done so far. I considered how it should be done combining an array of methodologies, which are qualitative and quantitative in content, how decentralising policies have been implemented without concern for the political history and model of a country and the setbacks of those policies in a post-conflict environment. Through this thesis I presented the example of Guatemala and how the assumptions of previous mainstream evaluations limit the relevance and effectiveness of decentralisation policies which are not changed and adapted to the current post-conflict realities. I demonstrated by providing strong evidence that a comprehensive evaluation, such as the one designed and carried out presenting key examples of its use, is necessary for a deeper and more extensive understanding of the multiple complexities present in post-conflict environments (again the example of Guatemala illustrated this key epistemological issue).

Also, my thesis provided more essential and critical elements to understand the limitations and potentialities of these crucial evaluation exercises to assess what kind of situations, processes, relationships, impacts and results have been produced under sectoral decentralisation. Those complexities have been critically analysed to measure the progress towards or stagnation of decentralisation, democratisation and participation. I am concerned and aware that after this exhaustive evaluative exercise and due to the difficulties of complex socio-political, socio-economic and socio-cultural scenarios that many more studies are necessary in order to understand why in many cases sectoral decentralisation has failed worldwide. I felt that despite a number of problems I faced during this journey, I achieved the objectives I set myself. Thus, the historical, comparative and analytical assessment

that I am presenting in this research went beyond mainstream structural-functionalist evaluation. I demonstrate the different kind of realities that can be evaluated, combining various methodologies and distinctive points of view and approach to these realities. Now other similar philosophical-epistemological exercises will provide further insight for further analysis of these categories, topics and issues contributing to the advancement of our understanding of processes of decentralisation and reform.

BIBLIOGRAPHY

ACPD – Asamblea Cosultiva de las Poblaciones Desarraigadas (1999). Declaración pública de la asamblea de las poblaciones desarraigadas con motivo del 5º aniversario del acuerdo de reasentamiento, del 24 de abril. Guatemala.

Acuerdos de Paz (1996). *SEPAZ,* diciembre. Guatemala.

Adeola, F. (1996). Military expenditures, health, and education. *Armed Forces and Society* 22 (3): 441–55.

Aguiluz, D. (1990). Democratización del estado y descentralización. *Revista Centroamericana de Administración Pública*. (18), ICAP. San José, Costa Rica.

Ahmed, S. and M. Rafi (1999). NGOs and evaluation: the BRAC experience. Paper presented at a conference on Evaluation and Poverty Reduction. June 14-15. Washington D.C., USA.

AIDPI - Acuerdo sobre identidad y derechos de los pueblos indígenas (1995). Maya-UNESCO: Guatemala.

Aitken, I. (1997). Decentralisation and reproductive health: opportunities and challenges. Paper presented at the meeting of the American Public Health Association. November 9-13 1997. Indianapolis, Indiana, USA.

Alegrett, J. R. (1997). Dimensión política de la descentralización. Document Presented as part of the Technical Consultation on Decentralization, Rome 16-18 December. [On line April 2003] http://www.fao.org/sd/ROdirect/ROfo0015.htm.

Amador, P. (1989). Aplicación de una metodología para el análisis del discurso. Universidad de Extremadura. España.

Amaro, N. (1990). Descentralización y participación popular en Guatemala. INCEP. Guatemala.

Angel, L. O., Deman, H. and A. Sánchez (1998). Sistema integral de atención en salud-SIAS-. MSPAS. Guatemala.

APRESAL - Proyecto apoyo a la reforma del sector salud. (1999) Foro internacional: la reforma del sector salud. Gobierno de Guatemala/Unión Europea. Guatemala Cuidad, Guatemala.

Archer D. and R. Gartner (1976). Violent acts and violent times: a comparative approach to post-war homicide rates. *American Sociological Review* 41(4) 937-63.

ASESA - Acuerdo sobre aspectos socioeconómicos y situación agraria. (1996). *ASIES,* 4. Guatemala.

ASIES - Asociación de Investigación y Estudios Sociales (2001). Los alcances y los logros de la descentralización municipal en Guatemala. Guatemala.

ASP/SNU – Análisis de Situación de País Guatemala/Sistema de Naciones Unidas en Guatemala (2000). Mayo. SNU. Guatemala. [On line April 2003] http://www.undg.org/documents/761-Guatemala_CCA_-_Guatemala_2000.pdf

Atkinson, S., Medeiros, R. L., Oliveira, P. H. L., and R. Dias de Almeida (2000). Going down to the local: incorporating social organisation and political culture into assessments of decentralised healthcare. *Social Science and Medicine*. 51, 619-636.

Baer, H., M. Singer, and I. Susser (1997). Medical anthropology and the world system: a critical perspective. Bergin and Garvey. Westport, Connecticut, USA.

Bah, R. and J. Linn (1994). Fiscal decentralization and intergovernmental transfers in less developed countries. *Publius* 24. 24 (1) 1-20.

Ball, N. (1988). Security and economy in the third world. Princeton University Press. Princeton, New Jersey, USA.

Barnum, H., Kutzin, J. and H. Sexenian (1995). Incentives and provider payment methods. *Human Resources Development and Operations Policy*. Washington D.C., USA.

Bauman, R. and C. Briggs (2003). Voices of modernity: language ideology and the politics of inequality. Cambridge University Press. Cambridge, UK.

BE - British Encyclopaedia (2002). Interactive and web interface. 2 CD ROM. Oxford, UK.

Belil, M., Borja, J. and M. Castells (1989). Descentralización y gestión urbana. En Mario Lungo (comp.) *Lo urbano: teoría y métodos*. Editorial Universitaria. San José, Costa Rica.

Bennett R. J. (ed.) (1994). Local government and market decentralization. UN University Press. Tokyo, Japan.

Bergen, P. and T. Luckman (1966). The social construction of knowledge. Penguin books. London, UK.

Bloom, G. (2000). Equity in health in unequal societies: towards health equity during rapid social change. IDS Working Paper 112. Brighton, UK.

Boisier, S. (1991). La descentralización: un tema difuso y confuso. Dieter Nohlen (comp.) Descentralización política y consolidación democrática Europa-América Latina. *Nueva Sociedad*. Caracas, Venezuela.

Boisier, S. (1995). La modernización del Estado: una mirada desde las regiones. *Nueva Sociedad*. 139. Caracas, Venezuela.

Bordignon, M. (2000). Problems of soft budget constraints in intergovernmental relationships: the case of Italy. *Research Network working paper R-398.* Inter-American Development Bank. Washington D.C., USA.

Bossert, T., Beauvais, J. and D. Bowser (2000). Decentralisation of health systems: preliminary review of four country case studies. Major Applied Research 6 Technical Report 1. Partnerships for Health Reform. Abt Associates Inc. Bethesda, Maryland, USA.

Bossuyt, J. and J. Gould (2000). Decentralisation and poverty reduction: elaborating the linkages. *Policy Management Brief 12, European Centre for Development Policy Management.* Maastricht, Netherlands.

Bracken, P. and C. Petty (1998). Rethinking the trauma of war. Save the Children UK. London, UK.

Brennan, S. and E. Hulteen (1995). Interaction and feedback in a spoken language system: A theoretical framework. *Knowledge-Based Systems,* 8:143-151.

Bryant, M. (1997). Is it possible to plan for decentralisation? *Management Sciences for Health.* Boston, Massachusetts, USA.

Burgess, H. (1992). Problem-led learning for social work: the enquiry and action approach. Whiting and Birch. London, UK.

Burgos, A. (2000). La descentralización y desconcentración en el área rural. *Cuadernos de Desarrollo Humano*. SNU-Guatemala. Guatemala.

Burr, V. (1995). An introduction to social constructionism. Routledge. London. UK.

Bush, K. (1998). A measure of peace: peace and conflict impact assessment (PCIA) of development projects in conflict zones. Working Paper No. 1. The Peace-building and Reconstruction Programme Initiative and the Evaluation Unit. International Development Research Centre. Ottawa, Canada.

Cabrero, E. (1996). Las políticas descentralizadoras en el ámbito internacional. Retos y perspectivas. *Nueva Sociedad.* 142. Caracas, Venezuela.

CACAP – Comisión de Acompañamiento en el Cumplimiento de los Acuerdos de Paz (2000). Cronograma de implementación, cumplimiento y verificación de los acuerdos de paz, 2000 – 2004. Guatemala.

Calvo, G. A. and E. G. Mendoza (1999). Regional contagion and the globalization of securities markets. NBER Working Papers 7153, National Bureau of Economic Research, Inc.

Castellanos-Cambranes, J. C. (ed.) (1992). 500 años de lucha por la tierra. FLACSO, Guatemala.

Castellanos-Cambranes, J. C. (1994). Coffee and peasants: the origins of the modern plantation economy in Guatemala, 1853-1897. *Plumstock Mesoamerican Studies,* South Woodstock. Vermont, USA.

CEH – Comisión de Esclarecimiento Histórico (1999). Guatemala: memoria del silencio. UNOPS Guatemala.

CEH/UNOPS – Comisión de Esclarecimiento Histórico/Oficina de Proyectos y Servicios de Naciones Unidas (1999). Memoria del silencio. informe de la comisión para el esclarecimiento histórico. Tomos I-V, CEH/UNOPS. Guatemala.

CIEN – Centro de Investigaciones Económicas Nacionales (1994). Fortalecimiento financiero de los gobiernos municipales. *Temas Públicos* 7. Octubre. Guatemala.

CIEN – Centro de Investigaciones Económicas Nacionales (1995). Estrategia de desarrollo económico y social para Guatemala, 1996-2000. Guatemala.

CIEN – Centro de Investigaciones Económicas Nacionales (2000). Descentralización: el proceso de modernización de la salud. Guatemala.

CIEN – Centro de Investigaciones Económicas Nacionales (2000a). Descentralización: El Proceso de Modernización de la Educación. Guatemala.

Clark, H. H. (1996). Using Language. Cambridge University Press, Cambridge, England.

Clark, H. H. and D. Wilkes-Gibbs. (1990). Referring as a collaborative process. In Cohen, P. R., Morgan, J. and M. E. Pollack, (eds.). *Intentions In Communication*. The MIT Press. Cambridge, Massachusetts.

Clark, H. H. and E. F. Schaefer (1987). Collaborating on contributions to conversations. *Language and Cognitive Processes*, 2, 19-41.

Clark, H. H. and E. F. Schaefer (1989). Contributing to discourse*. Cognitive Science.* 13. 2560.

Clark, H. H. and S. E. Brennan (1991). Grounding in communication. In Levine J., Resnik, L. B. and S.D. Teasley, (eds.) *Perspectives on Socially Shared Cognition*. 127-149.

Cohen, M. (1999). Micro-finance impact evaluation: going down market. Paper presented at a conference on Evaluation and Poverty Reduction. June 14-15. Washington D.C., USA.

Cohen, P. R. and H. J. Levesque (1994). Preliminaries to a collaborative model of dialogue. *Speech Communications* 15, 265-274.

Cole, K. (1999). Economy-environment-development-knowledge. Routledge. London, UK.

Collier, P. (1999). On the economic consequences of civil war. *Oxford Economic Papers,* 51. 168–83. Oxford, UK.

Collier, P. (2000). Economic causes of civil conflict and their implications for policy. World Bank paper from research program "The Economics of Crime and Violence." [On line April 2003] http://www. worldbank.org/researchiconf1ict/ pa_ers/civilconflict. pdf

Collins, C. D. and A. T. Green. (1994). Decentralisation and primary health care: some negative implications in developing countries. *International Journal of Health Services, 24(3)*, 459-76.

CONIC/CNM - Coordinadora Nacional Indígena y Campesina/Consejo Nacional Maya (1996). Guía para el desarrollo del subtema: pueblos indígenas. Aportes al desarrollo y legislación social. Modulo "B de desarrollo y política social". NimPopb'il, diciembre. Guatemala.

Conyers, D. (1986). Future Directions in Development Studies: The Case of Decentralization. *World Development* 14 (5) (May) 593-603.

Cortazzi, M. (2001). 'Narrative Analysis in Ethnography'. In Atkinson, P., Coffey, A., Delamont, S., Lofland, J. and L. Lofland (eds.) *Handbook of Ethnography*. 384–94. Sage. London, UK.

Costello, P. (1997). Historical background. IN *Accord Series Wilson, R. (ed.). Negotiating rights: the Guatemalan peace process.* London. UK. [On line, April 2001] http://www.c-r.org/our-work/accord/guatemala/historical-background.php

CPD – Chambers Pocket Dictionary (2000). Chambers Harrap Publishers Ltd. London, UK.

CRD/CDD - Consejos Regionales de Desarrollo/Consejos de Departamentales de Desarrollo (1997). *Coordinación interinstitucional para el desarrollo regional del país*. Documento Técnico. CRG/CDS. Guatemala.

CRD/CDD/MSPAS – Consejos Regional de Desarrollo/Consejos Departamentales de Desarrollo/Ministerio de Salud Pública y Asistencia Social (1998). Coordinación inter-institucional para el desarrollo regional del país. Documento Técnico. Guatemala.

CRG – Congreso de la República de Guatemala (1997). Código de salud decreto 90-97. Guatemala.

CRG – Congreso de la República de Guatemala (2002). Decreto número 14-2002, marco normativo del proceso de descentralización del organismo ejecutivo, a través de la ley general de descentralización. Septiembre. Guatemala.

Crook R. and A. Sverrisson (2001). Decentralisation and poverty alleviation in developing countries: a comparative analysis or is West Bengal unique? IDS. Working Paper 130, June 2001. Brighton, UK.

Crotty, M. (1998) The foundations of social research: meaning and perspectives in the research process. Sage, London, UK.

da Costa Pinto Neves, M. (1997). Lateinamerikanische verfassungen: zwischen autokratismus und demokratisierung. *Verfassung und recht in uebersee.* Nomos Verlag. 519. Baden-Baden, Germany.

Darquea, G. (1999). Planeación estratégica participativa municipal. *IULA/CELCADEL, Proyecto SACDEL y Proyecto MINGA. 156.* (352.007.2 D224). Quito, Ecuador.

Dary, C. (1997). El derecho internacional humanitario y el orden jurídico maya, una perspectiva histórico cultural. CIRC-FLACSO. Guatemala.

Dasgupta, P. (1999). Poverty reduction and non-market institutions. University of Cambridge. Cambridge, UK.

Davoodi, H. and H. Zou (1998). Fiscal decentralization and economic growth: a cross-country study. *Journal of Urban Economics* 43:244-257.

de León, S. and C. Quinto (2000*).* Propuesta de Análisis cualitativo sobre la participación comunitaria. Encuesta de evaluación del sistema integrado de atención en salud SIAS. MSPAS/BID/APRESAL and GSD/EU/APRESAL. Guatemala.

de León, S. and L. González (2001a). Indicadores sobre conocimientos, actitudes y prácticas dentro de la salud materno infantil en los grupos indígenas de Guatemala*.* Documento técnico, JHPIEGO/USAID/Johns Hopkins University.

de León S. and L. González (2001b). Document: technical evaluation report of psychosocial assistance to the Guatemalan population in conflict areas. Human Rights and Democratisation Project PDHR/USAID/CAII. Guatemala City, Guatemala.

Demeritt, D. (1998). Science, social constructivism and nature. In Braun, B. and N. Castree (eds.) *Remaking Reality*. Routledge, 173–92. London, UK.

DeRouen, K. (2000). The guns-growth relationship in Israel. *Journal of Peace Research* 37 (1): 69–84.

Dillenger, W., Webb, S. and G. Perry (1999). Macroeconomic management in decentralised democracies. Paper presented at the fifth annual conference on Development in Latin America and the Caribbean. Decentralisation and Accountability of the Public Sector. June 20-22. World Bank. Valdivia, Chile.

DiMarco, G. Hirst, G., Wanner, L. and J. Wilkinson (1995). Health doc: Customizing patient information and health education by medical condition and personal characteristics. *Proceedings of the Workshop on Patient Education*. Glasgow, UK.

Dodd, R. and E. Hinshelwood (2002). *Poverty reduction strategy papers – their significance for health.* Paper presented at a meeting of the WHO on Interested Parties. October. WHO.

ECAP- Equipo de Estudios Communitarios y Acción Psicosocial (2001). Encuentro Sudáfrica-Guatemala. Sociedades en transición experiencias en salud mental, niñez, violencia y post conflicto. ECAP (Comp.). Editorial Siglo Veintiuno/Save the Children Suecia. Guatemala.

ECAP/CUM-USAC/POC-GTZ -Equipo de Estudios Communitarios y Acción Psicosocial/Centro Universitario Metropolitano-Universidad de San Carlos/Programa de Apoyo al Proceso de Paz y Conciliación Nacional-Cooperación Alemana para el Desarrollo (2003). Psicología social y violencia política. Primera Edición, Siglo Veintiuno, Mayo. Guatemala.

ECAP/ODHAG/IRCT- Equipo de Estudios Communitarios y Acción Psicosocial/Oficina de Derechos Humanos del Arzobispado de Guatemala/El Consejo Internacional para la Rehabilitación de Víctimas de Tortura (2001). La tortura y otras violaciones de los derechos humanos. 1er seminario latinoamericano y del caribe, realizado del 5 al 7 de abril del 2000. Siglo Veintiuno Editores, Segunda Edición. ECAP/ODHAG/IRCT. Antigua, Guatemala.

Eid, F. and P. Ibern (1999). Governance and incentives in the public hospital sector. Paper presented at the fifth annual conference on Development in Latin America and the Caribbean. Decentralisation and Accountability of the Public Sector. June 20-22. World Bank. Valdivia, Chile.

ENSMI – Primera Encuesta Nacional de Salud-Materno-Infantil (1995). INE. Guatemala.

ENSMI – Segunda Encuesta Nacional de Salud Materno Infantil (1998-1999). INE. Guatemala.

Evans, R. G. (1997). Health care reform: who's selling the market, and why? *Journal of Public Health Medicine.* 19, 45-49

FAO - Food and Agriculture Organisation (1997). Relations de processus de décentralisation et pouvoirs traditionnels: typologie des politiques rencontrées. *N. Bako-Arifari. Decentralisation Et Developpement Rural 15.* FAO. Rome, Italy.

Fernández, R. (1999). Education and redistribution: efficiency and equity. *Poverty and Development. Journal of International Education and Development.* 4, 234-242.

Fiadeiro J. L. and T. S. E. Maibaum (1993). Generalising interpretations between theories in the context of institutions. In Gay, S., Burn, G. and M. Ryan (eds.). *Theory and Formal Methods*. 126-147. Springer-Verlag. London, UK.

Figueroa, A. (1999). Social exclusion and rural development. A paper presented at a conference on Evaluation and Poverty Reduction. June 14-15. World Bank. Washington D.C., USA.

Finkelman, J., Barillas, E., Rivera, M. and D. Victoria (1996). El proceso de transformación de la salud en Guatemala. OPS, Enero. Guatemala.

FLACSO/PADAM/SI – Facultad Latinoamericana de Ciencias Sociales/Programa Apoyo al Desarrollo de la Administración Municipal/Solidaridad Internacional (1988). Constitución política de la republica de Guatemala de 1985. Código municipal. ley preliminar regionalización (decreto 70-86). Ley de los consejos de desarrollo urbano y rural y su reglamento (decreto 52-87, acuerdo gubernativo 1041-87). Gobierno de Guatemala. Guatemala.

Foley, D. E. (2002). Critical ethnography: the reflexive turn. *International Journal of Qualitative Studies in Education.* 15 (4). July, 469 – 490.

Freire, M., Huertas, M. and B. Darche (1999). Sub-national governments and credit markets. Paper presented at the fifth annual conference on Development in Latin America and the Caribbean. Decentralisation and Accountability of the Public Sector. June 20-22. World Bank. Valdivia, Chile.

Frendeis, S. (1983). Explanation of variation and detection of covariation: the purpose and logic of comparative analysis. *Comparative Political Studies* 16: 255-72.

Füredi, F. (1990). Introduction. In Jakubowski, F. (ed.). *Ideology and superstructure in historical materialism.* vii-xxxi. Pluto. London, UK.

Furtado, X. (2001). Decentralization and capacity development: understanding the links and the implications for programming capacity development. *Occasional Paper Series.* CIDA Policy Branch. 4. August.

Gálvez Borrell, V. (1997a). Avances, estancamientos y retrocesos: el proceso de descentralización y desconcentración en Guatemala: 1986-1996. FLACSO-Guatemala. 87. Guatemala.

Gálvez Borrell, V. (1997b). Capacidad administrativa y financiera de las municipalidades de Guatemala. FLACSO-Guatemala. 153. Guatemala.

Gálvez Borrell, V. (1998). Experiencias de participación democrática y poder local en Guatemala. FLACSO-Guatemala. 108. Guatemala.

Gálvez Borrell, V., Dary, C., Esquit, E. and I. Rodas (1997). Qué sociedad queremos? : una mirada desde el movimiento y las organizaciones mayas. FLACSO-Guatemala. 164. Guatemala.

Gálvez Borrell, V., Hoffman, C. and F. Mack (1998). Poder local y participación democrática. *En Debate 40,* FLACSO. Guatemala.

Gartz, R. (1993). FIS Y FONAPAZ en Guatemala: una nueva relación ONG-Estado? COINDE. Guatemala.

Gergen, K. J. (1994) Realities and relationships. Harvard University Press. Cambridge, Massachusetts. USA.

Ghobarah, H., Huth, P. and B. Russett. (2003). Civil wars kill and maim people long after the shooting stops. *American Political Science Review. 97*, 189-202.

Ghobarah, H., Huth, P. and Russett, B. (2004). The post-war public health effects of civil conflict. *Social Science and Medicine* 59: 869–884.

Giacaman R., Abdul-Rahim, H. F. and L. Wick (2003). Health sector reform in the occupied Palestinian territories (OPT): targeting the forest or the trees? *Health Policy Planning.* 18 (2) March 59 - 67.

Gilson, L., Alilio, M. and K., Heggenhougen (1994). Community satisfaction with primary health care services: An evaluation undertaken in the Morogoro region of Tanzania. *Soc. Sci. Med.* 39(6): 767-780.

Glazer, N. and D. P. Moynihan, (eds.) (1975), Ethnicity: theory and experience. Harvard University Press. Cambridge, Massachusetts, USA.

Gleijeses, P. (1991). Shattered hope: the Guatemalan revolution and the United States, 1944-1954. Princeton University Press. Princeton, New Jersey, USA.

Goebel, A. (1998). Process, perception and power: notes from 'participatory' research in a Zimbabwean resettlement area. *Development and Change.* 29 (2) April. 277-305.

Goldstone, J. A. (1997). Methodological issues in comparative macro-sociology. *Comparative Social Research* 16. 107–120.

González, C. (2001). Servicios financieros rurales. *Cuadernos de Desarrollo Humano*. SNU-Guatemala. Guatemala.

Gramajo Morales, H. (1995). De la guerra a la guerra. La difícil transición política en Guatemala. Fondo de Cultura Editorial. Guatemala.

Grebe, H. (1996). Administrative decentralisation and healthcare reform in Bolivia: a case study. López Fundación. La Paz, Bolivia.

GRG – Gobierno de la República de Guatemala (1991). Política económica y social, período 1991-1995. Guatemala.

GRG – Gobierno de la República de Guatemala (2000). Ejes del Programa de Descentralización del Estado. Guatemala 2000-2003. Lineamientos básicos para su discusión con los gobiernos municipales, la sociedad civil y otros actores de la vida nacional. Presidencia de la República. Guatemala.

Griffin, C. (1996). Decentralisation in health. World Bank. Washington D.C., USA.

Griffin, C. (1999). Decentralisation of health services in Latin American countries. Paper presented at the fifth annual conference on Development in Latin America and the Caribbean. Decentralisation and Accountability of the Public Sector. June 20-22. World Bank. Valdivia, Chile.

Grosz, B. J. and C. L. Sidner (1990). Plans for discourse. In Cohen, P. R., Morgan, J. and M. E. Pollack. (eds.) *Intentions in Communication*. MIT. 417-444.

Gustafson, P., Gomes, V., Veira, C., Jaensen, H., Seng R., Norberg R., Samb B., Naucler, A. and P. Aaby (2001). Tuberculosis mortality during a civil war in Guinea-Bissau. *Journal of the American Medical Association* 286(5): 599-603.

Gutman, J. (1999). Effective decentralisation on roads. Paper presented at the fifth annual conference on Development in Latin America and the Caribbean. Decentralisation and Accountability of the Public Sector. June 20-22. World Bank. Valdivia, Chile.

Haeussler, R. and S. Lima (1996). Investigación de redes sociales comunitarias en salud como apoyo a la reducción de la mortalidad materna e infantil en municipios del Quiche, San Marcos y Huehuetenango. MSPAS/FNUAP. Guatemala.

Haggard, S. and R. Kaufman (eds.) (1992). The politics of economic adjustment. Princeton University Press. Princeton, New Jersey. USA.

Handy, J. (1984*).* Gift of the devil: a history of Guatemala. South End Press. Boston, USA.

Hoffman, M. (2004). Peace and conflict impact assessment methodology. Berhoff Handbook. Berhoff Centre for Constructive Conflict Management. Berlin, Germany. [On line, March 2004] http://www.berghof-handbook.net/uploads/download/hoffman_handbook.pdf

HRCA – The Human Rights Council of Australia (2001). The rights way to development: a human rights approach to development assistance, policy and practice. HRCA, Australia.

Husserl, E. (1931). Ideas: general introduction to pure phenomenology. Translated by W., R., Boyce Gibson. Library of Philosophy. Macmillan. New York, USA.

IICA/FLACSO – Instituto Interamericano de Cooperación para la Agricultura/Facultad Latinoamericana de Ciencias Sociales (1986). Centroamérica, la crisis en cifras. IICA/FLACSO San José, Costa Rica.

IMF/WB – International Monetary Fund/Word Bank (1998). Building poverty reduction strategies in developing countries. Washington D.C., USA.

IMF/WB – International Monetary Fund/Word Bank (1999). Poverty reduction strategy papers - operational issues. Draft for discussion. Washington D.C., USA.

IMF/WB – International Monetary Fund/Word Bank (2001). Poverty reduction strategy papers - progress in implementation. Washington D.C., USA.

INDH/PNUD – Informe Nacional de Desarrollo Humano/Proyecto de Naciones Unidas Para el Desarrollo (1998). Guatemala: los contrastes del desarrollo humano. Sistema de Naciones Unidas. Guatemala.

INDH/PNUD – Informe Nacional de Desarrollo Humano/Proyecto de Naciones Unidas Para el Desarrollo (1999). Guatemala: el rostro rural del desarrollo humano. Sistema de Naciones Unidas. Guatemala.

INDH/PNUD – Informe Nacional de Desarrollo Humano/Proyecto de Naciones Unidas Para el Desarrollo (2001). Guatemala: el financiamiento del desarrollo humano. Sistema de Naciones Unidas. Guatemala.

IPES - Instituto de Estudios Políticos, Económicos y Sociales (2001). ¡Que se cumpla con los compromisos de los acuerdos de paz! Construyendo la paz. Cronograma para el Cumplimiento de los Acuerdos de Paz, 2000-2004. CD-ROM and Document. Guatemala.

Jackson, P. (1988). Tomorrow's public relations. In R. E. Hiebert (ed.). *Precision public relations.* 373-377. Longman Inc. White Plains, New York, USA.

Jiménez, A. (1999). Descentralización y desarrollo local: aportes para una discusión*. Cuadernos del CENDES.* 40, Caracas. Venezuela.

Jiménez Leube, J. (1997). La construcción del discurso: notas sobre el método retórico. Ediciones de la Universidad Europea. Madrid, España.

Kobrak, P. (1999). Organizing and repression: in the university of san carlos, Guatemala 1944 to 1996. AAAS. Annapolis, Maryland, USA.

Kolehmainen-Aitken, R. L. (1999). Decentralization of the health sector. In Litvak, J. and J. Seddon (eds.) *Decentralization Briefing Notes*. World Bank Institute. Washington, D.C., USA.

Kolehmainen-Aitken, R. L. (1998). Descentralización y recursos humanos: implicaciones e impacto. *Recursos humanos. Periódico del Desarrollo de la Salud.* 2 (1) 1-16.

Kolodko, G.W. (1999). Incomes policy, equity issues, and poverty reduction in transition economies. *Finance and Development. 36(2)* September. [On line, March 2003] http://www.imf.org/external/pubs/£t/£andd/1999/09/kolodko.htm.

Kullenberg, L., Shotton, R. and L. Romeo (1997). Supporting rural local governments in practice: issues for consideration. Paper delivered at a Technical Consultation on Decentralization, December. United Nations Capital Development Fund, Rome. Italy. [On line February 2003] http://www.undp.org/uncdf/news/rome _paper.htm.

La Forgia, G., Price, C. and L. Sánchez (1995). Programa de Mejoramiento de los Servicios de Salud (Gua 0023). *Propuesta de préstamo.* BID. Washington D.C., USA.

Laks, A. and A. Neschke (eds.) (1990). La naissance du paradigme herméneutique: Schleiermacher, Humboldt, Boeckh and Droysen. Lille, France.

Lanjouw, S., Macrae J. and A. B. Zwi (1999). Rehabilitating health services in Cambodia: the challenge of coordination in chronic political emergencies. *Health Policy and Planning.* 14 (3) 229-242.

Larkin, M. (2003). De Montfort University lectureship homepage. Course: Introduction to cultural psychology: social constructionism and discourse. School of Psychology, Leicester, UK. [On line May 2003] http://www.psy.dmu.ac.uk/ michael/ soc_con_ disc.htm

Le Bot, Y. (1992a). Guatemala: violencia, revolución y democracia. *Debate 15.* FLACSO, Guatemala.

Lenihan, P. and S. Iliffe (2001). Community oriented primary care: a multidisciplinary community-oriented approach to primary care. *Journal of Community and Applied Social Psychology*. 11, 11-18.

Ley de los Consejos Urbanos y Regionales (2002) Artículo 10, Decretos 52-87. Congreso de la República de Guatemala. Guatemala.

Ley Electoral y de Partidos Políticos (1985). Decreto 1-85. Asamblea Nacional Constituyente de Guatemala. Guatemala.

Ley de Municipalidades Gobernando Aldeas de la República (1879). Artículo 4, Decreto 242. Gobierno de la República de Guatemala. Guatemala.

Lieberson, S. (1991). Small n's and big conclusions: an examination of the reasoning in comparative studies based on a small number of cases. *Social Forces* 70: December, 307-320.

Linares López, L. (1994). El municipio y la descentralización. IDAM/FUNCEDE. Guatemala.

Linares López, L. (1997). El rol del municipio en la construcción de la paz. *Serie Estudios: No. 4,* FUNCEDE, Febrero. Guatemala.

