Health sector reform and reproductive health in Latin America and the Caribbean: strengthening the links

A. Langer,[1] G. Nigenda,[2] & J. Catino[3]

Many countries in Latin America and the Caribbean (LAC) are currently reforming their national health sectors and also implementing a comprehensive approach to reproductive health care. Three regional workshops to explore how health sector reform could improve reproductive health services have revealed the inherently complex, competing, and political nature of health sector reform and reproductive health. The objectives of reproductive health care can run parallel to those of health sector reform in that both are concerned with promoting equitable access to high quality care by means of integrated approaches to primary health care, and by the involvement of the public in setting health sector priorities. However, there is a serious risk that health reforms will be driven mainly by financial and/or political considerations and not by the need to improve the quality of health services as a basic human right. With only limited changes to the health systems in many Latin American and Caribbean countries and a handful of examples of positive progress resulting from reforms, the gap between rhetoric and practice remains wide.

Keywords: reproductive medicine; health sector reform; health services, accessibility; financing, health; Latin America; Caribbean region.

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Introduction

The health sectors in many countries of Latin America and the Caribbean (LAC) — in different ways, at different speeds, and with mixed results — are currently being transformed: (1) by the introduction of sectorwide reforms to make the health services more effective and efficient (e.g. improving service quality and access, decentralizing management and decision-making, controlling costs, and expanding the role of the private sector), and (2) by the adoption of a broad-based reproductive health care model in accord with the action agendas that emerged from the International Conference on Population and Development (ICPD) in Cairo in 1994 and the Fourth World Conference on Women (FWCW) in Beijing in 1995. These international agreements call for a reproductive health approach based on human rights and responsiveness to holistic needs, particularly those of women.

Given the serious personal, economic, and social burden of reproductive health problems on people (especially women and adolescents) and on the health systems in low- and middle-income Latin American and Caribbean countries (Table 1), reproductive health should ideally be a priority focus within broader health sector reform. The various components of reproductive health care — including pregnancy-related care, family planning information and services, prevention and treatment of sexually transmitted diseases (STDs) and reproductive tract infections (RTIs), and prevention and treatment of unsafe abortions (*1*) — reflect key problems in the region and should be integrated into a high-quality health system that strives to meet the comprehensive health needs of the entire population based on human rights and gender-sensitive principles. However, very little information is available on the impact of health reforms on reproductive health care in practice. Since both movements (health sector reform and reproductive health care) are relatively recent in most LAC countries, there is no guarantee that the present motivations can continue or will last. For example, there is a clear risk that health sector reform will be driven by financial and/or political considerations and not by the need to improve health care quality.

Health sector reform presents both challenges and opportunities for improved sustainability and performance in reproductive health service delivery. To date, dialogue and coordination between regional, national, and local actors involved in the two movements have been very limited. In many cases in the LAC region, the two have become separate political and technical processes which are often not compatible or complementary (*2*).

[1] Director, The Population Council, Regional Office for Latin America and the Caribbean (LAC), Escondida 110, Colonia Villa Coyoacan, Mexico DF 04000, Mexico. Correspondence should be addressed to this author.

[2] Senior Researcher, National Institute of Public Health, Cuernavaca, Mexico.

[3] Program Associate, The Population Council, Regional Office for LAC, Mexico DF, Mexico.

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Table 1. **Reproductive health indicators in selected Latin American and Caribbean countries**

	MMR[a, b]	IMR[c, d]	% of skilled attendance at birth in 1996[b, e]	% of women aged 15–19 giving birth each year[d]	% of married women using a modern contraceptive method[b]	% of adult population infected with HIV[f]
LAC[g]	180	36	75	8	58	0.52
Bolivia	650	75	46	9	18	0.07
Brazil	220	43	73	9	70	0.63
Guatemala	200	51	35	13	27	0.52
Haiti	1000	74	20	8	14	5.17
Mexico	110	28	6	7	56	0.35

[a] Maternal mortality rate (MMR): the number of deaths of women from causes related to pregnancy and childbirth per 100 000 live births in a given year.

[b] Source: Population Reference Bureau (PRB): *Women of our world*, 1998.

[c] Infant mortality rate (IMR): the annual number of deaths of infants under 1 year of age per 1000 live births.

[d] Source: Population Reference Bureau (PRB): *World population data sheet*, 1998.

[e] Skilled personnel include doctors, nurses and midwives.

[f] Source: UNAIDS/WHO: *Information on the global HIV/AIDS epidemic*, June 1998.

[g] Latin American and Caribbean countries.

This paper outlines some of the most critical aspects of health sector reform and reproductive health in LAC countries and attempts to identify the links between them. Strategies of decentralization, changes in health services financing, and the role of the private sector were discussed in three regional workshops conducted by the Population Council's LAC Regional Office (PC/LAC), with support from the Inter American Development Bank (IADB). The goal of the workshops was to identify ways in which health sector reform can be used as an opportunity to improve the quality of — and access to — reproductive health services in the region.

Information on progress in health sector reform in individual countries was gathered in advance of the workshops, and PC/LAC was able roughly to assess and compare the situations in the countries based on a number of relevant indicators, including changes in financing and budget allocation, service structure, quality of care, and participation of the private sector (Table 2). Countrywide "progress" was not measured against a single regional standard, but was based on achievements towards the national plan for health sector reform. Classifications were therefore relative to plans developed by each country. A related exercise was undertaken to assess country-level reproductive health status by examining and comparing key reproductive health indicators such as total fertility rate (TFR), contraceptive prevalence, and maternal mortality rates across countries (Table 3). Countries were evaluated based on these indicators and then categorized.

The categorizations were not intended to draw a definitive picture of the processes of reform and reproductive health in the LAC region. Country-level responses to both movements are relatively recent and ongoing; therefore "progress" is continuing. The categories demonstrate the heterogeneity of country situations in the region and provide a basis for discussions from both country and regional perspectives.

What is health sector reform?

In general, health sector reform refers to a set of policy measures