Lincoln, Y. S. and E. G. Guba. (1985). Naturalistic inquiry. Sage, Beverly Hills, California, USA.

Lincoln, Y. S. and E. G. Guba. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Directions for Proaram Evaluation*. 30, 73-84.

Litvack, J., Ahmad, J. and R. Bird (1998). Rethinking decentralisation in developing countries. World Bank. Washington D.C., USA.

Lobkowicz, N. (1967). Theory and practice: history of a concept from Aristotle to Marx. Notre Dame, Indiana. USA.

Loughry, C. and C. Eyber (2003). Psychosocial concepts in humanitarian work with children: a review of the concepts and related literature. The National Academic Press. Washington D.C., USA.

LSHTM - London School of Hygiene and Tropical Medicine (2002). Health policy formulation in complex political emergencies and post conflict countries. LSHTM, November. Conflict and Health Program. London, UK.

Luckham, R., Goetz, A. M. and M. Kaldor (2000). Democratic institutions and politics in contexts of inequality, poverty and conflict. IDS Working Paper, 104. Brighton, UK.

Lustig, N. and A. Legovini (1999). Economic crises and social protection for the poor: Latin American experience. Paper presented at the conference on Evaluation and Poverty Reduction. June 14. Washington D.C., USA.

Macrae J., Zwi, A. B. and V. Forsythe (1995). Aid policy in transition: a preliminary analysis of post-conflict rehabilitation of the health sector. *Journal of International Development 7,* 669-84.

Marmot, M. and R. Wilkinson (eds.) (1999). The Social Determinants of Health. Oxford University Press. Oxford, UK.

Mathers C., Sadana R., Salomon J., Murray C.J. and A. D. López (2000). Estimates of DALE for 191 countries: methods and results. GPE discussion Paper No. 16. World Health Organization. Geneva, Switzerland.

MEDES - Médicos Descalzos (1999). Visión de la incorporación equitativa de la medicina tradicional y popular a la medicina institucional. MEDES. Guatemala.

Mercado-Martinez, F. J. (2002). Qualitative research in Latin America: Critical perspectives on health. *International Journal of Qualitative Methods.* 1(1), Article 4.

Messer, E., Cohen, M. and J. D'Costa (1998). Food from peace: breaking the links between hunger and conflict. Discussion paper and Policy Brief for IFPRI 2020 Vision on Food, Agriculture, and the Environment.

Middleton, N. and P. O'Keefe (1998). Disaster and development. The politics of humanitarian aid. Pluto Press. 185. London. UK.

Mintz, A. (1989). Guns versus Butter. *American Political Science Review* 83 (4): 1285–93.

MINUGUA – Misión de Naciones Unidas para Guatemala (2000a). Casos de violaciones a los derechos humanos. Guatemala.

MINUGUA – Misión de Naciones Unidas para Guatemala (2000b). Los linchamientos: un flagelo contra la dignidad humana. Diciembre. [On line January 2001] www.minugua.guate.net. (The webpage do nolonger exists, because the Mission left the country in 2004).

MINUGUA– Misión de Naciones Unidas para Guatemala (2002). Décimotercer informe sobre derechos humanos de la misión de verificación de las naciones unidas en Guatemala. Guatemala.

Mosquera, M., Zapata, Y., Lee, K., Arango, C. and A. Varela (2001). Strengthening user participation through health sector reform in Colombia: a study of institutional change and social representation. *Health Policy Planning.* December. 16: 52 - 60.

MOTHERCARE – ONG Internacional (1995). Desde la comunidad: percepciones de las complicaciones maternas y perinatales y búsqueda de atención. MOTHERCARE/USAID. Guatemala.

MSPAS – Ministerio de Salud Pública y Asistencia Social (1996). Indicadores básicos del análisis de situación. Guatemala.

MSPAS – Ministerio de Salud Pública y Asistencia Social (1998a). Cuentas nacionales en salud 1995 -1997. Agosto. Guatemala.

MSPAS – Ministerio de Salud Pública y Asistencia Social (1998b). Proceso de modernización, lineamientos políticos, estrategias, líneas de acción y avances. Guatemala.

MSPAS – Ministerio de Salud Pública y Asistencia Social (1999a). C*ó*digo de Salud. Decreto 90-97. Guatemala.

MSPAS – Ministerio de Salud Pública y Asistencia Social (1999b). Reglamento orgánico interno del ministerio de salud (ROI). Guatemala.

MSPAS – Ministerio de Salud Pública y Asistencia Social (2000a). Plan de análisis preliminar – investigación sobre participación comunitaria en la prestación de servicios básicos de salud. Unidad de Monitoreo y Evaluación/Programa de Mejoramiento de los Servicios de Salud. Guatemala.

MSPAS – Ministerio de Salud Pública y Asistencia Social (2000b). Participación comunitaria en la provisión de los servicios básicos de salud. Reporte final. Unidad

de Monitoreo y Evaluación/Programa de Mejoramiento de los Servicios de Salud. Guatemala.

MSPAS – Ministerio de Salud Pública y Asistencia Social (2002). Plan Nacional de Salud 2000-2004. Guatemala.

MSPAS/BID – Ministerio de Salud Pública y Asistencia Social/Banco Interamericano de Desarrollo (1995). Programa de mejoramiento de servicios de salud. Propuesta de préstamo. Guatemala.

MSPAS/BID – Ministerio de Salud Pública y Asistencia Social/Banco Interamericano de Desarrollo (1999). Programa de mejoramiento de servicios de salud. Guatemala.

MSPAS/BID/OPS/OMS – Ministerio de Salud Pública y Asistencia Social/Banco Interamericano de Desarrollo/Organización Panamericana de la Salud/Organización Mundial de la Salud (1991). Estudios básicos del sector salud. Guatemala.

MSPAS/BID/OPS/OMS – Ministerio de Salud Pública y Asistencia Social/Banco Interamericano de Desarrollo/Organización Panamericana de la Salud/Organización Mundial de la Salud (1994). Estudios básicos del sector salud. Guatemala.

MSPAS/BID/OPS/OMS – Ministerio de Salud Pública y Asistencia Social/Banco Interamericano de Desarrollo/Organización Panamericana de la Salud/Organización Mundial de la Salud (1998a). Estudios básicos del sector salud. Guatemala.

MSPAS/BID/OPS/OMS – Ministerio de Salud Pública y Asistencia Social/Banco Interamericano de Desarrollo/Organización Panamericana de la Salud/Organización Mundial de la Salud (1998b). Lineamientos políticos, estratégicos y programáticos. GSD consultores asociados: "los flujos de financiamiento" informe para el MSPAS. Guatemala.

MSPAS/DGSS/OPS – Ministerio de Salud Pública y Asistencia Social/Dirección General de los Servicios de Salud/Organización Panamericana de la Salud (1997).

MSPAS/IGSS – Ministerio de Salud Pública y Asistencia Social/Instituto Guatemalteco de Seguridad Social (1997). Guía para capacitación de personal de salud. Guatemala. Tercera evaluación de la estrategia de implementación en salud para todos en el año 2000, Guatemala.

MSPAS/OPS/OMS – Ministerio de Salud Pública y Asistencia Social/Organización Panamericana de la Salud/Organización Mundial de la Salud (2001). Estudio del manejo de los recursos humanos en salud. Guatemala.

MSPAS/PMSS – Ministerio de Salud Pública y Asistencia Social/Programa del Mejoramiento de los Servicios de Salud (1999a). Servicios básicos de salud. Serie: Guía para capacitar personal de salud No.1. Guatemala.

MSPAS/PMSS – Ministerio de Salud Pública y Asistencia Social/Programa del Mejoramiento de los Servicios de Salud (1999b). Integración del Equipo Básico de Salud. Serie: Guía para capacitar personal de salud, No.2. Guatemala.

MSPAS/PNS – Ministerio de Salud Pública y Asistencia Social/Plan nacional de salud 2000-2004 (2000). MSPAS. Guatemala.

MSPAS/SEGEPLAN – Ministerio de Salud Pública y Asistencia Social/Secretaría General de Planificación (2000). *Plan nacional de salud 2000-2004.* Guatemala.

MSPAS/SIAS – Ministerio de Salud Pública y Asistencia Social/Sistema Integral de Atención Primaria en Salud (1997a). Lineamientos para el nivel primario de atención en Salud. Guatemala.

MSPAS/SIAS (1997b). Normas de atención en salud. Tomo i y tomo ii. Guatemala.

MSPAS/SIAS – Ministerio de Salud Pública y Asistencia Social/Sistema Integral de Atención Primaria en Salud (1998). Proceso de modernización, lineamientos políticos, estrategias, líneas de acción y avances. Guatemala.

MSPAS/UPS/SIGSA -– Ministerio de Salud Pública y Asistencia Social/Unidad de Planificación Estratégica/Sistema de Información Gerencial de la Salud (2002). Economía y salud. Guatemala.

Mueller-Vollmer, K. (ed.) (1986) The hermeneutics reader. Oxford, UK.

Munar, W., Barrios, M., Nieves I., Savedof, B., Uribe B., Zavaleta, L. and D. Martín, (1999). Programa de mejoramiento de los servicios de salud. Segunda etapa (PMSS II). *Gu-0125. Informe de proyecto.* BID. Washington D.C., USA.

Murray, C. J. L. and A. López. (eds.) (1996). The global burden of disease. Harvard University, School of Public Health. On behalf of the World Health Organisation and the World Bank. Cambridge, Massachusetts, USA.

Ndulo, M. (1999). Democracy, institution building, and poverty in Africa. *Inclusion, Justice, and Poverty Reduction* - Villa Borsig Workshop Series (DSE).

Nelson, B., D., Simic, S., Beste, L., Vukovic, D., Bjegovic, V. M. and J. Van Rooyen, (2003). Multimodal assessment of the primary healthcare system of Serbia: a model for evaluating post-conflict health systems. *Pre-hospital Disaster Medicine.* January-March. 18 (1) 6-13.

Nieves, I. and G. La Forgia (2000). Large-scale government contracting of NGOs to extend basic health services to poor populations in Guatemala. WB. Washington D.C., USA.

Noriega, A. (2001). Guatemala, en el cruce de caminos – puntos para una reflexión estratégica sobre el futuro. Instituto de Estudios Políticos, Económicos y Sociales. Guatemala.

Nsibambi, A. (1997). Making democratic decentralisation an instrument of poverty eradication: Uganda's Challenge. Paper Presented at the UNDP development Forum. Kampala, Uganda.

ODHAG/REMHI - Oficina de Derechos Humanos del Arzobispado de Guatemala/Proyecto Interdiocesano de Recuperación de la Memoria Histórica (1996). *Guatemala: nunca más. informe de proyecto.* 4. ODHAG. Guatemala.

O'Donnell, G. (1998). Horizontal accountability in new democracies. *Journal of Democracy* 9(3):112-126.

OPS/OMS – Organización Panamericana de la Salud/ Organización Mundial de la Salud (2001). Establecimiento de las redes sociales locales, su epidemiología cultural, recursos etnoterapéuticos, su interacción con el medio social y las redes del sistema oficial de salud. OPS/OMS. Guatemala.

OPS/OMS/FUNMMAYAN – Organización Panamericana de la Salud/Organización Mundial de la Salud/Fundación de la Mujer Maya del Norte (1999a). Programas y servicios de salud mental en comunidades indígenas. Informe final del grupo de trabajo. Washington D.C., USA.

OPS/OMS/FUNMMAYAN – Organización Panamericana de la Salud/Organización Mundial de la Salud/Fundación de la Mujer Maya del Norte (1999b). Definición del rol de la comadrona y partero, dentro del sistema integral de atención en salud (SIAS). Guatemala.

OPS/OMS/FUNMMAYAN – Organización Panamericana de Salud/Organización Mundial de la Salud/Fundación de la Mujer Maya del Norte (2000). Propuesta de la fundación de la mujer Maya del norte tomando como base los resultados de una investigación realizada en cinco municipios de Alta Verapaz con comadronas y parteros. Guatemala.

OPS/OMS/USAID/PHRP –Organización Panamericana de la Salud/Organización Panamericana de la Salud/Agencia de los Estados Unidos para el Desarrollo Internacional/Proyecto de Reforma de la Salud en Latinoamérica (1998). Metodología para el seguimiento y la evaluación de las reformas del sector salud en América Latina y el Caribe. Iniciativa de reforma del sector salud en los países de América Latina y el Caribe. Washington D.C., USA.

Ortiz, R., Ruano, S., Juárez, H., Oliver, F. and A. Meneses (1991). A new model for technology transfer in Guatemala: Closing the gap between research and extension. OFCOR Discussion Paper No 2. ISNAR, The Hague, Netherlands.

Osner, K. (2004). Using exposure methodology for dialogue on key issues. In Chen et. al. (eds.) *Reality and Analysis.* 85-94.

Paek, T. and E. Horvitz (1999). Uncertainty, utility, and misunderstanding: a decision-theoretic perspective on grounding in conversational systems. Working Papers of the AAAI Fall Symposium on Psychological Models of Communication in Collaborative Systems. IDS, Brighton, UK.

PAHO/WHO – Panamerican Health Organisation/World Health Organisation (1998). Guatemala – profile of the health services system. Guatemala.

PAHO/WHO – Panamerican Health Organisation/World Health Organisation (2001). Profile of the health services system – Guatemala. Washington D.C., USA.

PAHO/WHO – Panamerican Health Organisation/World Health Organisation (2002). Profile of the health services system – Guatemala. Washington D.C., USA.

Palencia, T. (1997). Advocates and guarantors: establishing participative democracy inn post-war Guatemala. *In* Wilson, R. (ed.). *Accord Series Negotiating Rights: The*

Guatemalan Peace Process. London, UK. [On line April 2001] http://www.c-r.org/our-work/accord/guatemala/advocates-guarantors.php

Palmer, R. E. (1969). Hermeneutics: Interpretation theory. In Schleiermacher, Dilthey, Heidegger and Gadamer. Evanston, Northwestern University Press. Illinois. USA.

Patton, M. Q. (1990). Qualitative evaluation and research methods (2nd ed.). Sage. Newbury Park, California, USA.

Pearce, W. B. (1989). Communication and the human condition. Southern Illinois University Press. Carbondale, Illinois, USA.

Pedersen, D. (2002). Political violence, ethnic conflict, and contemporary wars: broad implications for health and social well-being. *Social Science and Medicine.* July 55 (2) 175-90.

PHRP – Partnerships for Health Reform Project (1998). Cuentas nacionales de salud: Guatemala, informe sobre iniciativas especiales 10. PHRP. Abt Associates Inc. Bethesda, Maryland, USA.

Pitman, M. and J. Maxwell (1992). Qualitative approaches to evaluation: Models and methods. In LeCompte, M., Millroy, W. and J. Preissle (eds.), *The handbook of qualitative research in education* (729-770). Academic Press. New York, USA.

PL – Prensa Libre (2002). Piden garantizar acceso a servicios de salud. Guatemala: bajo gasto en salud. *Prensa Libre Periódico Guatemalteco*, Octubre 1. Guatemala.

PL – Prensa Libre (2003). Q.40 anuales por persona en salud, cooperantes demandan que se amplíe la asignación a Q3,800 millones. *Prensa Libre Periódico Guatemalteco*, Octubre 28. Guatemala.

PNPD – Programa Nacional para la Paz y el Desarrollo 1996-2000 (1996). PRG/SEGEPLAN. Guatemala.

PRG – Presidencia de la República de Guatemala (1991). Hacia una democracia económica y social: Política económica y social del gobierno de Guatemala para el período 1991- 1996. Guatemala.

PRONICE/RED BARNA – Organización Pro Niño y Niña Centroamericano/Save the Children de Noruega (1998). Violencia organizada e intervención psicosocial. Radda-Barnen, Guatemala.

Putoto, G. (1997). The role of northern NGOs. In rehabilitating the health sector in post-conflict settings: a need for a critical analysis. *World Hospital and Health Services.* 33 (2) 17-21.

Q'UQ'KUMATZ-MENMAGUA – La Mesa Nacional Maya de Guatemala (1999). Programa: apoyo al desarrollo de los pueblos indígenas de Centroamérica. Proyecto específico Año I. Fortalecimiento institucional de MENMAGUA, borrador.

Ragin, C. C. (1989). New directions in comparative research. In Kohn M. (ed.), *Cross-National Research in Sociology.* Sage. Newbury Park, California, USA.

Ranis, G. (1997). Successes and failures of development experience since the 1980s. *Economic and Social Development into the XXI Century.* L. Emmerij (ed.). IDB. Washington, D.C., USA.

Rappoport, A. S. (1924). Dictionary of socialism. London, UK.

Ratinoff, L. (1999). Social-policy issues at the end of the 20th century. In Morales-Gómez, D. (ed.). *Trans-national Social Policies: The New Development Challenges of Globalization.* 43–65. Earthscan. London, UK.

Rayo, M. (1995). La descentralización y el sistema nacional de consejos de desarrollo urbano y rural. *I Foro Nacional de Descentralización,* SEGEPLAN/GTZ/CIEN. Guatemala.

Ricoeur, P. (1981). Hermeneutics and the human sciences. Cambridge University Press. Cambridge, UK.

Rivera, M. (1995). América Central: experiencias innovadoras de participación ciudadana y gestión de gobierno local. FLACSO, Guatemala.

Roberts, L., Charles, H. F., Belyakdoumi, L., Cobey, R., Ondeko, M. and J. Jeys (2001). Mortality in Eastern Democratic Republic of the Congo: results from eleven mortality surveys. Bukavu/Kisangani: International Relief Committee. Geneva, Switzerland.

Robinson, R. (1999). The US experience: evidence on managed care and lessons for Latin America. Paper presented at a conference on Reforming Latin American Healthcare Systems. September 15-16. LSE. London, UK.

Rodwell, M. K. (1987). Naturalistic inquiry: an alternative model for social work assessment. *Social Service Review*. 61, 231-246.

Rosada, H. (1987). Indios y ladinos. Editorial Universitaria, USAC. Guatemala.

Saiegh, S. and M. Tommasi (1999). An “Incomplete contracts” approach to inter-governmental transfer systems in Latin America. *Paper for the Annual World Bank Conference on Development in Latin America and the Caribbean*: *Decentralisation and Accountability of the Public Sector*. June 20-22, Valdivia, Chile.

Samayoa Urrea, O. (2003). La productividad y el empleo agrícola y no agrícola en área rural. *Cuadernos de Desarrollo Humano*. SNU-Guatemala. Guatemala.

Sánchez, A. (2000). La práctica de la reforma del sector salud (RSS) en Guatemala. Centro para el Desarrollo Estratégico en Salud. Disertación de Maestría. Universidad Católica de Lovaina. Lovaina, Bélgica.

Sartorius, R. (1998). Participatory monitoring and evaluation systems: improving programme performance while building capacity of partner institutions. *American Evaluation Association Annual Meeting.* Chicago, USA.

Schacter, M. (2000). 'Capacity building': A new way of doing business for development assistance organisations. *Policy Brief No. 6,* January. Institute on Governance. Ottawa, Canada.

Schirmer, J. (1999). Las intimidades del proyecto político de los militares en Guatemala. FLACSO. Guatemala.

Schofield, N. (1993). Political economy: institutions, competition and representation (co-edited with W., Barnett, and M., Hinich). *Proceedings of the Seventh International Symposium in Economic Theory and Econometrics Series: International Symposia in Economic Theory and Econometrics (No. 7).* Cambridge University Press. Cambridge, Massachusetts, USA.

SCPCD –Seminario Cultura de Paz y Consolidación de la Democracia (2001). *Publicación sobre el 1er Seminario Cultura de Paz y Consolidación de la Democracia; realizado el 26-27 de Octubre del 2000 en Guatemala.* Editores Siglo Veintiuno. Febrero, Guatemala.

SEGEPLAN/GSP – Secretaría General de Planificación/Gabinete Social de la Presidencia de Guatemala (1996). Programa Nacional para la Paz y el Desarrollo. Plan de Acción 1996 - 2000". Guatemala.

Shah, A. (1998). Balance, accountability, and responsiveness : lessons about decentralization. *Policy Research Working Paper Series 2021.* The World Bank. Washington D.C., USA.

Shepherd, A. (1999). Evaluation of DFID support to poverty reduction. *Paper presented at a conference on Evaluation and Poverty Reduction.* June 14-15. Washington D.C., USA.

Sieder, R. (1996). El derecho consuetudinario y la transición democrática en Guatemala, Instituto de Estudios Latinoamericanos/Universidad de Londres. FLACSO-Guatemala, Guatemala.

Sieder, R. (1997). Reframing citizenship: indigenous rights, local power and the peace process. *Accord Series. Wilson, R. (ed.). Negotiating Rights: The Guatemalan Peace Process.* London, UK.

Sieder, R., Thomas, M., Vickers, G. and J. Spence (2002). Who governs? Guatemala five years after the peace accords. Hemisphere Initiatives. Cambridge, Massachusetts, USA.

Sismondo, S. (1993). Some social constructions. *Social Studies of Science 23,* 515-553.

Skocpol, T. (1984). Vision and method in historical sociology. Cambridge University Press. New York, USA, and Cambridge, UK.

Slater, D. (1989). Territorial power and the peripheral state: the issues of decentralisation. *Development and Change*. 20, 501-531.

Smith, J. (1984). The problem of criteria for judging interpretive inquiry. *Educational Evaluation* and *Policy Analysis*. 6, 379-391.

Solares, J. (1995). Derechos humanos desde la perspectiva indígena en Guatemala. FLACSO. Guatemala.

Solórzano, M. (1987). Centroamérica, democracias de fachada. *Guatemala, autoritarismo y democracia*, FLACSO-EDUCA, San José, Costa Rica.

Spiegelberg, H. (1982). The phenomenological movement: a historical introduction. Martinus Nijhoff. The Hague, the Netherlands.

Stallings, B. (1992). International influence in economic policy: debt, stabilization and economic reform. In Haggard S. and R. Kaufman (ed.). *The Politics of Economic Adjustment*. Princeton University Press, New Jersey, USA.

Stein, A. and B. Russett (1980). Evaluating war: outcomes and consequences. *Handbook of Political Conflict*. Gurr, T. R. (ed.) Free Press. New York, USA.

Stewart, F. (1993). War and underdevelopment: can economic analysis help reduce the costs? *Journal of International Development,* 5 (4), 357–80.

Stewart, F. (2000). Crisis prevention: tackling horizontal inequalities. *Oxford Development Studies* 28(3), 245–262.

Stover, C. and G. Rosenthal (1997). Health financing, health sector delivery. *Paper presented in the 125th Annual Meeting of the American Public Health Association*. November.

Summerfield, D. (1997). The social, cultural and political dimensions of contemporary war. *Medicine, Conflict and Survival.* January-March*,* 13 (1), 3-25.
Suzumura, K. (1999). Consequences, opportunities and procedures. *Social Choice and Welfare,* 16: 17-40.

Tanzi, V. (1995). Decentralisation: good results aren't automatic. World Bank. Washington D.C., USA.

Theodore, A. (1950).The authoritarian personality. Harper and Row. New York, USA.

Thomas, M. (1998). Corruption and political finance in Africa. *PREM Seminar Series.* World Bank. Washington, D.C., USA.

Thomas, M. (1999). The incentive structure of systemic corruption. *Working Paper*. World Bank. Washington, D.C., USA.

Thorbecke, E. (1999). Evaluation of poverty alleviation impact of alternative development strategies and adjustment responses in Africa and Asia. *Paper presented at the fifth annual conference on Development in Latin America and the Caribbean. Decentralisation and Accountability of the Public Sector.* June 20-22. World Bank. Valdivia, Chile.

Tikare, S., Youssef, D., Donnelly-Roark, P. and P. Shah (2001). Organizing participatory processes in the PRSP. *PRSP Sourcebook.* World Bank, Washington D.C., USA.

Toole, M. J. (1997). Complex Emergencies: Refugee and Other Populations. In Noji, E. (ed.) *The Public Health Consequences of Disasters*. Oxford University Press. New York, USA.

Torres-Rivas, E. (2000). La metáfora de una sociedad que se castiga a si misma, en Guatemala; Causas y Orígenes del Enfrentamiento Armado Interno. CEH/FG. Guatemala.

Traum, A. and P. Dillenbourg (1996). Miscommunication in Multi-modal Collaboration, *In working notes of the AAAI Workshop on Detecting, Repairing, And Preventing Human--Machine Miscommunication*. 37-46.

UNDP – United Nations Development Project (1999). Decentralized Governance Monograph: A Global Sampling of Experience. September. New York, USA.

UNDP/HDR – United Nations Development Project/Human Development Report (1993). Human Development Report: People's Participation. New York, USA.

USAID/JHPIEGO – Agencia de los Estados Unidos para el Desarrollo Internacional/Universidad de Johns Hopkins (2000). Monitoreo y evaluación del rendimiento. USAID, Guatemala.

Van Dijk, T. A. (1985). Handbook of discourse analysis. I. Disciplines of discourse. II. Dimensions of discourse. III. Discourse and dialogue. IV. Discourse analysis in society. (4 Vols). Academic Press. London, UK.

Van Dijk, T. A. (ed.). (1997). Discourse as social interaction: Discourse studies: A multidisciplinary introduction. *2.* Sage Publications. Thousand Oaks, California, USA.

Villagrán, K. F. (1993). Biografía política de Guatemala. FLACSO, Guatemala.

Von Hoegen, M. (1990). La organización comunitaria en Guatemala. Apuntes y reflexiones. ASIES, Guatemala.

Von Hoegen, M. (1993). El proceso de descentralización: el caso de Guatemala. *Contribuciones, CIELA*, (40).

Wainwright, D. (1997) "Can sociological research be qualitative, critical and valid?" *The Qualitative Report.* 3, 2.

Walt, G. (1995). Análisis de política: un acercamiento. En Janovsky, K. (Ed.). *Política de Salud y Desarrollo de los Sistemas: Una Agenda para la Investigación.* OMS, Ginebra, Suiza.

Walt, G. (1998). Health policy: an introduction to process and power. Zed Books. London, UK.

WB – World Bank (1999). Development effectiveness in health, nutrition and population. Washington D.C., USA.

WB – World Bank (2000). Comprehensive development framework report on country experience: March 1999 - July 2000. Washington D.C., USA.

WB – World Bank (2001a). Poverty reduction strategy papers sourcebook. Preface, draft for comments. [On line July 2002] http://www.worldbank.org/poverty/ strategies/chapters/preface/prefa618. pdf

WB – World Bank (2001b). Grouping of HIPCs under the enhanced HIPC initiative: status as of December 2001. [On line July 2002] http://www.worldbank.org/hipc/ progress-to-date/Grouping_December.pdf

WB – World Bank (2002). Country health profile. WB. Washington D.C., USA.

WB, ED1, 2004 and 2001 – World Bank Electronic Website (2004 and 2001). What, why and where: *rationale of decentralisation and different kinds of decentralisation and the other electronic links available on the related sub-topics.* Washington D.C., USA. [On line April 2004 and May 2001]. Current web address as follows: http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPUBLICSECTORANDGOVERNANCE/EXTDSRE/0,,contentMDK:20246045~menuPK:509216~pagePK:210058~piPK:210062~theSitePK:390243,00.html
Former electronic web adresses in 2001 were separated as follows:
www1.worldbank.org/ public sector/decentralization/different.htm and
www.1worldbank.org /publicsector/decentralization/ rationale.htm

Weisbrot, M. (2002). Failure in developing world. *International Herald Tribune,* 7 August. UK

WHO – World Health Organisation (1948). *Definition of the concept of health*. agency's charter. Geneva, Switzerland.

WHO – World Health Organisation (2000). The world health report 2000: health systems: improving performance. Geneva, Switzerland.

Wolcott, H. F. (1994). Transforming qualitative data: description, analysis, and interpretation. Sage. Thousand Oaks, California, USA.

Workman, D. (1997). Decentralisation in Brazil: case studies of healthcare and primary education. Austin: University of Texas at Austin. Lyndon B. Johnson School of Public Affairs.

Wunsch, J. S. and Olowu, D. (1996/97). Regime transformation from below: decentralization, local governance , and democratic re form in Nigeria. *Studies in Comparative International Development* 31(4), 66-82.

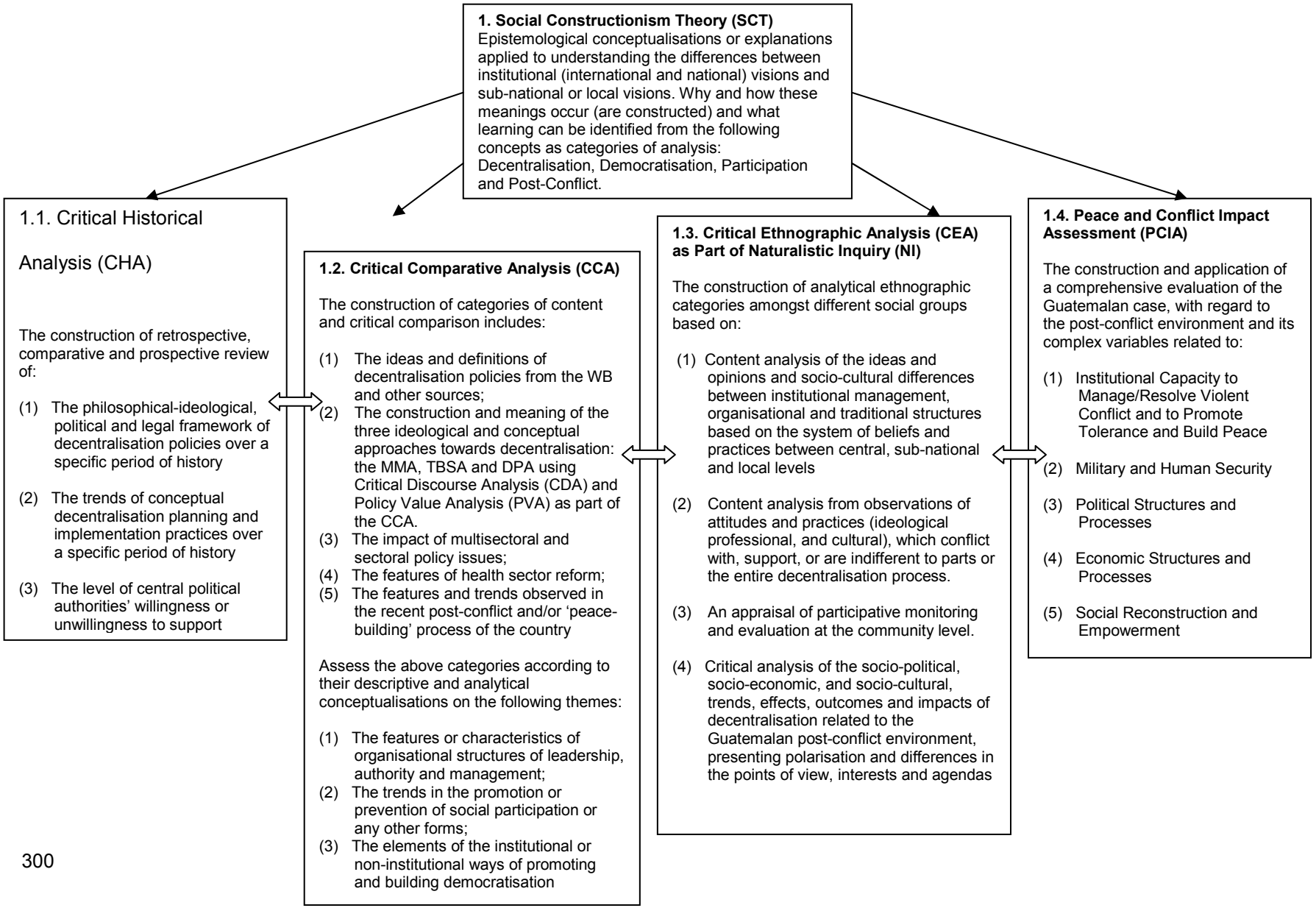
Zepeda López, R., López, C. and S. M. García (2004). Las prácticas y percepciones del recurso de la violencia en Guatemala. Proyecto de Cultura de Paz/UNESCO. Guatemala.

Zwi, A., Fustukian S. and D. Sethi (2002). Globalisation, conflict and the humanitarian response. In Lee, K., Buse, K. and S. Fustukian (eds.). *Health Policy in a Globalising World* Cambridge University Press. 229-247. Cambridge, UK.

Zwi, A. (1991). Militarism, militarization, health and the third world. *Medicine and War.* Oct-Dec. 7 (4), 262-268.

Zwi A. and A. Ugalde (1989). Towards an epidemiology of political violence in the third world. *Social Science and Medicine.* 28 (7), 633-642.

APPENDIX 1: Diagram of the Theory and its Methodologies



APPENDIX 2

The Three Ideological and Conceptual Approaches and Content Relationships with the Definitions of Decentralisation

This appendix shows some methodological examples using Critical Discourse Analysis and Policy Value Analysis to assess the ideological and conceptual approaches towards decentralisation analysed in Chapter III (MMA, TBSA and DPA). Also, the relationship between these approaches and the definitions of decentralisation with regard to: (1) policy/planning ideological vision and contents; (2) economic/administrative vision and contents; and, (3) institutional/cultural vision and contents. Using Critical Discourse Analysis (CDA) (Van Dijk, 1997 and 1985) and Policy Value Analysis (PVA) (Walt, 1998 and 1995), categories of content are shaped based on the analytical review of the rationale, knowledge, meaning and contents of the three general approaches towards decentralisation in this research: the market mechanism approach, the techno-bureaucratic approach and the democratic participative approach. The categories of content are assumptions, which were validated through the following methodological steps:

First, the analysis of the rhetorical contents or meanings underlined in the three approaches towards decentralisation, in order to determine the degree of validity of the three models as abstractions elaborated by myself, and their aims, goals and outcomes.

Second, based on those assumptions a value scale with adjectives belonging to each of the aims, goals and outcomes are abstractly constructed and contrasted with the definitions of the approaches and of the concepts of decentralisation (some examples are shown in the tables below).

Third, once adjectives of the value scale qualifying the contents regarding intentions, potentialities, actions and values of the aims, goals and outcomes sought by each approach are valued and determined, they are employed as a set of indicators of content to try to measure the ideological conceptual tendencies within the discourse of the definitions either of the approaches and the concepts of decentralisation (examples are shown in the tables below).

Fourth, the categories/indicators of content which are determined in their extension by parameters of content are grounded and compared, by contrasting them, their meaning and contextualisation regarding the information data (discourses) analysed through a retrospective (historical) and prospective (current) analysis using the primary and secondary information resources collected (some examples presented in the tables below).

Fifth, analytical questions (already completed for this research and presented in Chapter 1) are applied, to establish the process of comparison through the categories of significance defining the rationale, the vision(s), conceptualisation, reviewing group and individual statements, law, norms and other kinds of chosen or selected written and analytic resources ((some examples presented in the tables below).

Sixth, the content indicators determined below are also contrasted and compared by a group of relational indicators, measuring the ideological representation whether they are considered conceptually related or not to any of the three general

approaches. Likewise, they are also contrasted and compared by a group of situational indicators based on the identified stage of evolution of decentralisation, whether they belong to or not, to either approach. Also, whether the policy values and judgments are valid or not, they have to be modified and re-determined by critically analysing their meaning, contrasting them and seeking their particularities in the contextual examination (see examples in the tables below).

Also, a set of Relational Indicators is established as part of the Content Indicators (see tables below), which can be polyvalent (related to more than one approach and with more than one meaning). The indicators are presented with the following assumptions:

Directly related to one, two or three approaches if at least, half of the total amount of indicators is related to one or more approaches.

Relatively related to one, two or three approaches if at least, one third of the total amount of indicators is related to one or more approaches.

Scarcely related to one, two or three approaches if less than a third or none of the total amount of indicators is related to one or more approaches.

Content Value Indicators as ultimate aims through implementation policies:

Policy Values content with regard to Decentralisation as Market Mechanism refers to deconcentration, delegation, devolution, and appropriation categories developed through macro-economic changes and the market.

Policy values content with regard to Decentralisation as Techno-Bureaucratic System refers to deconcentration, delegation, devolution, and appropriation categories developed through formal rationale and knowledge.

Policy Values content with regard to Decentralisation as Democratic Participative Process refers to deconcentration, delegation, devolution, appropriation and ownership categories developed through democratisation and empowerment.

Interpretation Table Analysis

Analysis Broken Down by Columns

First, simplification and juxtaposition of words, phrases, clauses and sentences, considered directly (black italics column 1) associated to the ideological contents of the three approaches based in the analysis of their definitions. Through CDA an elaboration of the indicators of content regarding the Market Mechanism, Techno-bureaucratic, Democratic Participative Approaches towards Decentralisation

Second, definition of indicators according to their number based on the conceptual analysis of the vision(s), trend(s), objective(s), result(s), part(s) or element(s), and policy value(s) (column 2) of the content of the three approaches through CDA.

Third, determination of rhetorical/ideological content of the lines of thought between the three approaches towards decentralisation and the definitions of decentralisation through Policy Value analysis.

English Language Figures Used

Metaphor (MET): an expression in which the person, action or thing referred to is described as if it really were, what it merely resembles, as when a rejection is referred to as slap in the face; such expression in general, or their use.

Simile (SIM): Any phrase in which a thing is described by being likened to something, usually using 'as' or 'like' as in 'eyes sparkling like diamonds'.

Synecdoche (SYN): A figure of speech in which a part of something is used to refer to or denote the whole thing, or the whole to refer to or denote a part (for example wiser heads meaning wiser people).

Oxymoron (OXY): A figure of speech in which contradictory terms are used together.

Anecdote (ANE): A short, interesting and usually amusing account of an incident.

Hyperbole (HYP): The use of an overstatement or exaggeration to produce an effect.

Other analytical tools used by CDA are:

Negative or Positive Statement: judgement on the contents or meanings of a statement according to a set of values, the analysis of its content or the kind of evidence present in favour or against it.

Euphemism: mild or inoffensive term used in place of one considered offensive or unpleasantly direct.

Metaphorical or Direct Blame: subtle or overt meaning or judgment of a statement over its negative connotation, responsibility for causing undesirable effects or results.

Number Games: description of the manipulation of statistical information, to justify a statement with or as part of evidence presented to be considered valid or true.

Disclaimers: the denial of any negative implications of a meaning in a statement, action, and outcome.

Repetition: emphasis or over-emphasis in certain words, characteristics, elements or parts of something being described or analysed.

Association: direct or indirect links of between words, characteristics, elements or parts being described, whose meaning is explicitly or implicitly understood.

Some samples of the CDA analysis appear below in brackets using the above language figures as part of the categories of discourse for such assessment of the three conceptual approaches.

CDA of the Three Conceptual Approaches toward Decentralisation
The Conceptualisation of the Market Mechanism Approach (MMA)

1. *The concept of market mechanism comes from the idea of 'mean or instrument', used to allow or directed to a determined objective or aim in order to establish, enhance or expand a kind of market element or structure.* (SIM)

2. Therefore, *the market has its direct and indirect means (mechanisms) to recreate* its *exchange* structure and nature of *reproduction.* (SIM)

3. Furthermore, *the market mechanism is directed to building-up the necessary space(s) in order to install and operate itself, together with other groups of mechanisms,* in a sequential or random way that enable a feedback and loop cycle of *market features and economic and conceptual values (composition, growth, expansion, exclusion, integration, advantages, opportunities, profitability, and competitiveness).* (Adjetivisation, qualification of features as market values)

4. According to Rattinoff (1999:44-45), this kind of post-modern utopianism[9], *appears to expand* the scope and depth of equity concerns with a host of complimentary public policies and programmes, while *free-market ideology reduces social policies to a residual role.* (MET)

5. *Class-conflict* issues, apparently are *replaced by pragmatic economic-efficiency concerns*, and enlarged consumption *as the more real and effective political pacifiers* (social compensators). (MET)

6. *The rationale to implant a decentralisation process* through a MMA *begins with neo-liberal policies and conceptualisations targeting productivity levels and low-income groups, improving economic efficiency and allocation procedures and, cutting most or all public expenditures.* (Negative Statement) (Direct Blame)

7. Also, there is an attempt *to involve the local levels* of management through the improvement of their managerial skills, in order *to deliver better quality of services* at the *local and community levels.* (Positive Statement) (Euphemism of ideological Value)

8. Key concepts are *free market and privatisation* in order to *reduce government intervention in the service sectors* (Workman, 1997; and Barnum et. al., 1995). (Direct Blame) (Euphemism of ideological Value)

9. The impetus then, for this change may be *to streamline services, to make decisions faster and more relevant,* based on *cost-benefit assumptions* and, *to*

[9] The cornerstone of post-modernisation utopia is the idea that improved competitiveness reduces the risks of an open economy and expands opportunities for material progress, regardless of initial inequalities. Utopian discourse emphasises the role of a sequential evolution requiring an increasing supply of adequate human capital and the development of social and political capacities for decentralised co-ordination based on trust and democratic decision-making.

attract and increase the number of costumers with the provision *of more operative and efficient services*. (Positive Statement) (Euphemism of ideological Value)

10. *The implementation policies conceive decentralisation as a mechanism used for re-structuring public social services.* (Positive Statement) (Euphemism of ideological Value)

11. *Privatisation transforms social services from being paternalistic, duplicated, and inefficient to specialised, competitive and efficient, with increasing demand (IMF, 1998)*. (HYP) (Positive Statement)

12. *The private sector has a predominant role in this type of decentralisation*, which *can occur independently, parallel to or also in agreement with the government as an initiative* or *as a reinforcement policy.* (Positive Statement) (Euphemism of ideological Value)

13. *It may even inspire, the public sector for a progressive transference of services* under a loosely or a tight *set of regulations to be follow-up* (Litvack et. al., 1998; Ranis, 1997; and Tanzi, 1995). (Positive Statement) (Euphemism of ideological Value)

The Conceptualisation of the Techno-Bureaucratic Approach (TBSA)

1. Thus, taking in account the approach above, the approximated definition of *techno-bureaucracy* (using the theoretical framework of Sociology of Organisation), *is that it is related to the types of organisational networks in which, the role of specialised expertise is underpinned and emphasised.* (Positive Statement) (Euphemism of ideological Value)

2 .Within those social and cultural descriptive characteristics, such a conception typically draws a contrast between two forms of authority namely, *a bureaucratic authority* (typical or traditional[10]), which *derives from* the occupation of a position of office within a *hierarchical structure*, and from *the powers that reside in the office.* (Positive Statement) (Euphemism of ideological Value)

3. And also a *status authority,* which *derives from expertise*, which resides in the individual as *an authority based on* the *level of knowledge* and *experience* either in *formal or non-formal recognisable terms* (such as academic and *technical background* or years of *working experience* in determined theme or field, *political connections* and networks, and *corporative culture*). (Positive Statement) (Euphemism of ideological Value)

4. Hence, it is not just in regard to the *overall formal given position* within a *given organisation*, but the *perception of authority* by others in a given work environment as well. (Positive/Negative Statement) (Euphemism of ideological Value)

5. Another important feature about *the techno-bureaucracies composition and functional roles* is, their historical development and *expanding importance in designing, implementing, directing and monitoring of macro-policies at the*

[10] Typical refers to an authority given legally by written law, rules or norms, also by political positioning among groups. Traditional refers to an authority given by customs or traditions. Written records on when the command or direction was obtained or awarded hardly exist.

international and national levels worldwide. (Positive Statement) (Euphemism of ideological Value)

6. Also, *techno-bureaucracies are exerting* their *leverage and power influence* mainly from financial and development international institutions and agencies, national institutions and organisations as well as *from public sector entities* increasingly linked. (Positive/Negative Statement) (Euphemism of ideological Value)

7. Hence, the tendencies amongst *international bureaucracies are, to work through traditional hierarchical lines of authority, and also* to the creation and strengthening of *national of international exchange networks of technical expertise over determined fields.* (Association with Authority) (Negative Statement) (Euphemism of ideological Value) (Direct Blame)

8. These networks *exert authority directly or indirectly* according to the *institutional* and *power-knowledge levels* perceived and recognised within these *networks* within an *array of sectoral departments and sections,* which simultaneously reproduce the same patterns in their own micro-cosmos. (Direct Blame) (Associations of Authority) (Repetition)

9. The rationale *to systematise a decentralisation process* through a TBSA begins, with *increasing efficiency, cost-effectiveness and programme performance.* (HYP) (Association with Authority)

10. However, *decentralisation is used as a deconcentration system under central control or regulation, not partially driven by the private sector or the free-market mechanisms.* (Disclaimer) (Association with Authority) (Repetition)

11. *It is also expected to improve inter-sectoral co-ordination and promote community participation to some extent.* (Positive Statement) (Euphemism of ideological Value) (Metaphorical Blame)

12. Certain aspects of *policy-making and implementation procedures* are transferred from direct *central control to regional and local controls* (Grebe, 1996). (Association with Authority) (Repetition)

13. However, most of the time the *central government maintains or even increases normative and regulatory controls.* (Association with Authority) (Repetition)

14. Although *decentralisation may be initiated with the best of intentions,* under this approach towards *decentralisation*, it may take many years to develop the skills of and support at the *central and field levels* before these objectives are clearly achieved (Kolehmainen, 1998; and Aitken, 1997). (Negative Statement) (Direct Blame) (Repetition)

The Conceptualisation of the Democratic Participative Approach (DPA)

1. The meanings of the words participation, devolution and appropriation as some main analytical epistemological categories according to the dynamics and components of a more *community base model of decentralisation* and its values and meanings stated above. (Positive Statement) (Euphemism of ideological Value)

2. It is possible through this theoretical approach, to determine and define some important conceptual values from those analytical categories underlying in the composition of the model. (Positive Statement) (Euphemism of ideological Value) (Repetition)

3. It is also possible to initially assess and categorise the value, meanings and the roles of *individuals and their communities in the decision-making processes*, the receptive compromise of devolution and the participative and responsible appropriation in *seeking a more democratic development at the local and community level* can be assessed as well as to be defined and shaped below (Shah, 1998; and Baer, 1997). (HYP) (Positive Statement) (Euphemism of ideological Value)

4. The ideological vision and/or scope will accept as more factual and equivalent categorisation the concept of ownership or possession of certain assets or the means to act and to have influence in *a market space but in other realms of the community life, assets are more collectively shared and/or usufructed.* (Negative/Positive Statement) (Direct and Metaphorical Blame)

5. The act of appropriation is more a fact of property, obligations, concessions and rights through a traditional value system in customary terms within *a decentralisation framework* in this case, and between government and organisation, and groups (Dillenger et.al., 1999; Freire et. al., 1999; and Saiegh and Tommasi, 1999). (Association with Authority)

6. Thus on one hand, this ideological vision is mostly based on a non-elitist class representation or differentiation of *social structural conditions and status at the individual and collective levels (encompassing political and economic power and/or individual, institutional and corporative leverage).* (Positive Statement) (Euphemism of ideological Value)

7. But, it is more based on *the degree of inclusivity (participation and devolution and appropriation concepts of plurality, social/community wealth and shared financial resources about common or social services, organisational and institutional skills and political embeddedness)* (Evans, 1997). (Positive Statement) (Euphemism of ideological Value)

8. The rationale to establish a *decentralisation process* through a DPA begins with the understanding of the *relationships between macro-economic and micro-economic planning policies, central and peripheral management and organisational structures and networks* trying to work together (such as structural adjustment policies and their influence and impact on regional and local economic and socio-cultural circumstances and problems). (Positive Statement) (Euphemism of ideological Value)

9. This framework *also embeds and overlaps international and national sectoral policies with other related policies.* (Association with Authority)

10. Therefore it can assess several keys elements which are taking place according to the progress of the decentralisation process: *institutional and non-institutional decision making processes, individual and collective will that exists to boost or constrain the decentralisation process.* (Positive Statement) (Euphemism of ideological Value)

11. Also it includes the formulation and analysis of clear goals and objectives, defining the boundaries between *the functions controlled by central-level managers and those controlled by their diverse field-level counter-parts.* (Positive Statement) (Euphemism of ideological Value)

12. *In a participative and more democratic way this approach towards decentralisation defines* the most practical and strategic procedures to build local level capacity by providing technical and material support to field staff and other civil organisations and population in general, as *an initial stage to progressive appropriation of policies, resources and procedures at the local level.* (Positive Statement) (Euphemism of ideological Value) (Repetition)

PVA of the Three Conceptual Approaches toward Decentralisation

1. Market Mechanism Approach towards Decentralisation (MMA)

Visions, trends, objectives, results, sought as positive and ultimate aims (based on assumptions and suppositions) as indicators/policy values validated are (see also tables below):

1.1. Private Management and Finance Purpose is Agreed and Vindicated
1.2. Delegated/Deregulated Services Provision is Granted and Encouraged
1.3. Passive Community Participation is Expected and Accepted
1.4. Service Fee Orientation is Justified and Aimed
1.5. Cost-Benefit M&E is Rationalised and Practiced
1.6. Cost-Efficiency is Justified and Standardised (1,2) (polyvalent)
1.7. Market Oriented/Competitive Environment is Visualised and Supported
1.8. Deregulated Expansion of Services is Demanded and Practiced
1.9. Profitable Focus on Health is Granted and Encouraged
1.10. Private Ownership is Assured and Sustained
1.11. Costumer Service Attention is Conceptualised and Practiced
1.12. Neo-Liberal/Globalising Support Policies is Identified and Promoted (1, 2) (polyvalent)
1.13. Controlled Exertion of Health Knowledge is Granted and Practiced
1.14. Deregulated Administration Procedures is Accepted and Practiced
1.15. High Quality Services is Expected and Visualised
1.16. Governmental intervention is Selective and Rejected

2. Techno-bureaucratic Approach towards Decentralisation (TBSA)

Visions, trends, objectives, results, sought as positive and ultimate aims (based on assumptions and suppositions) as indicators/policy values validated are (see also tables below):

2.1. Public Government and Finance is Granted and Demanded
2.2. Vertical Flow of Decisions is Accepted and Practiced (1,2) (polyvalent)
2.3. Developmentalist Focus (on Health) is Granted and Justified
2.4. Authoritarian/Formal Organisational Inter-action is Exerted and Consented
2.5. Centralised/Regulated Services Provision is Practiced and Reinforced
2.6. Dependency of Macro-Economic/ Growth Policies is Accepted and Justified
2.7. User/Basic Service Orientation is Planned and Developed
2.8. State or Mixed Ownership/Partnership of the Services is Promoted and Supported
2.9. Compartmentalised Practice of (Health) Knowledge is Formalised and Accepted
2.10. Sectarian/Segmented/Directed Perception of Participation is Practiced and Accepted
2.11. Institutional Accountability and Liability is Entitled and Exerted
2.12. Indirect Community Involvement in M&E Activities is Accepted and Stimulated

2.13. Use of External Material/Human Resources is Granted and Practiced
2.14. Direct Community or Local Intervention is Promoted and Visualised
2.15. Expectation of a Minimum Quality Services is Accepted and Aimed

3. Democratic Participative Approach towards Decentralisation (DPA)
Visions, trends, objectives, results, sought as positive and ultimate aims (based on assumptions and suppositions) as indicators/policy values validated are (see also tables below):
3.1. Autonomous/Local Financing and Management (Re)solutions are Promoted and Visualised
3.2. Active Participation in the Decision-Making Process is Encouraged and Sought
3.3. Consensual /Solidarity Organisational Inter-action is Promoted and Idealised
3.4. Egalitarian Perception of Participation is Promoted and Sought
3.5. Communitarianism/Pluralism in daily politics is Granted and Promoted
3.6. Socialised Exertion of (Health) Knowledge Promoted and Justified
3.7. Democratic/Non-Formal Authority is Promoted and Practiced
3.8. Horizontal Flow of Decisions is Emphasised and Granted
3.9. Collective/Organised/Self-empowered Perception of Participation is Promoted and Idealised
3.10. Institutional Liability and Social Accountability is Promoted and Encouraged
3.11. Beneficiary/Vital Human Service Orientation is Promoted and Planned
3.12. Local/Alternative/Traditional Focus on Health Promoted and Visualised
3.13. Use of Local Material/Human Resources Tendency Emphasised and Boosted
3.14. Direct Community Involvement in M&E Activities is Emphasised and Visualised
3.15. Expectation of Satisfactory and Self-Reliant Services Visualised and Promoted

Ideological Content Categories Obtained through Critical Discourse Analysis (CDA)	**Key Words/Content Indicators/Policy Values Sought Based on Rhetorical/ Ideological contents through Policy Value Analysis (PVA)**
Market Mechanism Approach (MMA) Phrases, Clauses and Sentences Analysed *1. The concept of market mechanism comes from the idea of 'mean or instrument', used to allow or directed to determined objective or aim in order to establish, enhance or expand a kind of market element or structure.* 1.1.Market Economy Orientation 1.2.Market Enhancement and Expansion Forces 2. …*The market has its direct and indirect means (mechanisms) to recreate… exchange… reproduction.* 2.1.Market exchange and reproducing features 2.2.Market Financial Investment 2.3.Market Private/Public Management Orientation 3. …*The market mechanism is directed to built-up the necessary space(s) in order to install and operate itself, together with other group of mechanisms… market features and economic and conceptual values* (*composition, growth, expansion, exclusion, integration, advantages, opportunities, profitability, competitiveness, etc*.). 3.1.Build-up Macro- economic space 3.2.Economic growth, 3.3.Economic Sectoral integration, 3.4.Political and Economic Opportunities, Advantages 3.5.Profitability of Service Offer 3.5.Competitiveness 4. …*Appears to expand, … free-market ideology reduces social policies to a residual role*. 4.1. Neo-liberal Globalising Policies Support 4.2. Economic Incentives for Investment and Participation 4.3. Privatisation and Delegation Policies on Social Services 5. *Class-conflict …replaced by pragmatic economic-efficiency concerns, … as the more real and effective political pacifiers*. 5.1.Cost-Effective Delivery Service Improvement	1.1. Private Management and Finance Purpose is Agreed and Vindicated 1.2. Delegated/Deregulated Services Provision is Granted and encouraged 1.3. Passive Community Participation is Expected and Accepted 1.4. Service Fee Orientation is Justified and Aimed 1.5. Cost-Benefit M&E is rationalised and Practiced 1.6. Cost-Efficiency is Justified and Standardised (1,2) (polyvalent) 1.7. Market Oriented/Competitive Environment is Visualised and Supported 1.8. Deregulated Expansion of Services is Demanded and Practiced 1.9. Profitable Focus on Health is Granted and Encouraged 1.10. Private Ownership is Assured and Sustained 1.11. Costumer Service Attention is Conceptualised and Practiced 1.12. Neo-Liberal/Globalising Support Policies is

5.2.Social and Economic Inequality Issues 6. *The rationale to implant a decentralisation process …begins, with neo-liberal policies and conceptualisations targeting productivity levels and low-income groups*, *improving economic efficiency and allocation procedures and*, *cutting most or all public expenditures*. 6.1. Cost-Benefit Rationale 6.2. Improvement of Financial and Administrative Resource Allocation 7. …*To involve the local levels… to deliver better quality of services …local and community levels*. 7.1. Quality Assurance on Service Delivery 7.2. Indirect Local Involvement or Costumer Participation 8. …*Free market and privatisation… reduce government intervention in the service sectors* 8.1. Limited Government Intervention in the Economy 8.2. Privatisation or Delegation of Services Sector 8.3. Deregulation of Administrative and Financial Management 9. …*To streamline services*, *to make decisions faster and more relevant … cost-benefit assumptions*, *… to attract and increase the number of costumers … of more operative and efficient services*. 9.1.Costumer Service Orientation 9.2.Service Fee Orientation 9.3.Competitiveness Developmentalist Environment 10. *The implementation policies conceive decentralisation as a mechanism used for re-structuring public social services*. 10.1. Public Sector Reform 10.2.Deconcentration or Des-Institutionalisation of Social and Economic Policies and Services 10.3.Delegation of Authority and Responsibilities to Other Social Sector 10.4.Deregulation of Government Public Control10.5.Devolution to Private Ownership and Appropriation 11. *Privatisation transforms social services from being paternalistic, duplicated, and inefficient to specialised, competitive and efficient, with increasing demand…* 11.1. Privatisation Stages and Path 11.2. Specialisation on Service Deliver or Offer 11.3. Creation or Openness of Service Demand Strategy	Identified and Promoted (1,2) (polyvalent) 1.13. Controlled Exertion of Health Knowledge is Granted and Practiced 1.14. Deregulated Administration Procedures is Accepted and Practiced 1.15. High Quality Services is Expected and Visualised 1.16. Governmental intervention is Selective and Rejected

12.*The private sector has a predominant role in this type of decentralisation … can occur independently, parallel to or also in agreement with the government as an initiative … as a reinforcement policy*. 12.1. Predominance of Private Service Delivery 12.2. Private Sector Full Decision Making Participation 13. *It may even inspire, the public sector for a progressive transference of services … set of regulations to be follow-up …* 13.1. Private Service Market Shift and Joint Ventures 13.2. Sector Mobility according to Market expansion ***Market Mechanism Approach***: Initial Key Words/Indicators: Privatisation, Entrepreneurial Management, Private or Mixture of Finances, Profitability, Delegation, Macro-economic and Growth Delegation, Deregulation, Services Offer, Customer Participation, Limited Government intervention, Service Fee Orientation, Cost-Benefit Rationale, Cost-Efficiency approach, Market Orientation and Forces, Expansion, Private or Individual Ownership, Profitability, Costumer Service Attention, Neo-Liberal and globalisation, Support and Justification Policies, Controlled Exertion of Health Knowledge, Deregulated Administration and Supervision, Quality Assurance Services. **Key Words/Indicators/policy values and Rhetorical/Ideological content:** Private Management and Finance Purpose is Agreed and Vindicated Delegated/Deregulated Services Provision is Granted and encouraged Passive Community Participation is Expected and Accepted Service Fee Orientation is Justified and Aimed Cost-Benefit M&E is rationalised and Practiced Cost-Efficiency is Justified and Standardised (1,2) (polyvalent) Market Oriented/Competitive Environment is Visualised and Supported Deregulated Expansion of Services is Demanded and Practiced Profitable Focus on Health is Granted and Encouraged Private Ownership is Assured and Sustained Costumer Service Attention is Conceptualised and Practiced Neo-Liberal/Globalising Support Policies is Identified and Promoted (1,2) (polyvalent) Controlled Exertion of Health Knowledge is Granted and Practiced Deregulated Administration Procedures is Accepted and Practiced High Quality Services is Expected and Visualised Governmental intervention is Selective and Rejected	

Techno-Bureaucratic Approach (TBSA) Phrases, Clauses and Sentences Analysed 1. *The definition of techno-bureaucracy … [within] (the Sociology of Organisation framework)… it is related to the types of organisational networks in which, the role of specialised expertise*[11] *is underpinned and emphasised*… 1.1.Organisational Structuralism 1.2.Technical Experience Approach 2. …*Such a conception…draws a contrast between two forms of authority namely, a bureaucratic authority (typical or traditional*[12]*), which derives from the occupation of a position of office within a hierarchical structure, … and from the powers that reside in the office*. 2.1.Verticalist Decision-Making Processes 2.2.Hierachical Responsibilities and Functions 3. …*Also a status authority*, *which derives from expertise*, … *as an authority based on the level of knowledge and experiences …either in formal or non-formal recognisable terms (i.e. academic and technical background or years of working experience in determined theme or field, political connections and networks, corporative culture, etc)*. 3.1.Compartmentalisation of Knowledge 3.2. Behavioural Institutionalism 4. …*It is not just in regard to the overall formal given position within a given organisation, but the perception of authority by others in a given work environment as well.* 4.1.Autoritarianist Practices and relationships 4.2.Subordination and co-optation 5. …*The techno-bureaucracies…functional roles [are], their historical development and expanding importance in designing, implementing, directing and monitoring …macro-policies at the international and national levels worldwide*. 5.1.Regulated Macro and Growth Policies 5.2.Dependency Planning and Implementation procedures 6. …*Techno-bureaucracies are exerting their leverage and power influence mainly from financial and development international… national institutions…increasingly linked.*	2.1. Public Government and Finance is Granted and Demanded 2.2. Vertical Flow of Decisions is Accepted and Practiced (1,2) (polyvalent) 2.3. Developmentalist Focus on Health is Granted and Justified 2.4. Authoritarian/Formal Structural Organisational Inter-action is Exerted and Consented 2.5. Centralised/Regulated Services Provision is Practiced and Reinforced 2.6. Dependency of Macro-Economic/ Growth Policies is Accepted and Justified 2.7. User/Basic Service Orientation is Planned and Developed 2.8. State or Mixed Ownership/Partnership of the Services is Promoted and Supported 2.9. Compartmentalised Practice of (Health) Knowledge is Formalised and Accepted 2.10. Sectarian/Segmented/Directed Perception of Participation is Practiced and Accepted 2.11. Institutional Accountability and Liability is Entitled and Exerted 2.12. Indirect Community Involvement in M&E

[11] Special skill and knowledge acquired upon experience, systematic study and professional development over time, put into a best effort for one particular activity or field of study or purpose, Chambers Dictionary (2000: 317, 871)

[12] Typical refers to an authority given legally by written law, rules or norms, also by political positioning among groups. Traditional refers to an authority given by customs or traditions, hardly exist written records of when the command or direction was obtained or awarded.

6.1. Corporative Institutionalised Interests 6.2. Institutionalised Paternalism 7. …*The tendencies amongst international bureaucracies are, to work through traditional hierarchical lines of authority, and also …national of international exchange networks of technical expertise over determined fields*. 7.1Formal Technical and Managerial Authority 7.2.Professional Sectarianism 8.*These networks exert authority directly or indirectly according to … institutional … power-knowledge levels perceived and recognised …within an array of sectoral departments and sections*, … 8.1.Segmentation in Professional and Social Participation 8.2.Sectoral and Inter-sectoral Boundaries 9. *The rationale to systematise a decentralisation process … increasing efficiency, cost-effectiveness and programme performance*. 9.1.Cost-Effective Service Provision Improvement 9.2.Cost-Efficiency rationale 10. …*Decentralisation is used as a deconcentration system under central control or regulation, not partially driven by the private sector or the free-market mechanisms.* 10.1.Centralised Authority 10.2.Normative and Regulated Control 11. *It is also expected to improve inter-sectoral co-ordination and promote community participation to some extent.* 11.1.Indirect Local Authority Involvement and Community Participation 11.2. Inter-sectoral Co-ordination and Partnership Activities 12. …*Policy-making and implementation procedures are transferred from direct central control to regional and local controls…* 12.1. Deconcentration and Delegation Procedures 12.2. Institutionalised Monitoring and Evaluation Activities 13(contents similar to paragraph 10) 14. …*Decentralisation may be initiated with the best of intentions; … it may take many years to develop the skills of and support at the central and field levels…* 14.1.Develomental Implementation Approach 14.2.External Physical and Human Resources Organisational Inputs	Activities is Accepted and Stimulated 2.13. Use of External Material/Human Resources is Granted and Practiced 2.14. Direct Community or Local Intervention is Promoted and Visualised 2.15. Expectation of a Minimum Quality Services is Accepted and Aimed

Techno-Bureaucratic Approach (TBSA) Initial Key Words/Indicators Public Government and Finances, Verticalism (Top-bottom Decisions), Hierarchical Responsibilities and Functions, Organisational Structuralism, Institutionalism, Developmentalist Focus, Technical Experience Approach, Authoritarianism, Subordination, Paternalism, Centralised Control, Service Provision Orientation, Regulated Macro-economic and Growth Policies, Dependency, User and Basic Service Orientation, State or Mixed Ownership, Partnership, Compartmentalisation of Knowledge, Sectarianism, Segmentation in Participation, Institutional Accountability, Sectoral and Inter-sectoral Boundaries, Institutionalised M&E, Indirect or Complementary Community Involvement, Formal Managerial and Administrative Authority, External Physical and Human Resources Organisational Inputs, Minimum Quality Services. Key Words/Indicators/policy values: **Key Words/Indicators/policy values and Rhetorical/Ideological content:** Public Government and Finance is Granted and Demanded Vertical Flow of Decisions is Accepted and Practiced (1,2) (polyvalent) Developmentalist Focus on Health is Granted and Justified Authoritarian/Formal Structural Organisational Inter-action is Exerted and Consented Centralised/Regulated Services Provision is Practiced and Reinforced Dependency of Macro-Economic/ Growth Policies is Accepted and Justified User/Basic Service Orientation is Planned and Developed State or Mixed Ownership/Partnership of the Services is Promoted and Supported Compartmentalised Practice of (Health) Knowledge is Formalised and Accepted Sectarian/Segmented/Directed Perception of Participation is Practiced and Accepted Institutional Accountability and Liability is Entitled and Exerted Indirect Community Involvement in M&E Activities is Accepted and Stimulated Use of External Material/Human Resources is Granted and Practiced Direct Community or Local Intervention is Promoted and Visualised Expectation of a Minimum Quality Services is Accepted and Aimed	
Democratic Participative Approach (DPA) Phrases, Clauses and Sentences Analysed 1. …*Participation, devolution and appropriation as some main analytical epistemological categories according to the dynamics and components of a more community base model of decentralisation and its values and meanings…*	3.1. Autonomous/Local Financing and Management Resources and Solutions are Promoted and Visualised 3.2. Active Participation in the Decision-Making Process is Encouraged and Sought 3.3. Consensual /Solidarian Organisational Inter-

1.1.Active Participation at different levels of the Decentralisation Process 1.2.Devolution of Authority and Responsibilities Locally 1.3.Appropriation of Policies Resources and Procedures at the local level. 2. (Contents defined in paragraph 3) 3. …*Individuals and their communities in the decision-making processes*, …*and the participative and responsible appropriation in seeking a more democratic development at the local and community level* … 3.1.Local Decision-Making Process 3.2.Democratic Development 3.3.Local Community Based Compromise or Approach 4. …*The concept of ownership or possession is important…a market space but in other realms of the community life assets are more collectively shared and/or usufructed.* 4.1.Collective Social Ownership 4.2.Community Management and/or Usufructed 5.*The act of appropriation is more a fact of property, obligations, concessions and rights through a traditional value system in customary terms within a decentralisation framework …between government and organisation, and groups…* 5.1.Collective and Sharing Responsibilities 5.2.Traditional and Consuetudinary Authority 6. …*Based on a not-elitist class representation or differentiation of social structural conditions and status at the individual and collective levels (encompassing political and economic power and/or individual, institutional and corporative leverage).* 6.1.Equalitarianism, 6.2.Communitarianism, 6.3.Horizontalism (Extended-Decision Process) 7. …*It is based on the degree of inclusivity (participation and devolution and appropriation concept of plurality, social/community wealth and shared financial resources about common or social services, organisational and institutional skills and the political embeddedness)* 7.1.Pluralism 7.2.Self-empowered Perception of Participation	action is Promoted and Idealised 3.4. Equalitarian Perception of Participation is Promoted and Sought 3.5. Communitarianism/Pluralism in daily politics is Granted and Promoted 3.6. Socialised Exertion of (Health) Knowledge Promoted and Justified 3.7. Democratic/Non-Formal Authority is Promoted and Practiced 3.8. Horizontal Flow of Decisions is Emphasised and Granted 3.9. Collective/Organised/Self-empowered Perception of Participation is Promoted and Idealised 3.10. Institutional Liability and Social Accountability is Promoted and Encouraged 3.11. Beneficiary/Vital Human Service Orientation is Promoted and Planned 3.12. Local/Alternative/Traditional Focus on Health Promoted and Visualised 3.13. Use of Local Material/Human Resources Tendency Emphasised and Boosted 3.14. Direct Community Involvement in M&E Activities is Emphasised and Visualised 3.15. Expectation of Satisfactory and Self-Reliant Services Visualised and Promoted

8.*The rationale …begins, relationships between macro-economic and micro-economic planning policies, central and peripheral management and organisational structures and networks trying to work together (i.e. structural adjustment policies and their influence and impact on regional and local economic and socio-cultural circumstances and problems).* 8.1.Institutional Liability and Social Accountability 8.2. Direct Tendency in Community Involvement in M&E Activities 9. …*Also [it embeds, and overlaps international and national sectoral policies with other related policies*. 9.1.Policies Resources and Procedures at the local level. 9.2.Institutionalised and Non-institutionalised Organisational Inter-action 10. …*Institutional and non-institutional decision-making processes, individual and collective will that exist to boost or constrain the decentralisation process*. 10.1. Socialised Knowledge 10.2. Expectation of Satisfactory and Self-Reliant Services 11. …*Defining the boundaries between the functions controlled by central-level managers and those controlled by their diverse field-level counter-parts.* 11.1.Collective/Organised/Self-empowered Perception of Participation 11.2. Beneficiary and Vital Human Service Orientation 12.*In a participative and more democratic way this approach towards decentralisation defines… to build local level capacity… technical and material support to field staff and other civil participating organisations and population in general, as an initial stage to progressive appropriation of policies, resources and procedures at the local level.* 12.1.Local Material/Human Resources Management 12.2. Local Financing and Administrative reliance ***Democratic Participative Approach (DPA)*** Initial Key Words/Indicators Autonomy, Local Consensual Authority, Non-Formal, Consuetudinary Responsibilities, Local Financing reliance, Local Allocation and expenditure Decision Process, Local Solving Problem Procedures, Active Local Participation and Decision-Making, Consensual Authority, Solidarity, Institutionalised and Non-institutionalised Organisational Inter-action, Equalitarianism, Horizontal Flow of Decisions, Communitarianism, Pluralism, Socialised Knowledge, Non-Formal or Consuetudinary Authority, Collective/Organised/Self-empowered Perception of Participation, Institutional Liability and Social Accountability, Beneficiary and Vital Human Service Orientation, Alternative Traditional Local Focus on Health Promotion, Local Material/Human Resources Management, Direct Tendency in Community Involvement in M&E Activities, Expectation of Satisfactory and Self-Reliant Services, Appropriation of Policies Resources and Procedures at the local level.	

Key Words/Indicators/policy values and Rhetorical/Ideological content: Autonomous/Local Financing and Management Resources and Solutions are Promoted and Visualised Active Participation in the Decision-Making Process is Encouraged and Sought Consensual /Solidarian Organisational Inter-action is Promoted and Idealised Equalitarian Perception of Participation is Promoted and Sought Communitarianism/Pluralism in daily politics is Granted and Promoted Socialised Exertion of (Health) Knowledge Promoted and Justified Democratic/Non-Formal Authority is Promoted and Practiced Horizontal Flow of Decisions is Emphasised and Granted Collective/Organised/Self-empowered Perception of Participation is Promoted and Idealised Institutional Liability and Social Accountability is Promoted and Encouraged Beneficiary/Vital Human Service Orientation is Promoted and Planned Local/Alternative/Traditional Focus on Health Promoted and Visualised Use of Local Material/Human Resources Tendency Emphasised and Boosted Direct Community Involvement in M&E Activities is Emphasised and Visualised Expectation of Satisfactory and Self-Reliant Services Visualised and Promoted	

Examples of Categorical Analysis of Decentralisation Definitions Based on Content Indicators
Decentralisation in Relation to MMA, TBSA and DPA Conceptual Approaches

Table No.1 First Definition of Decentralisation	
Interpretation of Some of Definitions of Decentralisation Through CDA Key Indicators	**CDA and PVA Content/Meaning Parameters as Indicators**
1.1. *Decentralisation*, as the term *is used* here, *refers to the process of devolving political, fiscal, and administrative powers to sub-national units of government* [3.1.]	**3.1. DPA: Autonomous/Local Financing and Administration & Management of Resources and Solutions are Promoted and Visualised** Identifies three levels of devolved powers encouraging participation in the process of decentralisation. Shift in power structures towards local forms where autonomy from central government is crucial in decisions about resourcing.
1.2. Although there are *many entry points and strategies for decentralization*, for purposes of this report, a country *is not considered to have decentralized unless it has a locally elected sub-national government* [3.7.]	**3.7. DPA: Democratic/Non-Formal Authority is Promoted and Practiced** Related to the indicator 3.5., and an outcome of the process overall this identifies importance of lower forms of government as institutions of devolved powers and distinguishes importance between tiers of government and organisation of authority among these. A wider variety of bodies become involved in decentralisation of resources, allocation and local priorities. Process of participative democracy links participation of the local population to determination of how resources are used within a framework of determining local priorities. Some authority is vested in para-statal organisations. Where it is delegated there is some interaction with central government in the delivery of its programme. This may superimpose local determination or it may be compatible to it. If the transfer of power is devolved, central government has 'limited' to 'no' input at the local level of decision-making. The degree of participation (non-formal authority) by the local population is expressed at varying levels depending on delegated versus devolved powers. Devolved powers should consider more democratic forms of local government.
1.3. Decentralisation may consist of bringing such governments into existence, restoring them after a period of *authoritarian rule*, or *expanding the resources or responsibilities of existing elected sub-national governments* [3.15.] [2.1., 2.2.] (WB, 1999).	**3.15. DPA: Expectation of Satisfactory and Self-Reliant Services Visualised and Promoted** Related to the indicator 3.14., in that, satisfaction with arrangements is integral to continued service delivery. This also implies that where satisfaction levels become depressed, then the services delivered should change to continue to meet expectations. Consistency in feedback and communication is implied in the relationship between the local population and the provider sectors. There is a vision towards democratisation although in the initial period of development governments may not have assumed democratic form. Characteristic of this form of development is autonomy of decision-making structures and consensus that these are appropriate for the local population. Decentralisation can be implemented in a variety of ways but the outcome is contingent upon some expectation of satisfaction. The idea of self-reliance is closely linked to a greater outcome for the local population. **2.1. TBSA: Public Government and Finance is Granted and Demanded** Central government continues providing resources for service provision although how these are disseminated at the local level will depend on the local structures in place. Transference of resources to lower levels of government is integral to the process. The idea of institution building is important to the concept of transference of resources and linked to other processes such as management and decision-making capacities. There is a need to ensure a finance framework

	through various means such as user charges and taxation. Under the techno-bureaucratic approach, through financial arrangements central government continues to exert control. **2.2. TBSA: Vertical Flow of Decisions is Accepted and Practiced** Definitions are placed under this category where there has been no substantial change to vertical decision-making in that, central government continues in its decision-making capacity. An institutional structure assumes a certain degree of bureaucracy and hierarchy. Not all decisions are made in consultation or in consensus with the local population. At some point, decision-making is transferred but the system relies on a degree of skill and knowledge. There is limited decentralisation in that there is no change in how and where decisions are made regarding strategic issues such as planning, policy and practice decisions.

Table No. 2 Second Definition of Decentralisation

Interpretation of Some of Definitions about Decentralisation Through CDA Key Indicators	**CDA Content/Meaning Parameters of CDA Key Indicators**
2.1.*Decentralisation is still a term in constant construction and definition due to different development experiences over time* [2.3]	**2.3. TBSA: Developmentalist Focus is Granted and Justified** Conceptual planning and implementation policies are thought of in sequential stages and stadiums of development, and a selective pre-conditions or requirements for the acceptance and validity of experiences as formal rationale in development. There is also a tendency of a verticalist direction and management of expertise knowledge between central decision-making groups and their counter-parts with little room for more active participation on the design and implementation of policies and practices at the local level. Some times, this scope can be paternalistic and limited, restrictive or discriminatory towards policy initiatives and innovative experiences.
2.2. Thus, one of the concepts that may better describe the meaning of decentralisation is being applied in the study of decentralisation in Brazil that "decentralisation *may occur for a wide variety of reasons, be implemented in a wide variety of ways,* and have *any of several possible consequences*. [3.7]	**3.7. DPA: Democratic/Non-Formal Authority is Promoted and Practiced** Related to the indicator 3.5., and an outcome of the process overall this identifies importance of lower forms of government as institutions of devolved powers and distinguishes importance between tiers of government and organisation of authority among these. A wider variety of bodies become involved in decentralisation of resources, allocation and local priorities. Process of participative democracy links participation of the local population to determination of how resources are used within a framework of determining local priorities. Some authority is vested in para-statal organisations. Where it is delegated there is some interaction with central government in the delivery of its programme. This may superimpose local determination or it may be compatible to it. If the transfer of power is devolved,

2.3.It can be understood as *an array of processes leading to the transference of resources and responsibilities* [planning, management, financial administration, decision making process, development of organisational structures etc.] *to lower levels of government*; *within the same, competing, or complementary institutions and entities* or it can be the result of isolated [and] or uncontrolled occurrences [2.1., 2.2., 2.4., 2.5.].	central government has 'limited' to 'no' input at the local level of decision-making. The degree of participation (non-formal authority) by the local population is expressed at varying levels depending on delegated versus devolved powers. Devolved powers should consider more democratic forms of local government. **2.1. TBSA: Public Government and Finance is Granted and Demanded** Central government continues providing resources for service provision although how these are disseminated at the local level will depend on the local structures in place. Transference of resources to lower levels of government is integral to the process. The idea of institution building is important to the concept of transference of resources and linked to other processes such as management and decision-making capacities. There is a need to ensure a finance framework through various means such as user charges and taxation. Under the techno-bureaucratic approach, through financial arrangements central government continues to exert control. **2.2. TBSA: Vertical Flow of Decisions is Accepted and Practiced (1,2) (polyvalent)** Definitions are placed under this category where there has been no substantial change to vertical decision-making in that, central government continues in its decision-making capacity. An institutional structure assumes a certain degree of bureaucracy and hierarchy. Not all decisions are made in consultation or in consensus with the local population. At some point, decision-making is transferred but the system relies on a degree of skill and knowledge. There is limited decentralisation in that there is no change in how and where decisions are made regarding strategic issues such as planning and policy and practice decisions. **2.4. TBSA: Authoritarian/Formal Structural Organisational Inter-action is Exerted and Consented** Definitions are placed under this category where functions and resource movement tend to be vertical that is, remain with the auspices of central government but may be delegated to other government bodies responding to central government. Local population input to decision-making is limited. The system continues to rely on the techno-bureaucratic state apparatus. Some of this is transferred along with resource transference as a part of the political culture, although, during the transfer experience it may assume a local political character. Decentralisation has an impact on power relations. The nature of these relations will depend on the amount of resources that are decentralised. There will be a measure of control where resources are limited. Techno-bureaucratic authority structures are preserved through formal re-organisation at the local level and may continue to be a reflection of and represent

2.4. It may also result in *fundamental changes in power relationships* [at the international, national and local levels] and *control over* [certain or] *limited resources* in society..." (Workman, 1997:6; parentheses are not in original). [2.8., 1.2., 1.13.]	the interests of central government locally. The bureaucratic machinery of government can be transferred to the local level but forms of decentralised power that are locally defined remain limited. **2.5. TBSA: Centralised/Regulated Services Provision is Practiced and Reinforced** Related to indicator 2.4., taxation implies some form of central control under a techno-bureaucratic approach linked to the mixed economy of provision. Where local structures are weak to generate finance, central government involvement is inevitable. **2.8. TBSA: State or Mixed Ownership/Partnership of the Services is Promoted and Supported** Definitions are placed under this category, which involve a mixed economy of provision that is provision through partnerships of varying degrees. Ideas about partnerships imply co-ordinated actions of a number of bodies and actions undertaken through a process of consensus. These are continuous processes and it directly impacts upon resource decisions. The transformational role of the state, as a part of the process implies distribution of responsibility and powers based on how partnerships are organised and aligned. **1.2. MMA: Delegated/Deregulated Services Provision is Granted and encouraged** Some aspect of service provision is delegated to other sectors – lower sectors of government, local government, private sector or NGOs and voluntary sectors. The relationship between delegation and regulation is not clearly defined. For instance, a service can be delegated from central government to local government but central government may retain a regulatory function. The scope of this function may change slightly if the service is delegated from central government to the private sector where market forces may be stronger regulators than central government regulatory mechanisms. Definitions are placed under this category when central government forms relationships with other sectors and these relationships are characterised by forms of power, resource and management transference from central government to other sectors or intervention by other sectors in central government. **1.13. MMA: Controlled Exertion of Health Knowledge is Granted and Practiced** There is some exchange of knowledge between the different sectors. Deregulation can be exercised in many ways and lead to privatisations. The level of deregulation is important to consider and this may be concentrated in administrative functions.

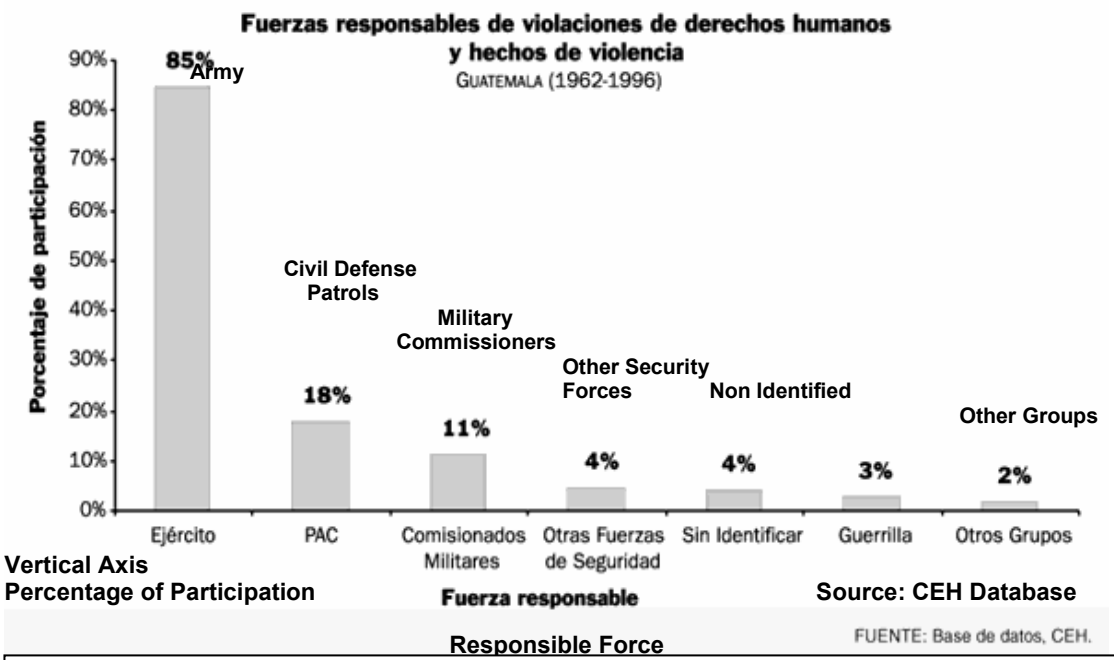
Table No.3 Third Definition of Decentralisation

Interpretation of Some of Definitions about Decentralisation Through CDA Key Indicators	CDA Content/Meaning Parameters of CDA Key Indicators
3.1. *Decentralisation* involves the *transfer of resources*, *decision-making, planning and management functions* from the central government system to such bodies as field agencies, subordinate units of government, semi-autonomous public corporations, local government, area-wide or regional development organisations, and/or specialised functional authorities. [3.5, 3.7, 3.8, 3.13.] [2.8., 2.14.]	**3.5. DPA: Communitarianism/Pluralism in daily politics is Granted and Promoted** Related to Indicators 3.2., 3.3., and 3.4., this recognises the importance of continuing such processes in all facets of community life and linking decentralisation of provision to issues such as democratisation. Linked to indicator 3.13., and relates to ideas about participative democracy – local organisational forms allow for greater opportunity for local involvement. Implicit in this arrangement is a two-way exchange. **3.7. DPA: Democratic/Non-Formal Authority is Promoted and Practiced** Same as 3.5., and an outcome of the process overall, this identifies importance of lower forms of government as institutions of devolved powers and distinguishes importance between tiers of government and organisation of authority among these. A wider variety of bodies become involved in decentralisation of resources, allocation and local priorities. There is a process of participative democracy linking participation of the local population to determination of how resources are used within a framework of determining local priorities. Some authority is vested in para-statal organisations. Where it is delegated there is some interaction with central government in the delivery of its programme. This may superimpose local determination or it may be compatible to it. If the transfer of power is devolved, central government has 'limited' to 'no' input at the local level of decision-making. The degree of participation (non-formal authority) by the local population is expressed at varying levels depending on delegated versus devolved powers. Devolved powers should consider more democratic forms of local government. **3.8. DPA: Horizontal Flow of Decisions is Emphasised and Granted** Definitions are placed under this category where decision-making is removed from vertical structures to more horizontal ones involving community participation as integral to the process. Decision-making structures to suit such forms of decision-making also have to be implemented. There is greater involvement although formal organisation has the impact of opening up decision-making structures and encouraging greater negotiation around resource use. Participative democratic process depends heavily on horizontal decision-making. Important to the process is access of political and social groups to political systems and processes. Where there is strong local population involvement there is more scope for social accountability. This should also mean that institutions are more responsive to local sectors.

3.2.It *is a political issue* that involved not only the distribution of *political power* within the state system but also the *access* of *social and political groups to the political decision-making process and the allocation of public resources.* [3.2, 3.7., 3.8., 3.9., 3.11.]	**2.8. TBSA: State or Mixed Ownership/Partnership of the Services is Promoted and Supported** Definitions are placed under this category, which involve a mixed economy of provision that is provision through partnerships of varying degrees. Ideas about partnerships imply co-ordinated actions of a number of bodies and actions undertaken through a process of consensus. These are continuous processes and directly impact upon resource decisions. The transformational role of the state, as a part of the process implies distribution of responsibility and powers based on how partnerships are organised and aligned. **2.14. TBSA: Direct Community or Local Intervention is Promoted and Visualised** Related to indicator 2.7., but implies community involvement in decision-making to a degree and recognises the role of participation in service delivery. **3.2. DPA: Active Participation in the Decision-Making Process is Encouraged and Sought** Definitions are placed under this category where community participation is integral to the way services are delivered. Participation is expected in decisions about services. Indicates a continuous process of change and construction, which is enabled through a participatory process which challenges existing values according to the experiences of the population. Process of active participation is integral to decentralisation. For decision-making to take place there is an assumption that democratisation processes take place at some point during the decentralisation processes. **3.7. DPA: Democratic/Non-Formal Authority is Promoted and Practiced** Same as 3.5., and an outcome of the process overall, this identifies the importance of lower forms of government as institutions of devolved powers and distinguishes importance between tiers of government and organisation of authority among these. A wider variety of bodies become involved in decentralisation of resources, allocation and local priorities. Process of participative democracy linking participation of the local population to determination of how resources are used within a framework of determining local priorities. Some authority is vested in para-statal organisations. Where it is delegated there is some interaction with central government in the delivery of its programme. This may superimpose local determination or it may be compatible to it. If the transfer of power is devolved, central government has 'limited' to 'no' input at the local level of decision-making. The degree of participation (non-formal authority) by the local population is expressed at varying levels depending on delegated versus devolved powers. Devolved powers should consider more democratic forms of local government.

3.3. It is necessary to stress this point, since far too often analysis of management and organisations is reduced to *more apparently technical issues or efficiency and effectiveness* (Collins and Green, 1994). [3.12]	**3.8. DPA: Horizontal Flow of Decisions is Emphasised and Granted** Definitions are placed under this category where decision-making is removed from vertical structures to more horizontal ones involving community participation as integral to the process. Decision-making structures to suit such forms of decision-making also have to be implemented. There is greater involvement although formal organisation has the impact of opening up decision-making structures and encouraging greater negotiation around resource use. Participative democratic process depends heavily on horizontal decision-making. Important to the process is access of political and social groups to political systems and processes. Where there is strong local population involvement there is more scope for social accountability. This should also mean that institutions are more responsive to local sectors. **3.9. DPA: Collective/Organised/Self-empowered Perception of Participation is Promoted and Idealised** Related to indicator 3.8., and as an outcome of the process, implicit in democratisation are forms of social and political power that are collective. **3.11.DPA: Beneficiary/Vital Human Service Orientation is Promoted and Planned** Related to indicators 3.8. and 3.10., as an outcome of the process, clear identification of benefits for the local population. This is linked to the democratisation process. The local population is involved in a process of determining local priorities and resource input. This is met with high levels of benefit for the local population. There is a relationship between local decisions and expected outcomes. **3.12. DPA: Local/Alternative/Traditional Focus on Health Promoted and Visualised** Definitions are placed under this category where there is scope to develop alternatives in service delivery, usually involving a range of providers working in co-ordination and involving high levels of information and knowledge exchange. Local focus confronts techno-bureaucratic organisation, promotes diverse views and feeds into the decentralisation process. There is a broadening process of democratisation and not just of decision-making but also of knowledge formation activity.

Appendix 3: Forces Responsible for Human Rights Violations and Acts of Violence

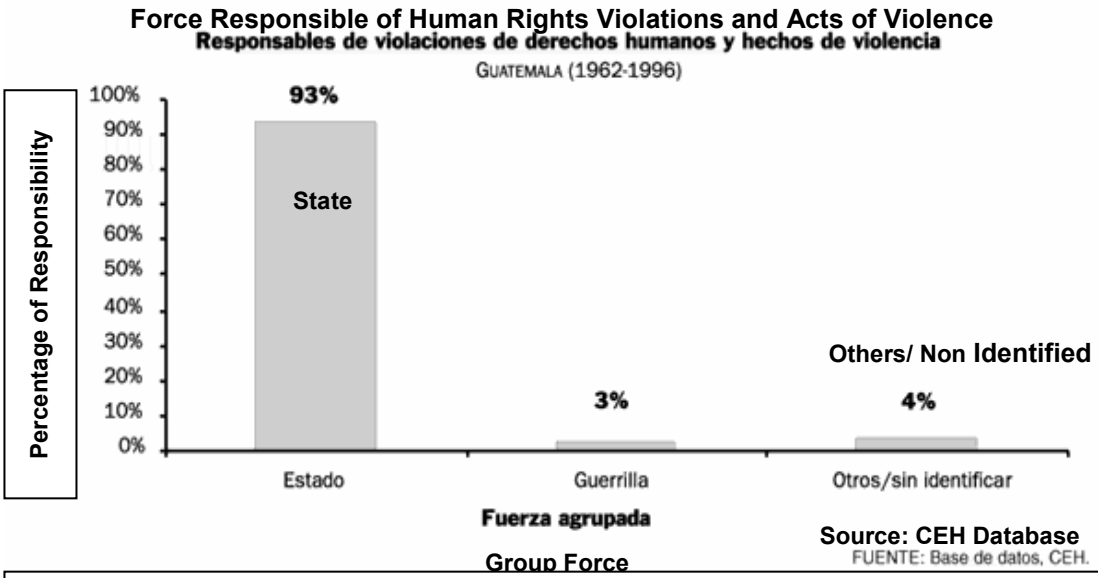


Vertical Axis
Percentage of Participation

Source: CEH Database

Responsible Force

The columns represent the responsibilities of the groups in the commissions acting in combination with other forces or independently. For this reason, 'the army' represents the highest number of violations and acts of violence. However the PACs and other forces could also have participated in acts committed by the army. Likewise the numbers attributed to the PACs also include combined or independent acts. Therefore the total number exceeds 100%



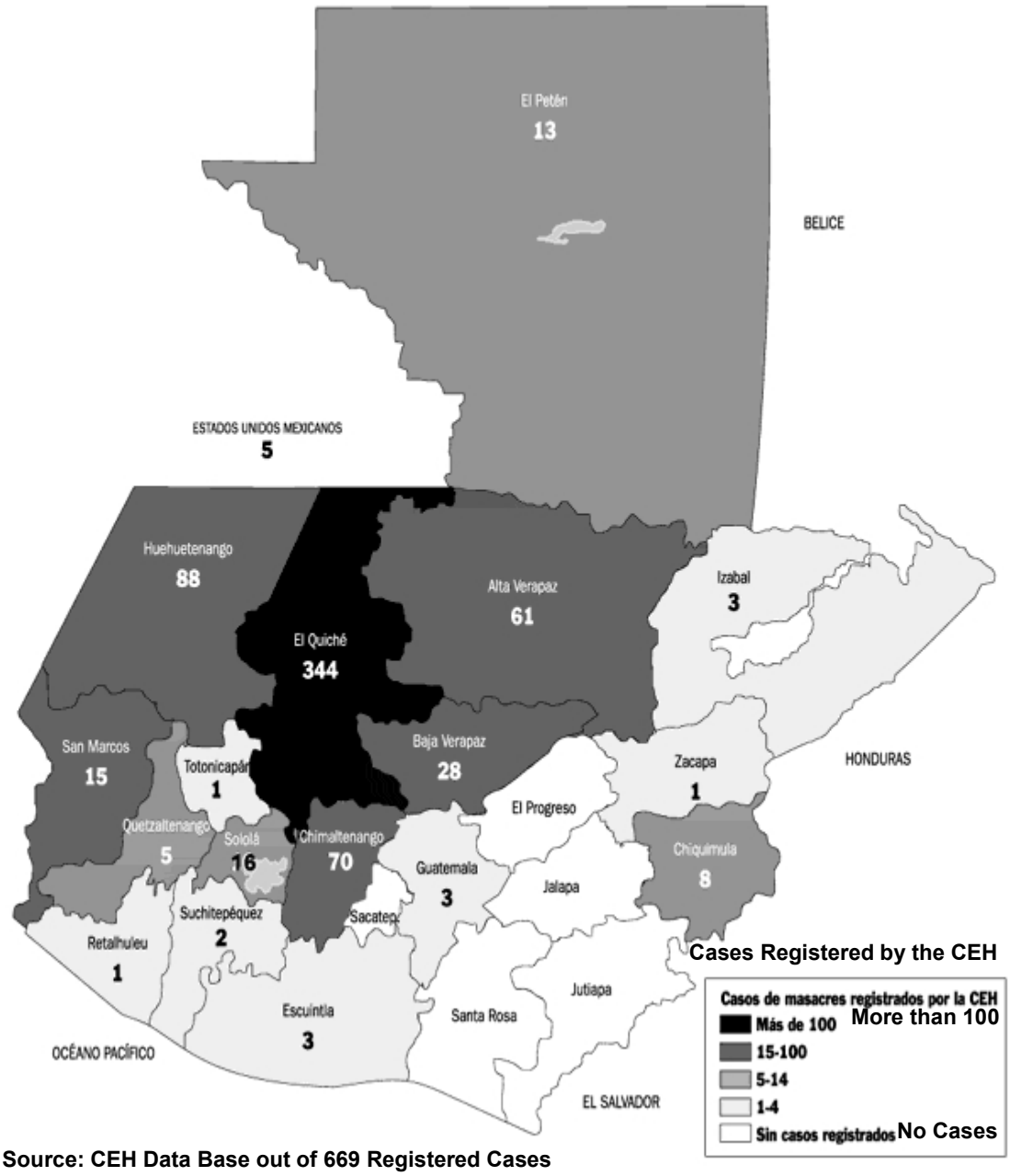
Source: CEH Database

Group Force

93% correspond to the state and the army, security forces, and PACs are included in this category. 3% are attributed to the guerrilla and 4% to other armed groups which include civil and public officials.

NUMBER OF MASSACRES BY DEPARTMENT IN THE COUNTRY

NÚMERO DE MASACRES POR DEPARTAMENTO



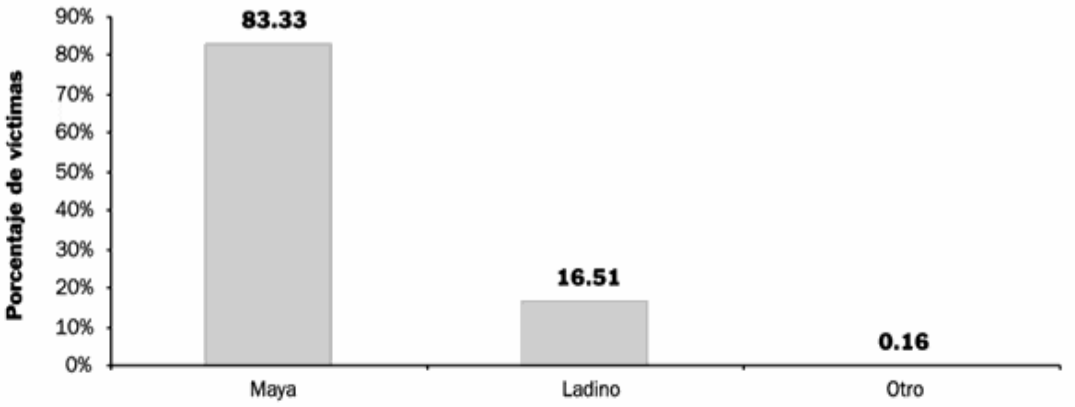
Source: CEH Data Base out of 669 Registered Cases Perpetrated by all the Responsible Forces

FUENTE: CEH, Base de datos; total de masacres —669 casos— perpetradas por todas las fuerzas responsables.

PERCENTAGE OF VICTIMS ACCORDING TO ETHNIC BACKGROUND

Porcentaje de víctimas identificadas según pertenencia étnica

GUATEMALA (1962-1996)



FUENTE: Base de datos, CEH.

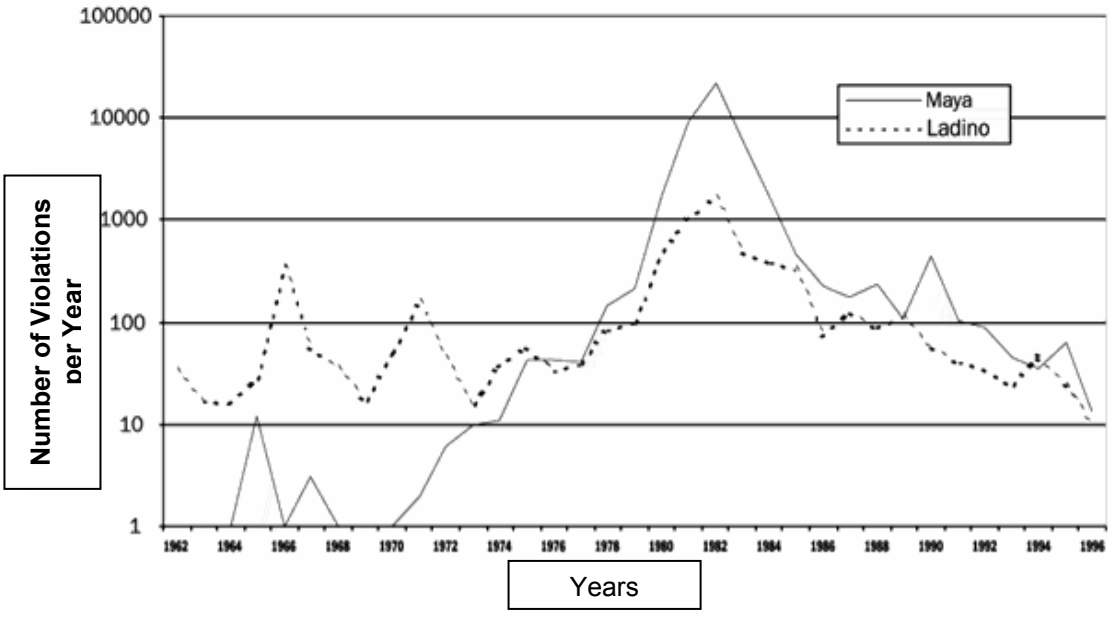
Vertical Axis
Percentage of Violations

Source: CEH Data Base

TOTAL HUMAN RIGHTS VIOLATIONS AND ACTS OF VIOLENCE ACCORDING TO THE ETHNIC BACKGROUND OF THE VICTIMS

Total de violaciones de derechos humanos y hechos de violencia, según pertenencia étnica de las víctimas

GUATEMALA (1962-1996)



Vertical Axis
No. of Violations (by 10x)

FUENTE: Base de datos, CEH.

Source: CEH Database

NOTA: Las líneas de la escala vertical —número de violaciones— representan una progresión con múltiplos de diez.

APPENDIX 4

GENERAL HEALTH PROFILE – SUMMARY OF ANALYSIS AND TRENDS

Data Sources: MSPAS/UPS/SIGSA (2002), MSPAS (1998b), and ENSMI/INE (1998-1999 and 1995).

GENERAL OVERVIEW

Guatemala has a land area of 108,889 km^2 and is divided administratively into 22 departments and 331 municipalities, which in turn have a total of 20,485 communities.

Demography: In 2000, the country had an estimated population of 11,433,694, and the average density was 102 inhabitants per km2. The indigenous population represents 48% of the total population. In 2000, the annual population growth rate was 2.9%. In terms of age distribution, 44% of the total population were children and adolescents under 15 years of age and 5.3% were 60 or older. Life expectancy was 67.2 years (64.7 years for men and 69.8 years for women). Agricultural activity accounted for 26% of GDP and generated 60% of employment.

Economy: In 1998, the Guatemalan economy grew 5%. In 1999 and 2000, GDP grew 3.6% and 3.3%, respectively, and per capita GDP at 1995 prices was 0.9% and 0.8%, respectively. In 1998, the net tax burden (not including returned tax credit) came to 8.9% of GDP. The internal debt as a proportion of GDP was reduced from 10.6% in 1990 to 5.2% in 1998, and the foreign debt went from 18% in 1990 to 10% in 1998. Twenty percent of the households received 63% of the income in the country, whereas 40% of households received only 8%. In 1998, 91.3% of the indigenous population was living below the poverty line. Open unemployment rose from 3.7% in 1995 to 5.6% in 1999. In 1999, the illiteracy rate was 31.7% (39.2% for women and 26.3% for men).

Health Overview: According to SIGSA, in 1999, the birth rate was 34 per 1,000 inhabitants. A total of 53,486 deaths were registered in 1999, for a mortality rate of 4.8 per 1,000 inhabitants. For both sexes, the leading causes of mortality were pneumonia and diarrhoea, which in 1999 represented 22.3% and 6.0% of all deaths, respectively. The distribution of proportional mortality for the six broad grouping of causes in 1997 was as follows: communicable diseases - 13%, external causes - 13%, diseases of the circulatory system - 12%, certain conditions originating in the perinatal period - 8%, tumors - 7%, and, all other causes - 47%. Physicians certified 59.8% of all deaths. Under-registration was around 56%.

SPECIFIC HEALTH PROBLEMS

Analysis by population group -

Children (0-4 years): In 1997 and 1999, the infant mortality rate was 37.7 per 1,000 live births, and 40.5 per 1,000 live births respectively. The rates for neonatal and post-natal mortality were 15.4 and 22.3 per 1,000 live births, respectively. According to ENSMI 1998-1999, estimated infant mortality was 45 per 1,000 live births. In 1999, acute respiratory infections accounted for 40% of all deaths in children under 1 years of age, acute disease claimed 12%, and perinatal causes claimed 11%. The mortality rate in children 1-4 years old was 14 per 1,000. It was 9 per 1,000 in the cities and 20 per 1,000 in rural areas.

Schoolchildren (5-9 years): In 1999, a total of 1,027 deaths were registered in the 5-9 years age group, for a rate of 0.6 per 1,000. Cases of acute disease rose from 16,015 in 1997 to 43,119 in 1998 and 50,799 in 1999.

Adolescents (10-14 years and 15-19 years): In 2000, Guatemala had a population of 2,752,924 adolescents, which comprised 24% of the national population with 51% in rural areas. The fertility rate in girls aged 15-19 was 123 per 1,000. According to data from MSPAS in 1998, the leading cause of death in youths aged 15-19 was gunshot wounds, followed by pneumonia, influenza, and intestinal infections.

Adults (20-59 years): In 1999, the population of adults between the ages of 20 and 59 totalled 4,116,147 and corresponded to 39.3% of the total. According to the findings of ENSMI 1995, maternal mortality during 1990-1995 was estimated at 190 per 100,000 live births. SIGSA indicated the maternal mortality rate was 98 per 100,000 live births in 1997, 100.2 in 1998, and 94.9 in 1999. The use of family planning has been on the rise, from 31.4% in 1995 to 38.2% in 1998 and 1999.

The Elderly (60 years and older): In 1999, the proportion of the population aged 60 and older was estimated at 5.3%. The leading reasons for consultation from this age group were: preventable, communicable, and infectious diseases.

Workers' Health: National Statistical Institute data for the period 1989-1999 indicate that women constitute 24% of the economically active. In the group of children and adolescents 7-14 years old, 34.1% were working. The Guatemalan Social Security Institute (IGSS) covers only 17% of the national population. In 1998, there were 1,131 cases of pesticide poisoning in six departments and in 1999 there were 754.

The Disabled: Disability is a legacy of the armed conflict and has especially affected those who fought in the Army and the demobilised combatants of the Guatemalan National Revolutionary Union as well as civilians from different parts of the country.

Indigenous Groups: Guatemala is one of the Latin American countries with a high percentage of indigenous population (48%). In 1998, illiteracy in the departments with 75% to 100% indigenous population was 52.2%. The 67.8% of the indigenous population suffered from chronic malnutrition.

Analysis by type of health problem -

Natural Disasters: In 1999 and 2000, a series of tremors caused damage in 12 departments. In November 1998, Hurricane Mitch caused heavy damage in 14 of the country's 22 departments, causing 106,000 people to be evacuated and taking the lives of 268. Heavy rainfall in 2000, double the level in the winter of 1999, caused rivers to rise and damage along the southern coast and in the west.

Vector-borne Diseases: In 1999, a total of 101,326 cases of malaria were reported and the annual parasite index was 12.2 per 1,000 inhabitants. Of the confirmed cases, 92% were attributed to Plasmodium vivax, 3.2% to P. falciparum, and 5.3% to 12 associated cases. In 2000, there were 109,874 reported cases of malaria (95.9%), P. vivax - 4%, P. falciparum - 0.1%. In 1999, a total of 3,617 cases of dengue were reported (931.7 per 100,000 inhabitants, two cases of hemorrhagic

dengue and one death). In 2000, there were 10,083 reported cases, 9,006 of which were clinically diagnosed as classical dengue (1,035 of them confirmed) and 42 were hemorrhagic dengue, leading to 9 deaths (case-fatality rate was 21.4%).

Diseases preventable by immunisation: The last case of poliomyelitis was reported in 1991. Epidemiological monitoring for the occurrence of acute flaccid paralysis continued during 1996-2000, when the system reported 49, 77, 51, 56, and 87 cases in those five years; none of them was confirmed to be polio. In 2000, the overall rate of acute flaccid paralysis was 1.7 per 100,000 in the population under 15 years. In 1996, there were no reported cases of measles. One isolated case occurred in 1997, but since then there have been no further cases. In the five years 1996-2000 there were reports of 128, 303, 171, 291, and 904 cases, respectively of unconfirmed measles. The numbers of reported cases of neonatal tetanus in the four years 1996-1999 were 17, 7, 5, and 2, respectively. In 2000, there were 6 cases and 3 deaths. Cases of pertussis increased during the period 1996-1999: 40 in 1996, 131 in 1997, 441 in 1998, 268 in 1999, and the age group most affected is now 6-9-year-olds. The 194 reported cases in 2000 represented 28% fewer than the year before. The last case of diphtheria was recorded in 1997. In 2000, there were five reported cases of tuberculous meningitis, one more than in 1999, with four deaths.

Intestinal infectious diseases: In 1999, there were a total of 385,633 cases of acute disease (incidence: 3,470 per 100,000 population) and 3,244 deaths (29.2 per 100,000). In 2000, morbidity was up 21.6% from that in 1999, with 468,981 reported cases (4,220 per 100,000). In 1999, children under 5 years old were most affected, with 238,434 cases, or 61.8% of the total. Cholera cases doubled from 1,008 in 1997 to 2,077 in 1999. In 2000 the number dropped to 790. The case-fatality rate has been declining: in 1999 there were 18 reported deaths, and in 2000 there were 6, with corresponding fatality rates of 0.9 and 0.8.

Chronic communicable diseases: In 1999, a total of 2,820 cases of tuberculosis were reported, 2,597 (87.1%) of them pulmonary; of the latter number 2,264 were diagnosed by positive sputum smear. Adults 25-34 years old were the group most affected, representing 21% of all cases in 1999. In 2000, there were 2,274 registered cases of tuberculosis, 46.6% in women, and 324 of them in children under 10 years of age. In 2001, only 27 cases of leprosy were registered at the national level, and the patients were undergoing treatment.

Acute respiratory infections (ARIs): ARIs are the leading cause of morbidity and mortality in the country. In 1999, a total of 1,019,247 cases of ARIs and 228,762 cases of pneumonia were reported, with 11,082 deaths. Pneumonia was the leading cause of mortality in infants under 1 year (10.6 per 1,000 population), while 63% of the cases and 50% of the deaths were in children under 5 years old.

Two cases of human rabies were reported in 1999 and six in 2000. A total of 13,207 persons were bitten by suspected rabid animals in 1999, and in 2000 the number was 15,053. HIV/AIDS. The epidemic has been concentrated in urban populations and groups traditionally regarded as being at high risk. As of 30 June 2001, a total of 4,197 cases had been reported officially (35.9 per 100,000 population), and under-registration is believed to be as high as 50%. Seventy-four percent of the affected individuals are males; the 15–49 years age group is most vulnerable, accounting for

87% of the cases. As of 1999, there were 141 known cases of mother-to-child transmission. A total of 266 cases of AIDS were reported in 1999 and 316 in 2000.

Nutritional and metabolic diseases: Forty-six percent of children under 5 years old have some degree of chronic protein-energy malnutrition. The prevalence of global malnutrition (as measured by weight-for-age) is 24% in children under 5 years of age. The vitamin A deficiency (serum retinol = 20 µ/dL) affected 15% of preschool children. Iron deficiency (Hb =12 g/dL) affected 35.4% of women of reproductive age, 39.1% of pregnant women, and 34.9% of non-pregnant women. The prevalence of anaemia (Hb = 11 g/dL) in children 1–5 years old was 26%.

Malignant neoplasms: Cancers of the reproductive system account for 42% of all neoplasms in both sexes. In 1999 there were 452 cases of cervical cancer and 240 deaths. Breast cancer is the third leading cancer and the second most frequent for women.

Accidents and violence: In 1999, a total of 2,741 deaths were caused by accidents (5.1% of all deaths), with a rate of 16 per 100,000 population. There were 384 suicides (0.7% of all deaths) and 1,774 homicides (3.3%).

Emerging and re-emerging diseases: In 2000, five cases of leptospirosis were documented. In 2000, there were 126 cases of meningitis, 4 of them meningococcal.

Health Sector Reform Issues to be Tackled According to the Government

Source for Tables: La Práctica de la Reforma del Sector Salud (RSS) en Guatemala (Sánchez, 2000); National Plan for Peace and Development (the Government Plan) for 1996-2000 (SEGEPLAN/GSP, 1996); and National Health Plan 2000-2004 (MSPAS/SEGEPLAN, 2000).

Table 1

MAIN HEALTH PROBLEMS AND THE ORGANISATION OF SERVICES IN 1995

- Persistent and high levels of infant mortality
- Continued high levels of maternal mortality
- Persistence of infectious diseases and increase of chronic degenerative illnesses and violence
- Resurgence of epidemics such as cholera, malaria and dengue
- Increase of cases of HIV/AIDS
- Deterioration of the health services networks
- Poor quality and quantity of the provision of health services
- Poor access to health services particularly in the rural areas
- A focus on hospital attention
- No availability of medicines and basic health inputs
- Centralised, bureaucratised and inefficient organisation
- Lack of social participation
- Insufficient budgets, inadequate implementation and lack of financial management
- Inadequate provision of human resources
- Insufficient quality of human resources
- Insufficient establishment of health teams and resources to satisfy immediate demand

Table 2
ACHIEVEMENTS IN IMPLEMENTATION OF THE NEW HEALTH MODEL
▪ Definition of the Integrated Health System as a new model of service provision at three levels of healthcare and the development of promotion actions, prevention, recuperation and rehabilitation ▪ Definition and implementation of joined-up basic health services at the primary level of attention ▪ Definition and implementation of mixed basic health services involving MSPAS, non-government organisations, cooperatives and churches ▪ Monitoring and control of transmittable diseases ▪ Incorporation of the population without access to health services ▪ Extension of coverage to children under one year of age with polio, DPT and BCG ▪ Increase of measles vaccination by 83% for children under one year of age ▪ No reports of measles and polio between 1996-98 ▪ Increase detection and control of outbreaks of illnesses which have the potential of becoming epidemics such as cholera, dengue, malaria, among others ▪ Strengthen the secondary level of attention by increasing the capacity of health centres and hospitals, human resources and extension of services ▪ Revise monitoring and management of financial resources and the provision of services in hospitals where significant increases have been planned: external consultation, surgery, and emergency medicine ▪ Financial and technical support to organisations and Special Units and fourth level of attention such as chronic renal illnesses, cardiovascular and cancer in children ▪ Remodel and reconstruct hospitals, health centres and health posts such as the Maternity Ward at Roosevelt Hospital ▪ Increase the rate of implementation of rural water projects by 150% once responsibility is transferred to INFOM under the framework of Water for Peace

Table 3
ACTION POINTS FOR INSTITUTIONAL DEVELOPMENT
Function of the Directorate Conduct ▪ Re-organisation at the central level ▪ Strengthen capacity and management ▪ Develop and strength human resources ▪ Put into operation the National Health Council Regulation ▪ Implement the legal framework for the health sector ▪ Elaborate and implement plans and programmes with the MSPAS, IGSS, INFOM and other institutions of the sector and outwith the sector ▪ Design the content of the model of attention and the programmes of attention Monitoring ▪ Development and strengthen the information system ▪ Analyse the current situation ▪ Epidemiological monitoring Provision of Services

- Definition and implementation of the heath attention model
- Re-organise health services
- Modernise and decentralise management and administration of resources
- Co-ordinate inter- and intra-sectoral contracts for the provision of services
- Design and implement programmes on training and human resource formation in relation to the health model and decentralisation of resources
- Design and implement decentralisation programmes regarding administrative management of human resources

Table 4

ACTION POINTS REGARDING FINANCING AND RESOURCING

Function of the Directorate:

Conduct

- Mobilisation of other public and private resources for provision of services through the development of individual and collective insurance mechanisms and payment methods
- Co-ordination of external finance and international co-operation in health through the elaboration of projects which sustain investment to the health sector

Regulation

- Modernisation and decentralisation of economic planning processes – financial and budgets of institutions which form the health sector
- Extension of social insurance under the criteria of solidarity through a process of concertation between the government, private sector and workers

Provision of Services

- Facilitate participation of municipalities, NGOs, the private sector and the community in the provision and financing of local health services
- Research and implement mechanism for the recovery of costs through differential tariffs under the criteria of equity and solidarity
- Support financial processes for health service provision
- Review the annual operational plan under the new model of attention, re-organise health services and new forms of public and private financing
- Implement a monitoring and evaluation system covering productivity, cost, public and private provision and efficiency in the use of resources

Table 5

ACTION POINTS ON COMMUNITY PARTICIPATION

Function of the Directorate:

- Definition of policies, plans and programmes which facilitate social and community participation in the planning, fiscalisation and financing of health provision services and improvement and protection of the environment
- Promotion of social participation through means of social, public and private communication and the development of the mechanisms which facilitate exchange of ideas on the reform and development of the heath sector
- Participation of the organised community in the planning, fiscalisation and

financing of the provision of health services at the local level
- Support strategies to strengthen the development of municipalities through the integration of health services in the prevention of illnesses, improvement and protection of the environment and social and community participation

Table 6

INTERNATIONAL COOPERATION PROJECTS INITIALLY INTEGRATED UNDER THE PMSS

- Health monitoring and planning project for the migrant population and indigenous women in the construction of peace – MSPAS/IGSS/ASDI/OPS
- Support project for programmes on health sector reform in Guatemala – MSPAS/European Union
- Project on primary health care– MSPAS/GTZ
- Agreement on the extension of coverage – MSPAS/USAID/INCAP

Table 7

BASIC HEALTH SERVICES

Concept: Basic Health Services are permanent and joined up services between health, institutional and voluntary personnel delivered with the participation of the community to improve the health situation.

Basic Health Services include:
- Integral attention to women – pregnancy, partum, post-partum, toxoid tetanic vaccination, nutritional supplements, spacing of pregnancies, detection of cervical cancer and breast cancer
- Attention to children – vaccination, monitoring of common illnesses such as diarrhoea, respiratory infection, nutritional deficiency, monitoring of growth of children under two years
- Emergency demand attention and morbidity – cholera, malaria, dengue, tuberculosis, rabies, sexually transmitted diseases and AIDS and others with a similar local epidemiological profile, fractures, burns, other injuries requiring emergency treatment, haemorrhage, intoxication and snake bites
- Attention to the environment – control of vectors, promotion of good sanitation and anti-littering, monitoring water quality, food hygiene, improvement of sanitary conditions in the home

These services include education actions, essential medicine provisions and traditional medicine considering risk and gender, psycho-social aspects and the promotion of health for integral development.

Basic Health Services should start at the primary attention level in the home, the community centre, health posts, private clinics, religious organisations, municipalities, NGOs, departmental hospitals which provide services of paediatrics, maternity, medicine and surgery, the third level of attention where specialised hospital services are offered.

APPENDIX 5

HEALTH CODE (HC) REGULATORY CONTENTS FOR THE PUBLIC AND PRIVATE SECTORS

Extracts from the MSPAS Health Code – Decree 90-97

CHAPTER II: THE HEALTH SECTOR

Article 8. **Definition of the health sector**. The term 'Health Sector' is understood as public organisms and institutions, centralised or decentralised, autonomous or semi-autonomous, those of the municipalities, private institutions, non-government organisations and community organisations where the tasks and objectives encompass the administration of health actions including those organisations dedicated to health research and health education at the community level. Hereinafter the health sector will be referred to as the 'Sector'.

Article 9. **Functions and responsibilities of the sector**. The institutions that form the health sector have the following functions and responsibilities:

(a) The Ministry of Public Health and Social Welfare hereinafter referred to as the 'Ministry of Health' is the directorate of the health sector and these responsibilities include conduct, regulation, monitoring, co-ordination and evaluation of health actions and institutions at the national level. The Ministry of Health should also formulate, organise, and implement policies, plans, programmes and projects around the delivery of services to the population. To complete these functions, the Ministry of Health should expand its facilities to all actors and oversee compliance to the law and regulations and ensure availability of services in carrying out its functions.

(b) The Institute of Social Security, in respect to its health actions, should be developed under the social security regime of the country according to the laws and regulations. In co-ordination with the Ministry of Health it will develop health prevention and recuperation programmes including maternal-infant health and prevention and attention to accidents.

(c) The municipalities, according to their own attributes and co-ordination functions along with other institutions of the sector, will participate in the partial or total administration and provision of health programmes and services in their respective jurisdictions.

(d) The universities and other institutions where human resources are formed will promote co-ordination through the state organisms and institutions of the health sector, research health themes, and provide human resource training at the professional and technical levels.

(e) Private entities, non-government organisations, community organisations and co-operation agencies will participate in co-ordination actions with other institutions of the sector to resolve health problems through the implementation of programmes and the provision of services, by improving the environment and through the integral development of communities according to the policies, regulations and norms of the Ministry of Health.

(f) The professional colleges related to the health sector will conform to the regulation of professional conduct.

Article 10. **Co-ordination of the sector.** The Ministry of Health, in order to complete its function of co-ordination will undertake the following actions:

(a) Co-ordination of the Ministry of Health-Guatemalan Institute of Social Security. The Ministry of Health and the Guatemalan Institute of Social Security will co-ordinate their health plans and programmes on prevention, promotion, recuperation, and rehabilitation through the utilisation of human resources, financial resources, and equipment to achieve the extension of coverage of health services, to ensure that they are delivered efficiently and to avoid the duplication of services, infrastructure and costs.

(b) Intra and inter-sectoral co-ordination. The Ministry of Health, in order to complete its functions of co-ordination within the sector and with other sectors, adheres to the agreements at the national and local levels and also those signed with international organisations.

Article 11. **Programming and administration of health services**. The organisation and administration of programmes and services on health prevention, promotion, recuperation and rehabilitation considered under the Code will be deconcentrated and decentralised according to the needs of the population and according to the requirements for administrative modernisation of the sector. The institutions of the sector relating to administration and provision of services will establish areas of influence to assist population groups preferably within the territorial areas of the departments and municipalities of the country.

CHAPTER IV
ORGANISATION AND FUNCTIONS OF THE MINISTRY OF HEALTH

Article 16. **Bases for the organisation of the Ministry**. The organisation of the Ministry of Health will be based on the Law on Executive Organism and will function under the framework of decentralisation, deconcentration and social participation strategies. The regulations will define the specific functions of each organisational level and structure corresponding to the completion of the following:

(a) Implement the health directorate to maintain principles of solidarity, equity and subsidiarity in health actions directed to the population.

(b) Support access for the population to public health services which should be provided on the basis of efficiency, efficacy and good quality.

Article 17. **Functions of the Ministry of Health**. The Ministry of Health should undertake the following functions:

(a) Through the directorate, develop health actions at the national level.

(b) Form national health policies.

(c) Co-ordinate health actions to be implemented by each sector or institution involved in the sector.

(d) Develop norms, undertake monitoring, supervision and evaluation of programmes and services, which are being developed and implemented under the framework of decentralisation.

(e) Ensure the completion of international agreements related to health.

(f) Oversee laws, regulations and other norms on services to ensure functions are completed and the health of the inhabitants is protected.

(g) Develop health promotion, prevention, recuperation and rehabilitation actions and any complementary actions which relates to the satisfaction of the health needs of the population.
(h) Strengthen community participation in the partial or total administration of health actions.

(i) Co-ordinate technical and financial cooperation from international organisations and between countries around the national policies and plans.

(j) Co-ordinate actions of non-government organisation related to health in order to promote complementarity between actions and to avoid duplication of efforts.

(k) Elaborate corrective regulations within the law to ensure review.

Article 18. **Integral Healthcare Model**. The Ministry of Health should define the model of integral healthcare, which promotes participation of sectoral institutions and organised communities, which prioritise health promotions and prevention actions, guarantee integral health attention and different levels of attention taking the national, multi-ethnic, pluri-cultural and multilingual context of the country into account.

Article 19, **Levels of organisation**. The organisation of the Ministry of Health will have the following levels and functions:

(a) The central level will be responsible for:
  i. Direction and conduct of health actions
  ii. Formulation and evaluation of health policies, strategies, plans and programmes
  iii. Establishing norms and overseeing health actions and supervising the provision of services

(b) At the executive level it will be responsible for the provision of health services based on the levels of attention, level of complexity of services required and capacity for resolution.

Article 20. **Management of health services**. The Ministry, in order to implement its technical, administrative, financial and human resource function as efficiently as possible, will establish responsibilities for different administrative and technical units at each level needed, taking into account the distinct professions and skills to manage the Ministry.

APPENDIX 6

SUMMARY OF THE SPECIFIC SET OF ANALYTICAL QUESTIONS USED FOR THE CRITICAL ANALYSIS OF THE MSPAS/PMSS/UME AND FOR THE DEVELOPMENT OF THE COMPREHENSIVE EVALUATION

The questions under Critical Historical Analysis (CHA) were:
What kind of ideological and conceptual approaches towards decentralisation have been developed through its different constructions at the international level by the IFIs in Guatemala throughout time?

The questions under a Critical Comparative Analysis (CCA) were:
How has the social construction of discourse, conceived as definitions, ideological representations, visions of decentralisation, democratisation and participation, been translated into institutional and normative policies in Guatemala by central authorities and sub-national and community authorities and representatives?

The questions under the Critical Ethnographic Analysis (CEA) as part of Naturalistic Inquiry (NI) were:
What kind of evaluation procedure exists? Are these robust, comprehensive and interconnected in terms of the collection of data according to the representation of groups in order to achieve decentralisation, democratisation, and participation in health services?
What opinions and perceptions exist on decentralisation, participation and democratisation between authorities, the population, NGOs, traditional and institutional health practitioners working in the sector at the central, sub-national and local levels?
What further democratic and participative planning, implementation, and monitoring and evaluation procedures need to be constructed regarding the primary healthcare system between the different stakeholders at the community level?
What additional evaluation components could be established through the construction of participative and democratic categories related to authority, responsibility, decision-making, organisational skills and practices, and health conceptualisations and treatments?
Whose decentralisation model and approach is it and whose vision is it? Who is heard and who goes unheard?
What leads to the hegemony of these discourses on decentralisation?

The questions under Peace and Conflict Impact Assessment (PCIA) were:

Did/will the programme, project or initiative (in this case the evaluation of decentralisation) help or hinder the consolidation of constructive political relationships within and between the state and civil society?

Did/will the programme, project or initiative (in this case the evaluation of decentralisation) contribute to the development or consolidation of equity and justice or the means of providing basic needs?

Did/will the programme, project or initiative (in this case the evaluation of decentralisation) provide/generate the skills, tools, capacity for individuals and communities to define issues/problems to be addressed and formulate solutions to those problems or resolve those self-defined problems?

Did/will the programme, project or initiative (in this case the evaluation of decentralisation) take into consideration the history/legacy of conflict in its design? (For example, does it consider the specific impact on children, women and other vulnerable groups such as internally displaced populations and the politically, socially and economically marginalised?)

To what extent did/will the programme, project and initiative (in this case the evaluation of decentralisation) incorporate/prioritise the views and interests of affected indigenous populations in those communities evaluated?

ANALYTICAL QUESTIONS USED FOR THE PARTICIPANTS OF THE FOCUS GROUPS UNDER COMPONENT 1

The interview guides were designed around the following analytical questions, which are constructed upon and associated to the questions presented in Chapter 1 using CHA, CCA, CEA and PCIA.

The questions under Critical Historical Analysis

1. What kind of political, economic and cultural positions have the social sectors held in Guatemala at the national, sub-national, and local levels on the process of decentralisation throughout time?

2. What are the characteristics of evolution and stagnation of the socio-political and socio-economic model in terms of power (authority and decision-making), and the provision of social services throughout time?

The questions under a Critical Comparative Analysis are:

3. How has the social construction of discourse, conceived as definitions, ideological representations, visions of decentralisation, democratisation and participation, been translated into institutional and normative policies in Guatemala by central authorities and sub-national and community authorities and representatives?
4. How could a more democratic and participative approach towards decentralisation based upon international and national concepts of delegation, devolution and appropriation be adapted and applied to a post-conflict environment like Guatemala?
5. Under what kind of political, economic, social and cultural frameworks have decentralisation policies been implemented (including international and regional agreements, peace agreements and inter-sectoral and sectoral development programmes)?

6. What kind of conceptualisations could be useful to evaluate this process within the framework of the three approaches towards decentralisation addressed throughout this study?
7. How have the visions and conceptualisations of the three approaches towards decentralisation: the MMA, TBSA and DPA been socially and culturally conceptualised, interpreted and practiced by the different social sectors involved in such processes in the Guatemala post-conflict-environment at the national, sub-national and local levels?

The questions under the Critical Ethnographic Analysis (CEA) as part of Naturalistic Inquiry (NI) are:
8. What kind of opinions and perceptions exist between authorities, population, NGOs, traditional and institutional health practitioners working in the sector at the central and international, national and local levels and how do they affect the implementation process with regard to decentralisation at the local level?
9. What is the nature of the constraints to health decentralisation? Is it the lack of resources and managerial skills? Is it the lack of legitimacy in the political and social context of the country? Is it the lack of more democratic forms of decision-making, organisation and participation?
10. What further democratic and participative planning, implementation, and monitoring and evaluation procedures need to be constructed regarding the primary healthcare system between the different stakeholders at the community level?
11. What additional evaluation components could be established through the construction of participative and democratic categories related to authority,

responsibility, decision-making, organisational skills and practices, and health conceptualisations and treatments?

12. Whose decentralisation model and approach is it and whose vision is it?

13. Who is heard and who goes unheard?

14. What leads to the hegemony of these discourses on decentralisation?

The questions under Peace and Conflict Impact Assessment (PCIA) with regard to Institutional Capacity to Manage/Resolve Violent Conflict and to Promote Tolerance and Build Peace, the questions are:

15. Did/will the programme, project or initiative (decentralisation) affect organisational capacity of individuals or collective organisations (institutions, social groups, public and private sector) and is this impact positive or negative?

16. Did/will the programme, project or initiative (decentralisation) identify and respond to peace and conflict challenges and current and future opportunities? If so, which groups and to what degree? How and why?

17. What were/might be the main obstacles to a positive peace building impact in the middle and long terms (with relation to democratisation, participation and decentralisation)?

With Regard to Political Structures and Processes, the questions are:

18. Did/will the programme, project or initiative (decentralisation) help or hinder the consolidation of constructive political relationships within and between the state and civil society?

19. How did/will the programme, project or initiative (decentralisation) affect the understanding, composition and distribution of political resources within and between state and civil society?

With Regard to Social Reconstruction and Empowerment, the questions are:

20. Did/will the programme, project or initiative (decentralisation) provide/generate the skills, tools, capacity for individuals and communities to define issues/problems to be addressed and formulate solutions to those problems or resolve those self-defined problems?

ANALYTICAL QUESTIONS USED FOR THE PARTICIPANTS OF THE FOCUS GROUPS UNDER COMPONENT 2

The following key questions as stated in the epistemological framework in Chapter 1 are also used to construct the interview guides for this part of the research.

The questions under Critical Historical Analysis (CHA) are:

1. What kind of political, economic and cultural positions have the social sectors held in Guatemala at the national, sub-national, and local levels on the process of decentralisation throughout time?

The questions under a Critical Comparative Analysis (CCA) are:

2. What is the current nature of the restructuring relationship between public, private and civil sectors, managers and policy makers, service providers and consumers according to the decentralisation model(s) and approaches implemented?
3. How could a more democratic and participative approach towards decentralisation based upon international and national concepts of delegation, devolution and appropriation be adapted and applied to a post-conflict environment like Guatemala?
4. What kind of conceptualisations could be useful to evaluate this process within the framework of the three approaches towards decentralisation addressed throughout this study?

The questions under the Critical Ethnographic Analysis (CEA) as part of Naturalistic Inquiry (NI) are:

5. What kind of opinions and perceptions exist between authorities, population, NGOs, traditional and institutional health practitioners working in the sector at the central and international, national and local levels and how do they affect the implementation process with regard to decentralisation at the local level?
6. What is the nature of the constraints to health decentralisation? Is it the lack of resources and managerial skills? Is it the lack of legitimacy in the political and social context of the country? Is it the lack of more democratic forms of decision-making, organisation and participation?

7. What further democratic and participative planning, implementation, and monitoring and evaluation procedures need to be constructed regarding the primary healthcare system between the different stakeholders at the community level?
8. Whose decentralisation model and approach is it and whose vision is it?
9. Who is heard and who goes unheard?
10. What general implications is the process producing at the local level and is this real participation?

The questions under Peace and Conflict Impact Assessment (PCIA) with regard to Political Structures and Processes are:
11. How did/will the programme, project or initiative (decentralisation) affect the understanding, composition and distribution of political (economic and human) resources within and between state and civil society?
12. Did/will the programme, project or initiative (decentralisation) help diffuse inter-group tensions? If so how?
13. Did/will the programme, project or initiative (decentralisation) provide/generate the skills, tools, capacity for individuals and communities to define issues/problems to be addressed and formulate solutions to those problems or resolve those self-defined problems?
14. To what extent did/will the programme, project and initiative (decentralisation) incorporate/prioritise the views and interests of affected indigenous populations?

Themes Addressed Through the above Analytical Questions are:

-Process of Health Sector Reform

-Levels of Knowledge and Understanding of Structures of Provision

-Decentralisation of Resources, Functions and Responsibilities

-Community Participation

-Incorporation of Traditional Medicine to Institutional Medicine

Interview Guides

INTERVIEW GUIDE 01
FOCUS GROUPS

ADMINISTRATION OF SERVICES, EVALUATION OF COMMUNITY PARTICIPATION AND THE IMPLEMENTATION OF TRADITIONAL MEDICINE

QUESTIONS ON THE RELATIONSHIPS, VALORISATIONS AND INSTITUTIONAL PERCEPTIONS

1. Do you agree or disagree with health sector reform or decentralisation at the rural and municipal levels?

2. Do you consider that health sector reform or actions towards decentralisation of the Ministry of Health, health providers and health administrators which attend the community are important or not for you and community?

3. Would you like the pace of the transfer of responsibilities and resources from the Ministry of Health, health providers and health administrators, which attend the community to be faster or slower depending on the problems and priorities of health in the community?

4. The decentralisation of resources and responsibilities should only come from the Ministry of Health, health providers and health administrators, which attend the community or could these also come from other actors and organisations such as the municipality, the extended community and the health committee among others?

5. Do you agree or disagree with community participation? Do you believe that there should be another way to organise the system of attention to improve the provision of services or is the current system working well for the community?

6. How should traditional medicine be incorporated within the process of health sector reform or the potential decentralisation of the service at the municipal and community levels? Should traditional agents and providers be incorporated within the SIAS, in the EBS or some other form?

7. What treatments do you think that traditional medicine could be effectively used for according to your perspective and experience of treating your family, friends and the community?

8. How should traditional medicine be systematised or do you believe the strategy for incorporation within the EBS of the SIAS is paulatine?

9. What kind of support is necessary for traditional medicine and its providers to improve the health profile of the community with the SIAS?

INTERVIEW GUIDE 02
FOCUS GROUPS
ADMINISTRATION OF SERVICES, EVALUATION OF COMMUNITY PARTICIPATION AND IMPLEMENTATION OF TRADITIONAL MEDICINE QUESTIONS ON THEIR RELATIONSHIPS, VALORISATIONS AND LOCAL PERCEPTIONS

1. Do you know when SIAS first started to operate in your community, who provided the services and how were they provided?

2. Do you know how many worked in the EBS from the organisations and institutions contracted by the Ministry of Health as providers and administrators of health services in the community?

3. Do you know the people who work in traditional medicine; have you used traditional medicine providers and medicinal plants for treatment?

4. How can people who work in traditional medicine use their knowledge together with the members of the EBS?

5. Can the health organisations and institutions contracted by the government to implement the SIAS provide better quality services than private medicine and/or traditional providers in the communities?

6. Should the Ministry of Health, health providers, and health administrators of the government within the SIAS, explain how funds are spent and how they work?

7. Who should pay for the services from the Ministry of Health, health providers and health administrators? Should be the government or you? Why?

8. Are you able to contribute money or generate revenue to improve the quality of health services? Under what conditions can you contribute?

9. Do you support community participation in health actions? What form should participation take and how can it be made more effective?

10. Do you support the decentralisation of health services?

11. Do you support or are you against a system of mixed, public, free and decentralised provision?

12. Do you support participation as open forum or a health committee to discuss health problems at the local/community level?

13. Do you support increased responsibilities and money from the Ministry of Health, health providers and health administrators of the community?

14. How can community participation be improved in health actions so that services can be improved? How should the SIAS function?

INTERVIEW GUIDE 03
FOCUS GROUPS
EVALUATION OF COMMUNITY PARTICIPATION AND IMPLEMENTATION OF TRADITIONAL MEDICINE WITHIN THE PROCESS OF HEALTH SECTOR REFORM AND/OR DECENTRALISATION OF SERVICES
QUESTIONS ON THE RELATIONSHIPS, VALORISATIONS AND INSTITUTIONAL AND COMMUNITY PERCEPTIONS

1. Do you agree or disagree with community participation? Do you think there should be some other way to organise the system of attention to improve the provision of services or do you think the system is currently working well in the communities?

2. Do you think the organisations and institutions contracted to carry out the SIAS and attend the communities can deliver better services than the private sector or the providers of traditional medicine?

3. How can community participation be improved in health actions in order to improve services? How would you like to see the SIAS operate in the communities?

4. How should traditional medicine be incorporated within health sector reform or the potential of decentralisation of health services at the municipal and community levels? Should traditional agents and providers be incorporated within the SIAS, to the EBS or in some other way?

5. For what treatments do you think that traditional medicine could be used effectively according to your perspective and experience in treating family, friends and the community among others?

6. How should traditional medicine be systematised or do you believe that the strategy of incorporation within the EBS as a part of the SIAS is paulatine?

7. How can people who provide traditional medicine use their knowledge together with members of the EBS?

8. What type of support is necessary so that traditional medicine and its providers can improve upon their work and contribute under the SIAS to improve the health conditions of the community?

9. How should the Maya/Kekchí cosmovision be articulated and adopted under institutional medicine of the SIAS?

10. In what levels of health attention (primary, secondary or tertiary) do you think the cosmovision can be articulated, adopted, and developed and at what level can the treatments of traditional medicine with respect to ARIs, DPDs and vertical delivery be incorporated?

11. Who should participate as providers of each type of medicine in order to improve the combined and effective use of both medicines and to undertake transference and counter-transference according to the gravity of the problems associated with ARIs, DPDs and vertical delivery?

12. Who should be responsible for the process of articulation and/or adoption of traditional medicine to institutional medicine?

INTERVIEW GUIDE 1
Mobile Physicians, Traditional and Popular Therapists: Traditional Birth Assistants, Herbalists, Healers, Masseurs and Shamans
Application: Focus Groups

GENERAL:

1. What are your personal and professional objectives?

2. What would you like to do in the community?

3. What would you like to achieve or accomplish this year in professional and personal terms and what would you like to achieve or accomplish in the community this year?

4. What kinds of patients do you receive? Do you go to their homes?

5. What illnesses do you see the most?

6. Are there illnesses that only you or those who provide attention can cure? Which ones?

7. Are there illness that you cannot cure? Why? What do you do in these cases? Who can cure these illnesses?

ACUTE RESPIRATORY ILLNESSES:

8. What do you do to cure these illnesses? Do you provide herbs and natural medicine? Do you provide pharmaceutical medicine? Which of the two do you provide? Can you explain or demonstrate how you prepare the medicine (ingredients, preparation, and dosage)? What are these remedies good for? What other remedies do you use?

9. Have you ever sent a person with these illnesses to someone else or some other place for attention? Where? What happened?

10. What do you do if you cannot cure a person with these illnesses or if they become worse?

11. What treatments do you use to cure these illnesses (cultural practices, steam baths, rituals, or others)? When and why do you use these treatments?

DIARRHOEA AND PARASITIC DISEASES:

12. What do you do to cure these illnesses? Do you provide herbs and natural medicine? Do you provide pharmaceutical medicine? Which of the two do you provide? Can you explain or demonstrate how you prepare the medicine (ingredients, preparation, and dosage)? What are these remedies good for? What other remedies do you use?

13. Have you ever sent a person with these illnesses to someone else or some other place for attention? Where? What happened?

14. What do you do if you cannot cure a person with these illnesses or if they become worse?

15. What treatments do you use to cure these illnesses (cultural practices, steam baths, rituals, or others)? When and why do you use these treatments?

PREGNANCY, PARTUM AND POST-PARTUM:

16. Do you know if any woman has brought her child with her either carrying the child or on foot? What do you do?

17. Have pregnant women become ill? Why? What are they ill with?

18. Are some of these illnesses more serious than others? Which ones? How do you know if the pregnant woman has them? Is it normal for them to have these illnesses? Why?

19. What do you do to treat these women? Do you provide herbs and natural medicines? Do you provide pharmaceutical medicine? Which of the two do you provide? Can you explain or demonstrate how you prepare the medicine (ingredients, preparation, and dosage)? What are these remedies good for? What other remedies do you use?

20. What other treatments do you use to cure these women (cultural practices, steam baths, rituals, or others)? When and why do you use these treatments?

21. What do you do if you cannot cure a person with these illnesses or if they become worse?

22. Have you on any occasion sent pregnant women to the nurses or other people who can provide a cure? Who and where do they go? What happened in these cases?

23. Can you assist deliveries in the home? In some other place? What do the people prefer? Why? What do you prefer? Why?

24. How do you assist pregnant women? What do you explain during the birth? Why do you do that? What things should not be done? Why?

25. What position to women give birth? Are the other positions? Are they good? Are they bad? Why? Who decides on the position?

26. Do you give natural medicine? Do you give pharmaceuticals? Both? What kinds? Can you explain how you prepare the medicine (ingredients, preparation and dosage)? What are these remedies for? What other remedies do you use?

27. How have you been treated at the Health Centre when you take pregnant women there?

28. Do you assist with the delivery at the Health Centre? How would you prefer it to be? What support is needed? What personnel are needed? What type of treatment is needed?

CULTURAL ILLNESSES:

29. Do you treat people who suffer from evil eye, fright, mollera caída and others? What are these illnesses? What do you do to cure them?

30. Do you treat these illnesses at the Health Centres? How do you treat them?

INTERVIEW GUIDE 2
Institutional Medicine: Doctors, Nurses and Assistant Nurses, Mobile Physicians, Health Monitors, Traditional (Trained) Birth Assistants, Community Facilitators
Application: Focus Groups

GENERAL

1. What are your personal and professional objectives?

2. What would you like to do in the community?

3. What would you like to achieve or accomplish this year in professional and personal terms and what would you like to achieve or accomplish in the community this year?

4. What illnesses do you see the most? What patients to do you see the most or what patients use institutional health services the most? Who do you see more in the homes?

5. Are there people in the communities that cure illnesses? Who are they?

6. Why do you think people look for people in the community when they are sick?

7. Are there people who do not come to you for attention? Why? What do you do?

8. What kinds of remedies do you use? Do you use natural remedies? Why? What do you do?

9. What do you think about the different types of remedies? What do you think about the different types of people who provide attention?

10. Are there illnesses that only you or people like you can cure? What are they?

11. Are there illnesses that you cannot cure here or with the resources that you have? Why? What do you do when someone has an illness you cannot cure? Who can cure these illnesses?

12. Are there illnesses that only traditional providers can cure? Why?

13. Why do you think people look for traditional providers for cures?

ACUTE RESPIRATORY ILLNESSES:

14. Do you think the traditional providers can cure ARIs? What do you think they know about these illnesses? What do you think they do not know? What do you think that they should know?

15. Do you think that traditional providers can cure ARIs? Why?

16. Do you know traditional providers who cure these illnesses? What do you think about these practices and illnesses?

17. Can these illnesses be cured in the home? Do you know how people cure them and what people say about them? What do you do about those illnesses that cannot be cured in the home?

18. What do you if these illnesses cannot be cured or if the patient becomes worse?

19. Have you ever sent people with these illnesses to other people or some other place for a cure? Where? What happened?

DIARRHOEA AND PARASITIC DISEASES:

20. Do you think the traditional providers can cure DPDs? What do you think they know about these illnesses? What do you think they do not know? What do you think that they should know?

21. Do you know traditional providers cure these illnesses? What do you think about these practices and illnesses?

22. Can these illnesses be cured in the home? Do you know how people cure them and what people say about them? What do you do about those illnesses that cannot be cured in the home?

23. What do you if these illnesses cannot be cured or if the patient becomes worse?

24. Have you ever sent people with these illnesses to other people or some other place for a cure? Where? What happened?

PREGNANCY, PARTUM AND POST-PARTUM:

25. Do you think that traditional midwives can provide attention to pregnancy, partum and post-partum? What do you think about this? What do you think they do not know?

26. Do you know what traditional midwives do to assist in pregnancy, partum and post-partum? What do you think about the practices and treatments? Which ones to you agree with? Which ones do you disagree with? Why?

27. Do you think that traditional midwives can detect and treat illnesses and complications during pregnancy, partum and post-partum? Which ones? Why?

28. In what position do you think women should deliver? Why? Are there other positions? What do you think about them? Who decides on the position?

29. How often do you see women who are pregnant or at the stage of partum and post-partum referred by traditional midwives? Why are they referred?

INTERVIEW GUIDE 3
Users of Institutional or Traditional
Application: Focus Groups

GENERAL

1. Who do you go to for attention (healthcare)? Who do you seek? Why?

2. What kind of service do you receive? Is there any service you would like that you do not have?

3. What kinds of illnesses do you seek attention (healthcare) for?

4. What kind of illnesses do you cure at home by yourself?

5. If you treat yourself, when or at what point would you seek attention (healthcare) outside the home?

6. Do you see any of the following group - Mobile Physicians, Traditional and Popular Therapists: Traditional Birth Assistants, Herbalists, Healers, Masseurs and Shamans? Why do see them? What do they treat you for? What do you think of the service they provide you?

7. Do you see any of the following group - Institutional Medicine: Doctors, Nurses and Assistant Nurses, Mobile Physicians, Health Vigilantes, Traditional (Trained) Birth Assistants, Community Facilitators? Why do see them? What do they treat you for? What do you think of the service they provider you?

8. Do you see some providers more than others? Why? Who do you prefer and why?

9. Who would you recommend to family, friends and others in the community?

10. What do you think of the two types of medicine? What do you think of the kind of service you receive and the quality?

ACUTE RESPIRATORY ILLNESSES:

11. Do you think the traditional providers can cure ARIs? What do you think they know about these illnesses? What do you think they do not know? What do you think that they should know?

12. Do you know traditional providers who cure these illnesses? What do you think about these practices and illnesses?

13. Can these illnesses be cured in the home? What do you do about those illnesses that cannot be cured in the home?

DIARRHOEA AND PARASITIC DISEASES:

14. Do you think the traditional providers can cure DPDs? What do you think they know about these illnesses? What do you think they do not know? What do you think that they should know?

15. Do you know traditional providers cure these illnesses? What do you think about these practices and illnesses?

16. Can these illnesses be cured in the home? What do you do about those illnesses that cannot be cured in the home?

PREGNANCY, PARTUM AND POST-PARTUM:

17. Do you think that traditional midwives can provide attention to pregnancy, partum and post-partum? What do you think about this? What do you think they do not know?

18. Do you know what traditional midwives do to assist in pregnancy, partum and post-partum? What do you think about the practices and treatments? Which ones to you agree with? Which ones do you disagree with? Why?

19. Do you think that traditional midwives can detect and treat illnesses and complications during pregnancy, partum and post-partum? Which ones? Why?

20. In what position do you prefer to deliver? Why? Are there other positions? What do you think about them? Who decides on the position?

APPENDIX 7: A Comprehensive Evaluation Framework: Examples of the Systematisation of Qualitative/Descriptive Indicators per Variable

The World Health Organisation (1948) defined health as 'a state of physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 1948). The indicators (as well as this research) were developed with this definition in mind and as such, those indicators that are specifically related to the health profile of an individual, community and/or country are identified as well as those indicators which the variable 'health' should be cross referenced with. For clarity, the indicators, which are related specifically to health are presented in bold type. The other indicators, which relate to issues such as political, social and economic development and 'health' are presented in plain type.

Procedure Suggested for the Systematisation of Qualitative/Descriptive Indicators for Variables

VARIABLE	Health, Health Decentralisation
KEY WORDS	Physical, mental and social wellbeing, social and economic relationships
QUESTIONS	1. What kind of opinions and perceptions exist between authorities, population, NGOs, traditional and institutional health practitioners working in the sector at the central and international, national and local levels and how do they affect the implementation process with regard to decentralisation at the local level? 2. What kind of evaluation procedures exist? Are these robust, comprehensive and interconnected in terms of the collection of data according to the representation of groups in order to achieve decentralisation, democratisation, and participation in health services? 3. What opinions and perceptions exist on decentralisation, participation and democratisation between authorities, the population, NGOs, traditional and institutional health practitioners working in the sector at the central, sub-national and local levels?
INDICATORS	Conventional indicators ▪ Country Health Profile (including socio-demographic, epidemiological, socio-economic, socio-political and institutional sectoral indicators) national, sub-national and local level (if available) ▪ Definitions of wellbeing and health (physical, mental and social) at the community level cross referenced against institutional and academic definitions identifying overlaps and gaps in understanding ▪ Range of definitions of wellbeing and health cross reference against achieved outcomes and impacts of existing poverty and health programmes ▪ Indicators on wellbeing – length of perceived illbeing and wellbeing, factors contributing to illbeing and wellbeing and

	nature of problems identified by the community categorised by conflict categories such as levels of conflict in the community at the individual, community and macro level (filtered to the community) ▪ Levels, results and effects of improved implementation of health programmes at the meso and micro levels ▪ Levels, results and effects of decreasing the duplication of services as the target populations are more specifically defined ▪ Levels, results and effects of reduction of inequalities between rural and urban areas ▪ Levels, results and effects of cost containment from moving to streamlined targeted programmes ▪ Types, levels and extension of the direct support to community financing and involvement of local communities ▪ Types, degrees and extension of the integration of activities between different public and private agencies ▪ Levels, results, and effects in the improvement of inter-sectoral coordination, particularly in local government and rural development activities ▪ Levels, types and results of monitoring and evaluation mechanisms on quality assurance of this kind of decentralisation process Multi-dimensional indicators (cross reference conventional with non-conventional) ▪ Rating the health (levels of stability, progress and development) of social and economic relationships with neighbours, the community and external factors ▪ Impacts on wellbeing over time (measured in terms of the impact of specific events on social and economic relationships) ▪ Levels of interaction between individual and community rated on a scale (determining the impact of damage of relationships through war and counter-insurgency) (where there is low level of interaction it will be difficult to achieve the aims of justice). The following should be mapped according to the impact of events ▪ Forms of contact with neighbour/community (informal, formal, based on economic exchange, is there a set of social factors) ▪ Levels of trust/distrust with neighbour/community ▪ Nature and levels of exchange activities undertaken ▪ Levels of consultation with neighbour/community ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on this kind of issue
VERIFICATION	A set of indicators to validate the variable **health** could be established in the following way: first, to compare the above definition of health, with other definitions used by the international co-operation agencies and Guatemala. Second, they could be compared with the outcomes and analysis of the country's health profile documents and the draft strategy to combat poverty elaborated by the Government under the supervision of the IFIs.

	Third, views on the technical documents (described above) and health could be compared. Fourth, the publications on macro and micro economics from the UN, WB and IDB (amongst others) could be reviewed per year of publication to assess whether such definitions have been achieved or not. Fifth, the macro and micro economic tendencies could also be contrasted with the goals of the PAs. Sixth, the comparative analysis could be focused on the health PAs implementation recommendations and their follow-up matrix with their implementation results since they were signed regarding the directed or indirect issues: access to social services and environmental health, education, status of women and gender issues, human rights status, employment, agricultural and industrial production, land tenure and small entrepreneurship, governance, justice and violence. Seventh, the results of the MSPAS/UME on community participation presented in the first part of chapter five should be reviewed. Eighth, across examination of publications, documents, articles by different IFIs, MCAs, BCAs, GOs, NGOs, CBOs, and other Civil and Popular Organisations, related to the health issues in the country. A set of indicators to validate the variable **health decentralisation** could be established in the following way: first, longitudinal assessment of the status of health managerial structures and financing mechanism through a situational analysis to identify strengths and weaknesses and obtain a profile of potentialities of health decentralisation. The situational analysis should include an assessment of capacities to identify local preferences, implement health programmes, oversee implementation, appropriately target populations in need with adequate services and community sustainability and generation criteria for resource accumulation and investment. Second, inter-relate the findings of the assessment against criteria for health sector reform and participation of the local population, exchange and input of knowledge, skills and resources and decision-making. Third, at the macro-level, review country health indicators broken down by region, size of the population, other demographic characteristics and the rural-urban dichotomy to longitudinally assess health conditions and degree of gap between areas. Cross-reference the above with socio-economic categories.

VARIABLES	Exclusion, Economic exclusion, Political-juridical exclusion, Social exclusion, Ethnic exclusion Inequality, Socio-Economic Inequality, Ethnic-Cultural Inequality, Socio-Political Inequality, Gender Inequality
KEY WORDS	**Exclusion**: Ethnic, cultural, socio-economic and socio-political inequalities, community participation, achievements, constraints, potentialities, limitations, formal procedures for economic and social development and wellbeing of the population, access to resources, management of the health system and appraisal capacity and decision making authority or impact upon development, right to choice and options, state and institutional transformation at structural and managerial levels, partnership

	between public and private sector and between the former and the communities or any other third party (primary, secondary and tertiary), individual versus collective objectives, training roles, administration, managerial roles **Economic exclusion**: limits on resource and income generation **Political-juridical exclusion**: constraints on social and community participation and the exercise of civic rights **Social exclusion**: Ignores ethnic identity, gender and social support networks **Ethnic exclusion**: discriminates against ethnic minorities and operates a system of segregation, oppression and assimilation **Inequality**: lack of fairness, evenness and disparity **Socio-economic inequality**: access **Ethnic-cultural inequality**: different levels of poverty, vulnerability and empowerment **Socio-political inequality**: differences in political and social participation **Gender inequality**: Social, economic and cultural differences based on gender
QUESTIONS	1. What general implications is the process producing at the local level and is this real participation? 2. What are the roots and manifestations of the exclusion model? 3. How is exclusion referred to, conceptualised and practiced in Guatemala?
INDICATORS	Conventional indicators ▪ Perceptions of the communities' sense of health inequality categorised by economic, social, cultural and ethnic criteria ▪ Levels of participation anticipated and achieved in the following: economic and social development, access to health, decision-making, resource management and categorised as voluntary participation, forced participation or some where in between ▪ Rating levels of choice in health and development (socio-economic and cultural) according to priority, achieved and anticipated or expected at individual and collective levels ▪ Degree of impact on health choices cross referenced against categories of choice (to determine how different choices impact on one another) ▪ Numbers of training needs identified (overall needs) ▪ Number of training needs met ▪ Nature of use of training acquired per field or area ▪ Number and nature of management and administration skills needed (in key areas) ▪ Number and nature of management and administrative training received ▪ Type and nature of use of management and administrative training ▪ Impacts of training on a series of factors including resource management, decision-making, administration, managerial roles and choice ▪ Types and nature of obstacles to obtaining training, using training and receiving follow-up training

	▪ Levels of interaction (at primary, secondary and tertiary levels) between the community and the range of providers ▪ Levels of perceived choice for services, decision-making, resource management and managerial roles of the community per range of provider ▪ Numbers and nature of access opportunities identified per range of provider and types of access ▪ Types of access to health achieved at individual and collective level ▪ Types of access to health achieved where different types of access and level was required ▪ Nature of disadvantage from the perspective of the community categorised into conflict and post-conflict environments ▪ Levels of disadvantage perceived – among individuals, within the community as a whole, between the community and the institutional health providers or among gender and ethnic groups in the conflict and post-conflict environment ▪ Levels of resource and income generation for health activities in conflict and post-conflict environments in relation to health needs in each period ▪ Levels of change (in resource and income generation activity) in conflict and post conflict environments in relation to health needs in each period ▪ Levels of community participation achieved in conflict and post conflict environments in health ▪ Perceptions of civil rights, levels of understanding, levels of achievement, obstacles to achievement at micro, meso and macro levels and direct impact of health sector reform Multi-dimensional (cross reference conventional with non-conventional) ▪ Indicators regarding decision-making experience, levels of participation and perceptions of choice - All of the above broken-down by categories – levels of conflict in an area, status of the area as PAC or non-PAC, did the area pertain to a region at some point in its history, is the population re-settled, number of deaths experienced by the community during the civil war, degree of militarism of the community measured on a scale ▪ Indicators regarding definitions and perceptions – levels and forms of repression that existed (or continues to exist in communities), the current history of individual members (were they members of the army, were they members of the guerrilla, did they have formal or informal political experience, did they work with NGOs and other organisations) ▪ Indicators on participation – levels of confidence in engaging in participation opportunities, levels of trust with 'authorities' and perceptions about identifying needs and demands, perceptions of safety in relation to disagreement with 'authorities', perceptions on the fear of reprisal where a disagreement was identified ▪ Indicators on exclusion – nature of participation of excluded people, levels of exclusion measured against levels, types

	and perceptions of participation, definitions of 'real' participation by the community ▪ Levels and degrees should be assessed using categories such as high, medium, low, or no (non) and each category should be developed using examples ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on these issues ▪ Degrees of change measured against appropriate conflict, post-conflict and racism and exclusion categories (affecting access to health, and incorporation of the community to the health systems) ▪ Perceptions on the levels of persistence of resource and income generation activity based on categories of health need, resource and income activity in conflict and post-conflict environments, and factors that continue to affect access (based on categories of historical memory and levels of presence of the military) ▪ Impacts of categories of historical memory on levels of exclusion (ethnic identify, gender and social capital) and change in conflict and post-conflict environments in relation to access to health and improved healthcare ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on these issues ▪ For all of the inequality variables - levels of access to health services and how different factors such as conflict and post-conflict categories and categories of historical memory interact with changing patterns of access and persist ▪ Community profile on levels of poverty, vulnerability and empowerment cross referenced against categories of conflict, post-conflict and historical memory to understand how the categories promote, advance prevent, or hinder inequality ▪ A further cross reference between ethnic cultural inequality with categories measuring racism ▪ Levels of participation achieved and anticipated and impacts on mental health in relation to the categories of historical memory (feelings of protection, safety, fear, retribution and ability to voice disagreement) ▪ Levels of progress and/or hindrance to participation ▪ Levels of recognition of participation by the range of external actors and organisation and levels of institutionalisation of participation ▪ Impacts of levels of participation achieved or anticipated on other inequality variables ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on these issues
VERIFICATION	A set of indicators to validate the variable **exclusion** could be established in the following way: first, the examination of Chapters II, III, and IV of this research regarding outcomes of the economic and social policies on the different social sectors of the country mainly in the rural areas. Second, the review of technical and academic sources (on social, cultural, economic and political

	exclusion) to conduct a situational comparative analysis. Third, the comparison of different social and economic sectors to establish which of them have been affected by the situation of exclusion considered by year, region, sub-region, department, municipality, community and socio-demographic profile. Fourth, a critical analysis on the impact of the decentralisation process particularly in the health sector over the excluded social sectors of the country, before and after the peace-building process. Fifth, a systematisation of the different indicators already constructed to measure the exclusion phenomena to interlink them in order to appraise the information used to implement other indicators. A set of indicators to validate the variables **exclusion, economic exclusion, political-juridical exclusion, social exclusion and ethnic exclusion** could be established in the following way: first, the review of profiles of exclusion (examples of documents and strategies such as poverty reduction strategy). Longitudinal measurement assessing degree of impact, change and success of policies and strategies in spheres of life. Second, comparison of exclusion between ethnic groups and between groups and micro, meso and macro political and economic levels. Third, mapping shifting parameters in terms of access to forms of spaces (social, economic, political and cultural), interactions and behaviour (institutional and individual). Fourth, the variable economic exclusion can be further elaborated by longitudinally reviewing shifts in employment patterns (types of jobs and duration), social mobility patterns and movement between urban and rural areas (length of movement to and from areas and reason for movement). Fifth, the variable political-juridical exclusion could be elaborated further by reviewing the content of the PAs against legislative initiatives categorised as initiatives to protect, ensure or guarantee equal rights, initiatives to advance or promote rights, and initiatives to address historical exclusion. Sixth, the variable ethnic exclusion can be elaborated further through comparative assessment of access by groups (class, sector, and stratum) and individuals to the state apparatus including power, to opportunities for cultural fulfilment and social and environment opportunities. A set of indicators to validate the variables **inequality, socio-economic inequality, ethnic-cultural inequality, socio-political inequality and gender inequality** could be established in the following way: first, comprehensive assessment based on quantitative and qualitative measures of diverse views from minority and majority groups obtaining information on individual and group perceptions of equality, definitions of equality and duration of inequality broken down by categories of analysis including political, economic, social, cultural and racial equality/inequality. Second, the comprehensive assessment should take account of the political-historical diagnostic of inequality based on the country's profile in variables such as poverty, equity and racialism. Third, assessments of the impacts of the exclusion model to identify impacts at the micro, meso and

	macro levels of society and towards a critical analysis of the impacts of inequality in a post-conflict environment. Fourth, an analysis of the above cross referenced against socio-economic inequality and measurements of livelihood defined by factors such as access to economic infrastructure and to opportunities for income generation. This analysis could also consider a historical-political perspective by assessing how groups of people and individuals based on ethnic background are able to break away from 'traditional' labour categories and sustain livelihood in 'new' areas of work. Fifth, an analysis of the above cross referenced against ethnic-cultural inequality and measurements of poverty, vulnerability and empowerment defined by factors such as acceptance and rejection of distinct identities at the micro, meso and macro levels in political and economic and socio-cultural life. Sixth, an analysis of the above cross referenced against socio-political inequity defined by factors of participation at micro, meso and macro levels and broken down by forms of participation achieved. Seventh, an analysis of the above cross referenced against gender inequality.

VARIABLES	Direct participation, Indirect participation, social participation, political system
KEY WORDS	**Direct participation**: influence (government policy), principles and values (political, ethical, religious, sectoral and professional), transitional process to democracy, partnership supporting the peace-building process, communities political power at national, sub-national and local levels in development agendas **Indirect participation**: selection of institutional and traditional leaders, formal, institutional, hierarchical **Social participation**: common values and goals for social action, re-vindication or adaptation and change in the status quo, inclusion within emerging socio-economic structure, social action **Political system**: extension and operative forms of oppression within the state institutions, prevention of self-reliance and self-empowerment of community organisational structures, political violence, military control and surveillance, limited social participation
QUESTIONS	1. How has the social construction of discourse, conceived as definitions, ideological representations, visions of decentralisation, democratisation and participation, been translated into institutional and normative policies in Guatemala by central authorities and sub-national and community authorities and representatives? 2. How could a more democratic and participative approach towards decentralisation based upon international and national concepts of delegation, devolution and appropriation be adapted and applied to a post-conflict environment like Guatemala? What opinions and perceptions exist on decentralisation, participation and democratisation between authorities, the population, NGOs, traditional and institutional health practitioners working in the sector at the central, sub-national and local levels?

	3. What is the nature of the constraints to health decentralisation? Is it the lack of resources and managerial skills? Is it the lack of legitimacy in the political and social context of the country? Is it the lack of more democratic forms of decision-making, organisation and participation? 4. What further democratic and participative planning, implementation, and monitoring and evaluation procedures need to be constructed regarding the primary healthcare system between the different stakeholders at the community level? 5. What additional evaluation components could be established through the construction of participative and democratic categories related to authority, responsibility, decision-making, organisational skills and practices, and health conceptualisations and treatments? 6. Whose decentralisation model and approach is it and whose vision is it? 7. Who is heard and who goes unheard? 8. Did/will the programme, project or initiative (decentralisation) affect organisational capacity of individuals or collective organisations (institutions, social groups, public and private sector) and is this impact positively or negatively? 9. What were/might be the main obstacles to a positive peace-building impact in the middle and long terms (with relation to democratisation, participation and decentralisation)? 10. Did/will the programme, project or initiative (decentralisation) provide/generate the skills, tools, capacity for individuals and communities to define issues/problems to be addressed and formulate solutions to those problems or resolve those self-defined problems?
INDICATORS	Conventional indicators ▪ Levels of importance placed by communities in decision-making and influence on health policy ▪ Categories of values communities consider important in the policy process broken-down by political, ethnic, religious, sectoral and professional categories ▪ Categories of values cross referenced against experience of influence categorised by outcomes (positive, negative), impacts (change, no change) and ability to participate again ▪ Types of influence recognised by the community per health outcomes and health impacts expected ▪ Examples of democratic transition perceived by communities categorised according to strengths and weaknesses of the health decentralisation process ▪ Levels of involvement in the examples mentioned above ▪ Number, type and profile of representatives in health sector reform ▪ Type of institutions, organisations, collectives in health sector reform ▪ Duration as representatives and policy pursuits measured over different time periods Multi-dimensional indicators (cross referenced with conventional

	indicators) ▪ In regard to democratic transition – level and forms of repression experienced by the community cross referenced against levels of participation, effectiveness of different types of participation structures and degree and nature of change ▪ Political, economic, and social influences and interests supporting or preventing the selection of representatives and the policies they are likely to pursue ▪ Ways of manipulating manipulation for indirect participation (monetary, social, cultural and psychological) ▪ Forms of indirect participation used in relation to outcome (on policy) and impact (on community) ▪ Historical forms of indirect participation used by the community or available to the community and levels of change in the current situation ▪ Impact of the categories of fear in relation to levels of participation ▪ Community perceptions on the validity of political institutions/organisations ▪ Incidence and example of 'high' validity in relation to 'low 'or 'no' validity ▪ Type and nature of actions identified in relation to validity issues ▪ Impacts of the forms of political violence, military control and surveillance cross referenced against forms of social participation ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on these issues
VERIFICATION	The analytical statement on **direct participation** could be evaluated through a set of indicators established by: first, reviewing and systematising the parameters (scope and range of variables) of the response tendencies with a narrow or limited scope on community participation that appear in the tables of the MSPAS/UME evaluation analysis in Chapter V. Second, a systematic review of the number and type of organisations registered (non-registered in certain areas) by region, department, municipality and community. Third, a systematic review of organisations registered by the kind of objectives, year of foundation, number of members, (if possible) broken down by a socio-demographic profile of the members, achievements, and membership with other organisational networks. Fourth, a systematic review of the structures, tasks and organisational membership of the Regional Development Councils, the municipalities, the churches, NGOs, CBOs and other types of community organisations broken down by region, department, community, and socio-demographic profile of the population. Fifth, a systematic and critical review of the decisions that have been made throughout these organisational networks with a special emphasis on health issues related to SIAS. Seventh, a systematic review of the political procedures, decision-making processes and problem-solving strategies that national and local authorities, NGOs, CBOs and other organisations use to address problems

	(such as public consultation with different social sectors, hearings and deliberations between traditional leaders in the communities and committees) and classification of the type of problems with special emphasis in health issues. The analytical statement on **indirect participation** could be evaluated through a set of indicators established by: first, reviewing and systematising the parameters (scope and range of variables) of the responses with a narrow or limited scope on community participation that appear in the tables of the MSPAS/UME evaluation analysis in Chapter V. Second, a systematic review of the number and type of organisations registered (non-registered in certain areas) by region, department, municipality and community. Third, a systematic review of the national and municipal elections and the voter's socio-demographic background (where possible) by national and local authorities focused on voter turn-out. The analytical statement on the variable **social participation** regarding Guatemala could be evaluated through a set of indicators established by: first, reviewing and systematising the parameters (scope and range of variables) of the response tendencies with a narrow or limited scope on community participation that appear in the tables of the MSPAS/PMSS/UME evaluation analysis in Chapter V. Second, a systematic review of the number and types of organisations registered (non-registered in certain areas) by region, department, municipality and community. Third, a systematic review of organisations registered by kind of objective, year of foundation, number of members (if possible) socio-demographic profile of the members, achievements and setbacks, and membership in and ties with other organisational networks and political alliances (where possible). Fourth, a systematic and critical review of the authorities and leaders (within traditional and institutional or other social structures) at the national, sub-national and local levels classified by their background, affiliation and political-ideological stand. The analytical statement on the variable **political system** regarding Guatemala could be evaluated through a set of indicators established by: first, a critical historical comparison of the military dictatorships and the roles of other regimes in Guatemala over a historical period of time (perhaps considering the last 125 years, 100 years, 50 years, 20 years, 10 years, and 5 years) according to the scope needed for the research's assessment. Second, a critical and systematic review of the characteristics and trends of the government administrations according to the chosen periods of history examined by the evaluation research in the focused areas. A critical and systematic review of the status, objectives and outcomes of social, economic, security, cultural, legislative, normative contents of the national government multi-sectoral and sectoral plan. Both kinds of plans could be broken down by development sector, especially the social and economic sectors, by ministry and other

	institutions belonging or related to the sector examined: health education, poverty, labour, and production. Second, a review of the crime and security control, civil and human rights policies, cases of human rights violations documented, implications and results. A cross examination of the former information obtained by breaking it down by socio-demographic profiles and by regions, sub-regions, departments, municipalities and communities according to the objectives and scope of the research evaluation. Third, the implementation approaches of those economic, social and decentralisation policies implemented by the military dictatorships and other regimes during the selected cohort periods suggested above. Residual impact (middle and long-term effects) of such policies over the civil society mainly the ethnic indigenous minorities by regions. Fourth, the political models of military dictatorships, their oppressive and repressive institutionalised control and power reinforcement over the country mainly in the rural areas during the 19th and 20th centuries. Fifth, the counter-insurgency policies of the military dictatorships and other regimes in the last quarter of the last century (1975 to 2000), the characteristics of the current political system called 'democratic transition period' in the last twenty years (1980 to 2000).

VARIABLES	Democracy, Direct democracy, Representative democracy, Liberal or constitutional democracy
KEY WORDS	**Democracy**: historical and personal life, transition, Peace Agreements, violence, public insecurity, loss of credibility, **Direct democracy**: historical impossibility and the right to make political decisions **Representative democracy**: forceful, coercive and manipulative exercise in expression and unequal representation **Liberal or constitutional democracy**: absence of democratic culture and practice of constitutional, civil and human rights
QUESTIONS	1. How has the social construction of discourse, conceived as definitions, ideological representations, visions of decentralisation, democratisation and participation, been translated into institutional and normative policies in Guatemala by central authorities and sub-national and community authorities and representatives? 2. How could a more democratic and participative approach towards decentralisation based upon international and national concepts of delegation, devolution and appropriation be adapted and applied to a post-conflict environment like Guatemala? What opinions and perceptions exist on decentralisation, participation and democratisation between authorities, the population, NGOs, traditional and institutional health practitioners working in the sector at the central, sub-national and local levels? 3. What is the nature of the constraints to health decentralisation? Is it the lack of resources and managerial skills? Is it the lack of legitimacy in the political and social context of the country? Is it the lack of more democratic forms of decision-making,

	organisation and participation? 4. What further democratic and participative planning, implementation, and monitoring and evaluation procedures need to be constructed regarding the primary healthcare system between the different stakeholders at the community level? 5. What additional evaluation components could be established through the construction of participative and democratic categories related to authority, responsibility, decision-making, organisational skills and practices, and health conceptualisations and treatments? 6. Whose decentralisation model and approach is it and whose vision is it? 7. Who is heard and who goes unheard? 8. What were/might be the main obstacles to a positive peace-building impact in the middle and long terms (with relation to democratisation, participation and decentralisation)?
INDICATORS	Conventional indicators ▪ Types of spaces identified for formal involvement in health of under-represented groups ▪ Perceptions of the community around the involvement of women in formal health politics ▪ Community perceptions of political culture around heath categorised according to expectations, experience of political space and categories of influence, negotiation and power identifying levels of success and failure Multi-dimensional indicators (cross referenced with conventional indicators) ▪ Definitions of involvement (political and also social and economic) categorised according to history (community has always been involved in this way, community started to become involved in this way when certain events occurred, community is developing new ways of involvement) ▪ Definitions (based on categories of community experience) of direct democracy cross referenced against values, levels of expectation and categories of experience (fear, reprisal, coercion, credibility and validity) ▪ Definitions of rights from the community perspective in comparison to the categories of direct democracy (right to make political decisions) ▪ Definitions of transformational culture and democratic transition from the community perspective in assessment of the following – degrees and levels of change, interaction and fomentation of political space, sustainability factors for preserving and developing political space and impact of historical memory on repeating adverse political practice, helping to evolve political practice and levels of protection of civil and human rights ▪ Assessment of the impact of historical memory (as categorised above) in relation to present and future probability of incidence of direct democracy (levels of action required, levels of credibility and validity required of public institutions

	and culture) ▪ Sustainability indicators defining categories where permanent, periodic, transitional and/or transformational change is required ▪ Community definitions of democracy categorised according to levels of importance and the values and priorities placed on each category (multivariate analysis) ▪ Community assessment of success and failures of the self-defined categories broken-down by reason (including institution/organisation relations, events, and levels of conflict experienced) ▪ Categories of conflict – levels and nature of violence (individual, community, local, state), impact of violence on community (displacement, death, torture, force and coercion) and cycles of perpetuation (continued, better, worse, has nature and incidence changed, stayed the same) cross reference against the community's ability, opportunity and pattern of participation and involvement in democracy ▪ Perceptions of public insecurity categorised according to levels, nature and origin of insecurity ▪ Categories of insecurity cross referenced against incidence of involvement in democracy ▪ Perceived levels of democratic transition broken down by political, economic and social factors ▪ Involvement of the community in decision-making, resource management and responsibility in relation to perceptions of democratic transition ▪ Mapping historical memory under categories of violence, repression, fear and public lifestyle (political behaviour and social interaction) in relation to perceptions of success and failure of democratic transition ▪ Categories of historical memory cross referenced against community expectations for democratic transition ▪ Types and nature of representative political space created – ad hoc or permanent, formal or informal, linked to other institutions and organisations, transitory, and levels of inclusion cross reference against categories of conflict and historical memory ▪ Incidence of representative democracy achieved and patterns of failure in relation to categories of historical memory and conflict ▪ Impact of the categories of conflict and historical memory on current political culture ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on these issues
VERIFICATION	A set of indicators to validate the variable **democracy** could be established in the following way: A retrospective, comparative, ideological, political and legal review tracking democratic development of the country and identifying critical periods in the country's development to understand the nature of the differences between institutional and local visions and concepts of democracy. The study could be conducted in phases. Phase 1

	could examine political developments in the country in relation to legislative culture and the condition of legislature. The latter refers to the capacity of the law-making bodies to introduce, develop and implement law. Examples of periods for consideration are the period of democratic transition and the Peace Agreements. Phase 2 could involve a study of 'phenomena' in relation to political culture considering categories of information such as conflict and post-conflict, culture of violence and repression to review impacts and change over time. Phase 3 could involve an in-depth study tracking trends in participation at the micro, meso, and macro levels, at the community and individual levels and in relation to the types of decentralisation practiced in the country. A set of indicators to validate the variable **direct democracy** could be established in the following way: longitudinally tracking, through the study of documents on democratic development of the country identifying critical periods in the country's development. A phased approach could examine political developments in the country in relation to legislative culture and the condition of legislature. The latter refers to the capacity of the law-making bodies to introduce, develop and implement law. Examples of periods for consideration are the period of democratic transition and the Peace Agreements. Phase 2 could involve a study of 'phenomena' in relation to political culture considering categories of information such as conflict and post-conflict, culture of violence and repression to review impacts and change over time. Phase 3 could involve an in-depth study tracking trends in participation at the micro, meso, and macro levels, at the community and individual levels and in relation to the types of decentralisation practiced in the country. The framework for analysis above could be elaborated by reviewing variables on citizen participation and tracking electoral trends such as type of electoral management by political parties in distinct areas of the country related to historical-political events especially significant in the post-conflict environment, voter turnout and trends in voting, and social, economic and cultural impacts affecting the casting of a ballot. A set of indicators to validate the variable **representative democracy** could be established in the following way: first, through longitudinal study tracking democratic development of the country identifying critical periods in the country's development. The study could be conducted in phases. Phase 1 could examine political developments in the country in relation to legislative culture and the condition of legislature. The latter refers to the capacity of the law-making bodies to introduce, develop and implement law. Examples of periods for consideration are the period of democratic transition and the Peace Agreements. Phase 2 could involve a study of 'phenomena' in relation to political culture considering categories of information such as conflict and post-conflict, culture of violence and repression to review impacts and change over time. Phase 3 could involve an in-depth study tracking trends in participation at the micro, meso, and macro

	levels, at the community and individual levels and in relation to the types of decentralisation practiced in the country. This framework of analysis could be elaborated by building off of Phases 2 and 3 and by reviewing categories of definitions which could be interpreted as variables and indicators such as categories of conflict and post-conflict, repression which could be broken down by forms of repression experiences, historical memory and culture of violence (under democratic transition). This review encompasses psycho-social impacts on behaviour at the individual and community levels in relation to merging democratic culture and democracy as well as identity formation (rural activism and indigenous leadership) and beliefs and interpretations of rights, obligations and guarantees. A set of indicators to validate the variable **liberal democracy** could be established in the following way: first, through longitudinal study tracking democratic development of the country identifying critical periods in the country's development. The study could be conducted in phases. Phase 1 could examine political developments in the country in relation to legislative culture and the condition of legislature. The latter refers to the capacity of the law-making bodies to introduce, develop and implement law. Examples of periods for consideration are the period of democratic transition and the Peace Agreements. Phase 2 could involve a study of 'phenomena' in relation to political culture considering categories of information such as conflict and post-conflict, culture of violence and repression to review impacts and change over time. Phase 3 could involve an in-depth study tracking trends in participation at the micro, meso, and macro levels, at the community and individual levels and in relation to the types of decentralisation practiced in the country. The framework could be elaborated by building off of phase 1 and by identifying variables measuring democratic culture such as longitudinal assessment of political behaviour, knowledge and practice over critical periods in the history of the country cross referenced against institutional, organisation and community development considering interactions with the state and forms of power under decentralisation.

VARIABLES	Citizenship Rights and Nationality
KEY WORDS	**Citizen rights**: Status of freedom with accompanying responsibilities **Nationality**: Status of citizenship, balance, fairness reciprocal relationships
QUESTIONS	1. Did/will the programme, project or initiative (decentralisation) help or hinder the consolidation of constructive political relationships within and between the state and civil society? 2. What was/will be the impact of the programme, project or initiative (decentralisation) on human, citizen and legal rights in the country or/and region (awareness, legislation, and levels of abuse/respect)?
INDICATORS	▪ Community understanding of rights and freedom (in relation to

	health) at the individual and community levels. ▪ Relationship between rights and access to health – levels of existing access (actual and expected) to health and different levels of attention cross referenced against categories of understanding (freedom and rights) ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on these issues ▪ Comparison between conflict and post-conflict understanding, achievements and failures of fairness, reciprocity and balance in access, community opportunities and views on citizenship.
VERIFICATION	A set of indicators to validate the variable citizenship rights could be established in the following way: first, Review rights and protections guaranteed under law over time. Second, review meanings and understandings applied to rights and protections by individuals and communities. Third, develop categories for interpreting local visions and concepts compared against institutional views on the same. A set of indicators to validate the variable nationality could be established in the following way: by reviewing meanings and understandings applied to the formation of identity (ethnic and racial) and recognition of distinctions in law.

VARIABLES	Racism, Oppression, Discrimination
KEY WORDS	**Racism**: derogative terms, submission, subordination, control and obliteration through conquering and through the social and cultural practices in daily life, justified in the development of a political system based on exclusion and suppression, despotic nature of the state based on indentured labour, territorial reduction and control **Oppression**: Powerful people and power structures working for their own interests **Discrimination**: Treating people unequally manifested in behaviour
QUESTIONS	1. Did/will the project (decentralisation) affect the military/paramilitary/criminal environment indirectly or directly, positively or negatively? If so how? 2. To what extent did/will the programme, project or initiative (decentralisation) contribute to the demilitarisation of minds? 3. Did/will the programme, project or initiative (decentralisation) help or hinder the consolidation of constructive political relationships within and between the state and civil society? 4. Did/will the programme, project or initiative (decentralisation) take into consideration the history/legacy of conflict in its design? (For example, does it consider the specific impact on children, women and other vulnerable groups such as displaced populations and the politically, socially and economically marginalised?)
INDICATORS	Importance is placed on cross-referencing a number of multi-dimensional indicators - ▪ Build-up an experience base by understanding levels of

	impact and environmental factors as contributors based on the health profile of the community identifying ways in which the following experiences have been racist, oppressive, or discriminatory – levels of suppression of community knowledge, skills and cultural practice, levels of subordination and control experienced by institutional actors of knowledge, skills and cultural practice, levels of obliteration (replacement of knowledge, skills and cultural practice) ▪ The above should be cross referenced against levels of impact where the category 'high positive' is balanced mixture of community knowledge, skills and cultural practice with institutional practice, 'low positive/negative' is some degree of retention but balance favours institutional expertise, and 'high negative' is no retention of knowledge, skills and cultural practice ▪ Further testing of levels of impact in relation to the following – is each impact category at micro, meso, or macro levels in terms of locality, policy, institution/organisation and actors ▪ Experiences in health decentralisation of communities in interaction with a range of actors measured on a scale and cross referenced against categories of power (decision-making, perceptions of authority, perceptions around imposition and collaboration, and interests) ▪ Perceptions of the range of actors on the following – role of community knowledge, skills and cultural practice in relation to health decentralisation, levels of receptiveness, incorporation and reciprocity, perceptions of own role in the community, understanding of health impacts on community knowledge, skills and cultural practice, and levels of impact on institutional behaviour as defined by the institutional personnel categorised as follows – 'high positive' (balance between community knowledge, skills and cultural practice and institutional expertise), 'low positive/negative' (some incorporation of community knowledge, skills and cultural practice but institutional expertise is still dominant), and 'high negative' (no incorporation of community knowledge, skills and expertise) ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on these issues
VERIFICATION	A set of indicators to validate the variables **racism, oppression and discrimination** could be established in the following way: first, review the contents of the (organisations and reports) to monitor incidence reporting on race and racism over time. Review reports on views on ethnic, cultural and racial differences and issues, formation of identity, protection of rights and issues around access, acceptance and mobilisation. Second, research and study reports for views on those directly affected by racism covering impacts of change to the status quo measured in terms of access, acceptability and mobilisation. Third, based on these reports, depth analysis of the rural-urban, indigenous-ladino dichotomies covering social and cultural practices, impacts of access to opportunities away from 'traditional' or historically

	accepted forms of employment and organisation and occupation of physical space (interaction or lack thereof). Fourth, legislative review on laws and political initiatives protecting individuals and groups covering incidence monitoring, enforcement, and advancement. Review of changes at the supra-structural level over a period of time to monitor institutional change, process of systematisation of values and incorporation of diverse backgrounds (racial, ethnic and cultural) to political life (formal and organised or as manifested through forms of participation). Fifth, profile of employment and socio-economic variables relating to status and access issues conducted over time. Sixth, longitudinal assessment of power relations between the individual or community and the state at the micro, meso and macro levels considering factors such as transfer, assimilation, and adoption of knowledge (decision-making, political process, and participation) based on following documents and reports: human rights verification and monitoring reports by MINUGUA, UN, UN special envoy for indigenous affairs, human rights international and national NGOs, GOs, indigenous organisations, churches. International and national research: studies, essays, manifestos, and press articles all in hard or electronic form on indigenous rights, human rights and especially focused on discrimination, racism and forms of oppression (labour exploitation, forced migration, and violence against rural communities.

VARIABLES	Ethnicity and Ethnic Identity
KEY WORDS	**Ethnicity**: shared heritage, ethnic differentiation, social and economic stratification **Ethnic identity**: nationality, otherness, paternalism, institutional reinforcement of negative stereotypes
QUESTIONS	1. Did/will the programme, project or initiative (decentralisation) identify and respond to peace and conflict challenges and current and future opportunities? If so, which groups and to what degree? How and why? 2. Did/will the programme, project or initiative (decentralisation) help diffuse inter-group tensions? If so how?
INDICATORS	Importance is placed on cross-referencing a number of multi-dimensional indicators - ▪ Levels of access to health mapped against social and economic stratification and categories of conflict, post conflict and historical memory ▪ Levels of access to health measured against levels of exclusion and simulation ▪ Community's own perception of nationality measure against categories of conflict, post-conflict and historical memory ▪ Levels of access to health measured against perceptions of paternalism, feelings of otherness ▪ Institutional action to address negative stereotypes compared against levels of inclusion by institutions of community knowledge, skills and cultural practice ▪ Levels, types, results and effects of monitoring and evaluation

	mechanisms on these issues
VERIFICATION	A set of indicators to validate the variables **ethnicity and ethnic identity** could be established in the following way: First, review studies by the following research and academic institutions: universities, research centres, international and national organisations especially Mayan and other ethnic groups involved in this issue in order to build up a comprehensive way of understanding historical-political impacts of ethnicity and ethnic identity. This could include content analysis of the socio-cultural differences between institutional management, organisational and traditional structures based on social and cultural differences and institutional or traditional structures of organisation. Second, map the formation of ethnicity and ethnic identity in critical periods in the history of the country, draw out links between socio-economic and political development and formation of ethnic identity, reactions in legislation and policies around issues of ethnicity. Review views on identity – rejection of identity and why, acceptance of identity and why, changes in identity, level of absorption by dominant or imposed culture (in the case of Guatemala the ladino culture). Third, track the following sets of legislation over time and how questions of identity are explored and linked to political and economic issues at the micro, meso and macro levels: the ideological and pedagogical contents of the education programmes, projects and initiatives at the national, sub-national and local levels.

VARIABLES	Prejudice by Blaming, Prejudice by Anger
KEY WORDS	**Prejudice by blaming**: scapegoating ethnic minorities for external troubles and their own troubles **Prejudice by anger**: intolerance, ethnocentrism
QUESTIONS	1. To what extent did/will the programme, project or initiative (decentralisation) contribute to the demilitarisation of minds? 2. Did/will the project include members from the various communities affected by the conflict? What are the criteria for effectiveness? 3. To what extent did/will the programme, project and initiative (decentralisation) incorporate/prioritise the views and interests of affected indigenous populations?
INDICATORS	Importance is placed on cross-referencing a number of multi-dimensional indicators - ▪ Impact of internalised and externalised scapegoating and anger on access to health ▪ Measurement of categories of scapegoating and anger against categories of conflict, post-conflict and historical memory ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on these issues
VERIFICATION	A set of indicators to validate the variables **prejudice by blaming and prejudice by anger** could be established in the following way: first, review the legal system and constitutional laws dealing with discrimination and the issues related to discrimination.

	Second, undertake the review according to date of implementation of legislation and track changes in legislation in subsequent periods. Third, review through various means including publications, sources in the communications media, research and study (newspapers and editorials, incidence monitoring reports and international cooperation documents specifically in relations to the PAs) covering issues such as ethnic and cultural differences, gender, class and economic status, social and political status and differences based on area, region and locality. Include the current phenomenon of lynching. This review should be done periodically, longitudinally tracking patterns and shifts in public opinion, views of institutions and other actors. The review should help to identify a knowledge base on the issues related to discrimination in society and obtain a picture of the level of awareness of society in general on these issues. Fourth, review specific documents such as monthly, quarterly and annual verification reports published by the UN System on incidence monitoring. Fifth, review complaints reports by the Office of the Ombudsman.

VARIABLE	Pluralism
KEY WORDS	Social parity
QUESTION	1. Did/will the project include members from the various communities affected by the conflict? What are the criteria for effectiveness? 2. To what extent did/will the programme, project and initiative (decentralisation) incorporate/prioritise the views and interests of affected indigenous populations?
INDICATORS	Importance is placed on cross-referencing a number of multi-dimensional indicators - ▪ Levels of access to health measured against community knowledge, skills and cultural practice (retention and balanced with institutional expertise) and levels of participation and institutionalisation of knowledge, skills and cultural practice ▪ Levels, types, results and effects of monitoring and evaluation mechanism on these issues
VERIFICATION	A set of indicators to validate the variable **pluralism** could be established in the following way: composition of ethnic, social and economic background by group of individuals represented on the different political, public, semi-private, private, autonomous and semi-autonomous institutions which are part of the state in the country. Include other sectors of society according to the scope of the information needed in this regard. Also include the functions of the organisations, the roles of their members, and the level of political power (authority, management, decision-making, responsibilities, and levels of impact upon the rest of society). Levels of institutional organisations and hierarchies. Levels and/or types of decentralisation of these institutions, their geographical location, their network compositions and links with other institutions by type of sector(s): financial, administrative, services, managerial, political, legislative, and normative. Include

	institutional charters and interactions: partnerships, contractual, statutory, governmental, non-governmental and grassroots.

VARIABLES	Assimilation, Segregation
KEY WORDS	**Assimilation**: Gradual adoption of dominant culture **Segregation**: Physical and social separation of categories of people
QUESTIONS	1. To what extent did/will the programme, project or initiative (decentralisation) contribute to the demilitarisation of minds?
INDICATORS	Importance is placed on cross-referencing a number of multi-dimensional indicators - ▪ Levels of access to health measured against community knowledge, skills and cultural practice (retention and balanced with institutional expertise) and levels of participation and institutionalisation of knowledge, skills and cultural practice (where a loss of knowledge, skills and cultural practice is detected this should be measured against levels of impact on ethnic identity and perceptions of racism and prejudice of the individual and community) ▪ Levels of access to health measured against conflict and post-conflict categories and against the following –ethnicity, geographic area, current levels of military presence or interaction with the area ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on these issues
VERIFICATION	A set of indicators to validate the variables **assimilation and segregation** could be established through critical analysis of socio-political, socio-economic and socio-cultural trends, effects, outcomes and impacts of culture and ethnicity in relation to access to the resources and other wealth of society in a post-conflict environment reviewing polarisation, differences, divisions and interests of groups of people, networks and structures at the national and sub-national levels.

VARIABLE	Genocide
KEY WORDS	Systematic annihilation, Scorched-earth
QUESTIONS	1. Did/will the programme, project or initiative (decentralisation) take into consideration the history/legacy of conflict in its design? (For example, does it consider the specific impact on children, women and other vulnerable groups such as displaced populations and the politically, socially and economically marginalised?)
INDICATORS	Importance is placed on cross-referencing a number of multi-dimensional indicators - ▪ Levels of access to health in those areas which experienced high levels of genocide measured against conflict and post-conflict categories and against the following –ethnicity, geographic area, current levels of military presence or interaction with the area ▪ Characteristics could also include number of clandestine grave, level of human rights violations in areas and massacres

	registered over the last forty years assessed in relation to the health status of the area and mental health issues ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on these issues
VERIFICATION	A set of indicators to validate the variable genocide could be established through a review of reports and studies from the following organisations: Report on the Commission for Historical Verification in Guatemala, National Commission on Human Rights, Office of the Ombudsman for Human Rights, the Catholic Church Human Rights Office and the Association for Forensic Anthropology on massacres, clandestine cemeteries and human rights abuses.

VARIABLE	Political Decentralisation
KEY WORDS	More power in public decision-making Influence in formulation and implementation of policies
QUESTION	1. What visions, definitions and practices have been employed through different constructions of the decentralisation models at the international level by the IFIs in Guatemala throughout time? 2. What kind of ideological and conceptual approaches towards decentralisation have been developed through its different constructions at the international level by the IFIs in Guatemala throughout time? 3. What kind of political, economic and cultural positions have the social sectors held in Guatemala at the national, sub-national, and local levels on the process of decentralisation throughout time? 4. What are the characteristics of evolution and stagnation of the socio-political and socio-economic model in terms of power (authority and decision-making), and the provision of social services throughout time? 5. Under what kind of political, economic, social and cultural framework have decentralisation policies been implemented (including international and regional agreements, peace agreements and inter-sectoral and sectoral development programmes)? 6. What kind of conceptualisations could be useful to evaluate this process within the framework of the three approaches towards decentralisation addressed throughout this study?
INDICATORS	From the community perspective - ▪ Definitions of effective decision-making in health services and decision-making roles within the community ▪ Categories of decision-making history – levels of effectiveness, disruptions to the decision-making process, causes for the disruption, impact of the disruption on the community in decision-making ▪ This should be cross-referenced against categories of conflict, post conflict and historical memory to assess present decision-making behaviour ▪ Levels of expectation in formulation and implementation of health policies – levels of involvement at each stage, factors for continued involvement, and levels of confidence in the

	process From the institutional perspective – ▪ Levels of effectiveness of decision-making in relation to community interaction ▪ Levels of incorporation of decentralisation of decision-making to community knowledge, skills and cultural practice ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on this kind of decentralisation process (especially in health provision or related services)
VERIFICATION	A set of indicators to validate the variable **political decentralisation** could be established in the following way: first, historical content analysis of the nature of participation broken down by sectors, types of institution and/or organisation, socio-economic groups and locality. Further categorisations can include population profiles on who participates, in what instances people participate and in what instances people do not participate within decentralised organisations, programmes, projects, and initiatives. The impact of their participation in the medium and long terms at the micro, meso and macro political levels, as well as in geographical terms: region, sub-region, department, municipality, community and impacts of change on trends in participation. The emphasis on the historical-political perspective provides insight to how democracy or ideas about democracy are perceived, interpreted and developed. Comparative analysis by tracking the development of democratisation over a historical period of time and identifying critical political events and impacts on the ideas, systems and processes of democratisation can provide the framework for the consideration of indicators on political decentralisation. Comparative analysis of democratisation between the different kind of state, private, semi-private, semi-autonomous and autonomous institutions and/or organisations (impact upon society and the development of the country and region). Any changes in these trends in the post-conflict environment and since the signing of the peace agreements through an analysis of impacts of selected experiences such as the level of power in decision-making and instances for the emergence of pluralism in politics. Include the kind of government, its degree of representativeness, degree of pluralism in existence or emerging, levels of information available and accessed in decision-making, quality and scope of coverage of legislation and degree of transfer (of skills, knowledge and resources) for local units. Further categorisations can include psycho-social dimensions of power, the individual and the state cross referenced against elements of repression, racism, inequality, violence and civil war. Review of micro, meso and macro instances of democratisation in relation to the emerging political culture and by means of cross comparisons against categories of information based on historical-political analysis such as conflict and post-conflict and the social, cultural and economic significance of participation or lack thereof.

VARIABLE	Fiscal Decentralisation

KEY WORDS	Adequate levels of revenue
QUESTION	1. What can be identified, assessed and learnt from the three approaches towards decentralisation?
INDICATORS	From the community and institutional perspective ▪ Conventional assessment of health needs and resource requirements projected over a period of time ▪ Non-conventional assessment by cross-referencing needs and resources against categories of conflict, post conflict and historical memory to assess impacts on changing patterns of need, emergence of new need as a direct result and impact on health service provision and decision-making ▪ Levels of credibility of the community in public institutions in delivering health services and impact of categories of post-conflict in generating revenue ▪ Values placed on payment per health service ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on this kind of decentralisation process (especially in health provision or related services)
VERIFICATION	A set of indicators to validate the variable **fiscal decentralisation** could be established in the following way: first, undertake a diagnostic of economic and social profile of the population based on levels of risk (health, economic and social) in relation to poverty indicators. Cross reference information to profile the level of implementation that could be sustainable for user fees broken down by type of fees to impose. Include level of charging, services to be charged and how charging structures will be maintained. An important factor to be considered within the diagnostic is the level of 'generation' of income and resources the community is capable of sustaining in order to determine the level and nature of user fees. This should take account of a historical comparison of community capacity in critical periods in history during the conflict and post-conflict environment to understand the level of sustainability in relation to the level of damage the community has experienced over its recent history (125 years in the case of this research). Second, review systems of transfer between micro, meso and macro economic and political institutions and organisations on specific projects and programmes with categories of efficiency, effectiveness, resources management capability, investment potential, outcomes achieved and planned and monitoring capabilities. Third, examine and review the investment profile of communities in public works of resources allocated. Comparison of project or programme spend per community broken down by spend in administration and operational activities, implementation, planning, and monitoring activities. Fourth, adapt cost effective analysis approaches relevant to the reality of the country. At the macro political level review patterns of consistency in the provision of resources, skills and knowledge to local levels, management of transfer and development of capabilities to ensure sustainability. At the micro level, review local development capabilities in relation to investment or contribution received in key areas such as leadership, participation and provision (or infra-

	structure). Fifth, review of co-production and co-financing arrangements under a cost effective analysis approach.

VARIABLE	Economic or Market Decentralisation
KEY WORDS	Privatisation and deregulation
QUESTION	1. How have the visions and conceptualisations of the three approaches towards decentralisation: the MMA, TBSA and DPA been socially and culturally conceptualised, interpreted and practiced by the different social sectors involved in such processes in the Guatemala post-conflict-environment at the national, sub-national and local levels? 2. What can be identified, assessed and learnt from the three approaches towards decentralisation?
INDICATOR	▪ Levels of accessibility (economic and geographical) by the community under market decentralisation to health ▪ Levels of satisfaction and confidence of the users ▪ Levels of interpretation of community health need and response by private providers – levels of sensitivity to community knowledge, skills and cultural practice and levels of incorporation by providers ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on this kind of decentralisation process (especially in health provision or related services)
VERIFICATION	A set of indicators to validate the variable **economic or market decentralisation** could be established in the following way: first, comparison of historical-political development of economic systems in the Guatemalan context based on an integral analysis of factors including access to private goods (private and public administered by the private sector), history of the relationship with private sector entities and instances to achieve participation and decision-making in private productive choices by the population (study of law, contracts and agreements to carried out, and deregulation and privatisation steps within the decentralisation process). Second, review concepts of 'choice' and 'decision-making power' at the theoretical and practical levels in relation to socio-economic status of groups, cross comparison among groups and cross referenced against macro and micro economic livelihood indicators. Third, impacts assessment of market development policies (SAPs for instance) and economic liberalisation on sectors, groups and organisations and interests at the micro, meso, and macro levels. Fourth, measurement of the policy implementation, impacts, outcomes, potentialities and limitations of privatisation and deregulation weighted against criteria for political decentralisation and the country's, national, sub-national or local socio-demographic profile (indicators) as a way to identify and assess optimal and minimal outcomes and impacts.

VARIABLE	Privatisation
KEY WORDS	Legal process of leaving the provision of goods and services entirely to the free operation of the market to public-private

	partnerships
QUESTION	1. How have the visions and conceptualisations of the three approaches towards decentralisation: the MMA, TBSA and DPA been socially and culturally conceptualised, interpreted and practiced by the different social sectors involved in such processes in the Guatemala post-conflict-environment at the national, sub-national and local levels? 2. What can be identified, assessed and learnt from the three approaches towards decentralisation?
INDICATOR	▪ Role of community in the health partnership process ▪ Effectiveness of the health partnership process on levels of community involvement, participation and decision-making ▪ Impact of deregulation of health service provision ▪ Levels of competition between private and public sectors providing the same kind of health services ▪ Levels of interaction of the community measured against post-conflict and historical memory categories ▪ Type and number of private or privatised institutions, enterprises and companies in the country (special emphasis in the health sector or related sectors) ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on quality assurance of the private or privatised services provided (especially health provision or related services)
VERIFICATION	A set of indicators to validate the variable **privatisation** could be established in the following way: first, diagnostic of levels of privatisation achieved and outcomes. Second, review protocol arrangements between public and private partnerships and assess them on the basis of defined performance indicators in key areas of participation, democratisation and decision-making with the community. Third, ongoing assessment of resource profiles of communities broken down into the following categories, internal generation capacity, external investment potential, investment of resources to achieve priorities, generation of further resources and sustainability of level of resources in relation to addressing needs and priorities. Fourth, at the macro-level, integral assessment of the degree of transformation of state structures in relation to public-private investment in critical areas of reform such as transfer of decision-making, level of consensus building, and macro economic transformation as per the policies of the IFIs. Fifth, risk assessment at distinct levels – macro, meso, and micro and between the private enterprise and the community of resource generation capacity, investment and return.

VARIABLE	Deregulation
KEY WORDS	Reduced legal, financial, administrative and operative constraints of private participation in the public sector
QUESTION	1. What can be identified, assessed and learnt from the three approaches towards decentralisation?
INDICATOR	▪ Role of community in the health partnership process ▪ Effectiveness of partnership process on levels of community

	involvement, participation and decision-making ▪ Impact of deregulation of health service provision ▪ Levels of competition between private and public sectors providing the same kind of health services ▪ Type and number of institutions, enterprises and companies deregulated and regulated in the country (special emphasis in the health sector or related sectors) ▪ Levels of interaction of the community measured against post-conflict and historical memory categories ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on quality assurance of the services deregulated and regulated services provided (especially in health provision or related services)
VERIFICATION	A set of indicators to validate the variable **deregulation** could be established in the following way: first, diagnostic per community of the effectiveness of commissioned services to deliver local priorities and assessment of transfer arrangements from deregulation to monitoring and evaluation against defined performance indicators based on participatory monitoring and evaluation systems. Second, review of law and contracting procedures and guidelines for the implementation of deregulatory policies. Third, review of the sectors that have had the most benefits from the legal, administrative, financial deregulation policies. Include the extension of the results and impacts of deregulation by sectors and by geographical areas in the country. Fourth, statistical descriptive information on the pace of deregulation with the same former characteristics.

VARIABLE	Administrative Decentralisation
KEY WORDS	Redistribute authority, responsibility and financial resources for providing public service among different levels of government
QUESTION	1. How have the visions and conceptualisations of the three approaches towards decentralisation: the MMA, TBSA and DPA been socially and culturally conceptualised, interpreted and practiced by the different social sectors involved in such processes in the Guatemala post-conflict-environment at the national, sub-national and local levels? 2. What can be identified, assessed and learnt from the three approaches towards decentralisation? 3. What is the nature of the constraints to health decentralisation? Is it the lack of resources and managerial skills? Is it the lack of legitimacy in the political and social context of the country? Is it the lack of more democratic forms of decision-making, organisation and participation?
INDICATORS	▪ Levels of redistribution of authority, responsibility and financial resources for providing public services among different levels of government. ▪ Types of transference of responsibility for the planning, financing and management of certain public functions from the central government and its agencies to field units of government agencies, subordinate units or levels of

	government, semi-autonomous public authorities or corporations, or area-wide, regional or functional authorities. ▪ Type and number of deconcentration, delegation, and devolution law, policies, procedures, decisions by type of sectoral institutions, organisations, enterprises and companies in the country (special emphasis in the health sector or related sectors) ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on this kind of decentralisation process (especially in health provision or related services)
VERIFICATION	A set of indicators to validate the variable **administrative decentralisation** could be established in the following way: first, assessment of the impacts and outcomes of redistribution arrangements at the political and economic levels within the different tiers of government, measured at the micro, meso and macro levels. Longitudinal assessment at the macro level of the impacts of democratisation by tracking the impacts of redistribution on shifts in managerial power and decision making structures. Second, longitudinal assessment reviewing the arrangements between central government and local units in relation to the redistribution of authority taking account of factors such as measuring the emerging relationship according to its effectiveness of management and fomentation of local authority, participation and mutual exchange, local input, types of exchange (resource, management, skills and/or finance), the number and types of new organisation and agencies that have emerged as product of the arrangement and their respective function and authority, and representativeness achieved at the micro, meso and macro levels by specified by geographical areas.

VARIABLE	Deconcentration
KEY WORDS	Redistribute decision-making authority and financial and management responsibility among different levels of central government
QUESTION	1. What is the current nature of the restructuring relationship between public, private and civil sectors, managers and policy makers, service providers and consumers according to the decentralisation model(s) and approaches implemented? 2. What can be identified, assessed and learnt from the three approaches towards decentralisation?
INDICATORS	▪ Types of decision making authority and financial and management responsibilities among different levels of central government ▪ Types of shift in responsibilities from central government officials in the capital city to those working in regions, provinces or districts ▪ Kinds of field administration or local administrative capacity under the supervision of central government ministries ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on this kind of decentralisation process (especially in health provision or related services)

VERIFICATION	A set of indicators to validate the variable **deconcentration** could be established in the following way: first, develop a country profile on a comparative analysis of democratisation and the development thereof, in the post-conflict environment and since the signing of the peace agreements through an analysis of impacts of selected experiences such as the level of power in decision-making, instances for the emergence of pluralism in politics, degree of representative government, level of information available and accessed in decision-making, quality and scope of coverage of legislation and degree of transfer from central authority (tasks, skills, knowledge and resources) to local units by geographical area. Further categorisations can include psycho-social dimensions of power, the individual and the state cross referenced against elements of repression, racism, inequality, violence and civil war. Second, review categories of redistribution of tasks depending on local capacity to absorb and sustain skills, knowledge, authority and responsibilities and cross reference these against level of development of political culture.

VARIABLE	Delegation
KEY WORDS	Central government transfers responsibility for decision-making and administration of public function to semi-autonomous organisations not wholly controlled by central government
QUESTION	1. What is the current nature of the restructuring relationship between public, private and civil sectors, managers and policy makers, service providers and consumers according to the decentralisation model(s) and approaches implemented?
INDICATORS	▪ Degree and extension of transfer responsibilities and tasks for decision-making and administration of public functions to semi-autonomous organisations not wholly controlled by the central government, but ultimately accountable to it ▪ Degree or extension of delegated responsibilities in public enterprises or corporations, housing authorities, transportation authorities, special service districts, semi-autonomous school districts, regional development corporations, or special project implementation units ▪ Type of institutions and organisations that have a great deal of discretion in decision-making and implementation policies ▪ Types of institutions and organisations exempt from constraints on regular civil service personnel and are able to charge users directly for services ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on this kind of decentralisation process (especially in health provision or related services)
VERIFICATION	A set of indicators to validate the variable **delegation** could be established in the following way: first, develop a country profile on a comparative analysis of democratisation and the development thereof, in the post-conflict environment and since the signing of the peace agreements through an analysis of impacts of selected experiences such as the level of power in decision-making, instances for the emergence of pluralism in politics, degree of

	representative government in existence or emerging, level of information available and accessed in decision-making, quality and scope of coverage of legislation and degree of transfer (of skills, knowledge and resources) for local units. Further categorisations can include psycho-social dimensions of power, the individual and the state cross referenced against elements of repression, racism, inequality, violence and civil war. Second, review categories of redistribution depending on local capacity to absorb and sustain skills, knowledge, authority and responsibilities ad cross reference these against level of development of political culture.

VARIABLE	Devolution
KEY WORDS	Transfer authority, finance and management to quasi-autonomous units of local government with corporate status
QUESTION	1. What is the current nature of the restructuring relationship between public, private and civil sectors, managers and policy makers, service providers and consumers according to the decentralisation model(s) and approaches implemented? 2. How could a more democratic and participative approach towards decentralisation based upon international and national concepts of delegation, devolution and appropriation be adapted and applied to a post-conflict environment like Guatemala? 3. What can be identified, assessed and learnt from the three approaches towards decentralisation?
INDICATORS	▪ Type and number of Institutions and organisations with devolved functions and transfer authority for decision-making, finance, and management ▪ Kind and number of transferred responsibilities for services to municipalities that elect their own mayors and councils, raise their own revenues, and have independent authority to make investment decisions ▪ Type and number of local governments which have clear and legally recognised geographical boundaries over which they exercise authority and within which they perform public functions ▪ Level and conditions of semi-autonomous or autonomous administrative decentralisation that is exerted by these authorities, institutions, organisations ▪ Levels, types, results and effects of monitoring and evaluation mechanisms on this kind of decentralisation process (especially in health provision or related services)
VERIFICATION	A set of indicators to validate the variable **devolution** could be established in the following way: first, develop a country profile on a comparative analysis of democratisation and the development thereof, in the post-conflict environment and since the signing of the peace agreements through an analysis of impacts of selected experiences such as the level of power in decision-making, instances for the emergence of pluralism in politics, degree of representative government in existence or emerging, level of information available and accessed in decision-making, quality

	and scope of coverage of legislation and degree of transfer (of skills, knowledge and resources) for local units. Further categorisations can include psycho-social dimensions of power, the individual and the state cross referenced against elements of repression, racism, inequality, violence and civil war. Second, review categories of redistribution depending on local capacity to absorb and sustain skills, knowledge, authority and responsibilities ad cross reference these against level of development of political culture. Include review of type and nature of enterprises created, levels of accountability of enterprises to central government and the community, degree of participation of community in enterprises, types of arrangements agreed between enterprises and central government and level of function and responsibility assumed and achieved.

VARIABLES	Macro-Economic Problems and System of Compensation
KEY WORDS	**Macro-economic problems**: An economic crisis created by current cycles of budget deficits and inflation as well as the drastic reduction of the international monetary reserves, which impact in the balance of payments to external and internal creditors and lenders and reduce the possibilities of trade and access to capitals internationally. **Systems of compensation**: Systems of macro-economic and socio-economic policies created by the IFIs, bilateral and multilateral agencies and followed by national governments with the aim to balance internal macro-economic and social disequilibria.
QUESTION	1. How did/will the programme, project or initiative (decentralisation) affect the understanding, composition and distribution of political resources within and between state and civil society?
INDICATORS	▪ Types of key decisions and policies made by international bodies (IMF, World Bank, UN) and national governments under their guidance or authority to rescue the country when financial deficits arise at the national and sub-national levels and impact on health ▪ Amount and kind of democratic deficits in terms of direct authority and decision-making to use financial resources in a discretionary way by the national or sub-national governments ▪ The extension and level of constraints imposed through non or re-negotiable international agreements with the IFIs, bilateral and multilateral institutions and agencies ▪ Macro-economic and micro economic indicators, socio-democratic indicators and poverty profile of the country break down at the national and sub-national and local levels ▪ The index of human development by sectors and sub-sectors addressing the political, economic, social and cultural trends and strives in the country and the level of economic vulnerability of the population
VERIFICATION	A set of indicators to validate the variable **macro-economic**

	problems could be established in the following way: first, longitudinal assessment tracking the manifestations of political power based on a historical overview and comparative analysis of power in relation to decentralisation. Categories for information and analysis include emerging and establishing power relations in society in critical moments in the development of the political system and culture, the formation of socio-economic relationships in direct correlation to concentrations of power, and forms of political power manifested in planning and implementation policies. Second, longitudinal assessment tracking macro economic development in relation to the manifestation and concentration of political power cross referenced against categories measuring levels of decentralisation at the micro, meso and macro levels. A set of indicators to validate the variable **system of compensation** (related to equity) could be established in the following way: first, a diagnostic of the socio-economic status of distinct regions linked to the poverty reduction strategy providing information on the following: financial status of regions, capacity of regions to accumulate wealth and generate resources, capacity of regions to manage resources and levels of sustainability regions are able to achieve in terms of managing tax and transfers from central government. Second, reviewing the levels of vulnerability of the internal markets and the competition in international markets, the degree of hegemony of international firms, the level of cycles of exposure to capital flights, and the levels of pressure via conditionality by the IFIs, bilateral and multilateral agencies of financial support and development.

VARIABLE	Poverty Assessment
KEY WORDS	Assessment exercise to know the characteristics, extension and trends of poverty in developing countries.
QUESTION	1. What kind of evaluation procedures exist? Are these robust, comprehensive and interconnected in terms of the collection of data according to the representation of groups in order to achieve decentralisation, democratisation, and participation in health services?
INDICATORS	▪ Amount, types, dates, contents, scope and focus of PRSPs carried out, to be in process or to be carried out in the country ▪ Types of institutions, organisations, and agencies that are carrying out or have carried out the PRSP exercise(s) ▪ Type of contents of the PRSPs exercise with regard to the intentions and aims, results and follow-up procedures based on such information ▪ Population background involve(d) in the PRSP exercise, the kind of methodologies used and the kind of policies enacted as part of the process ▪ Types of structural problems, causes and factors (historical, political, economic, social, cultural, and psychosocial) which maintain or increase the level of poverty in the country, break

	down at the national, sub-national and local levels according to the information needed ▪ Levels and trends of poverty analysed and linked to other structural causes of that condition by sector of population, region, department, municipality, cohort by age, ethnic and nationality and gender and family status also by level of education, type of employment, income and assets (where possible)
VERIFICATION	A set of indicators to validate the variable poverty assessment could be established in the following way: first, assessment and measurement of the country's poverty reduction strategy under the Comprehensive Development Framework taking account of the identified characteristics of poverty (socio-economic, cultural, ethnic and regional), links between the poverty reduction strategy and technical documents on health sector reform. Second, development of an analytical framework to take account of the impacts and duration of poverty based on distinct experience and linked to the historical-political reality of the country. This framework can include categories for analysis based on conflict and post-conflict, violence and repression, and democratic transition. This will take account of the historical position of economic development patterns and socio-economic class and ethnic group distinctions which have been maintained over long durations and are imbedded in the history of the country. Third, longitudinal assessment based on the impact of interventions at various levels in poverty reduction including micro, meso, and macro political and economic levels and local and community-based interventions Fourth, development of a monitoring and evaluation system taking account of poverty reduction and providing appropriate measures of other 'phenomena' such as local participation and decision-making. Fifth, situational appraisal of investment through resources, infrastructure and other inputs on the conditions of poverty taking account of sustainability factor at the local level.

VARIABLES	Equity and Accountability
KEY WORDS	**Equity**: Fairness and parity of any citizen of having the same kind of rights, support, privileges, obligations and sanctions regardless of any social, economic and cultural and racial differences **Accountability**: Direct responsibility where in command, direction, and management for the decisions, actions, practices, and results.
QUESTION	1. Did/will the programme, project or initiative (decentralisation) contribute to the development or consolidation of equity and justice or the means of providing basic needs?
INDICATORS	▪ Amount, type and conditions of financial transferences from the central government to other tiers of government at the national and sub-national levels ▪ Level of socio-economic disparities at the national level, broken down by and between regions, departments, municipalities and communities, ethnic groups, gender, age,

	income, employment and education ▪ Level of social, cultural, judicial and human rights disparities at the national level, broken down in the same sub-groups as above ▪ Level of political, institutional organisational and infra-structural disparities at the national level, broken down in the same groups as above ▪ Levels of health status disparities at the national level, broken down in the same groups as above ▪ Types and ways of legal, normative, procedural or managerial and other kind of sanctions ▪ Types of authority and responsibilities by institutional and organisation sectors ▪ Levels, types and results of monitoring and evaluation mechanisms on accountability of various kinds of authorities, politicians, representatives, officers, and workers. ▪ Levels, types and results of monitoring and evaluation mechanisms on accountability of various kinds of institutions, organisations, agencies, enterprises, business and offices.
VERIFICATION	A set of indicators to validate the variable **equity** could be established in the following way: a diagnostic of the socio-economic status of distinct regions linked to the poverty reduction strategy providing information on the following: financial status of regions, capacity of regions to accumulate wealth and generate resources, capacity of regions to manage resources and levels of sustainability regions are able to achieve in terms of managing tax and transfers from central government. A set of indicators to validate the variable **accountability** could be established in the following way: first, a revision of constitutional, legal, political, normative, technical documents, studies, articles, newspapers, essays and comments, analysing and providing diagnostics of the legal, normative, procedural and customary sanctions, compensations, rewards, and acknowledgements to the different kinds of authorities in functions in the country. Second, include liability mechanisms, tools, strategies, procedures on authorities, representatives, leaders, officers by regions, sub-regions, municipalities, and communities with regard to the management of financial, administrative, economic and infrastructural resources.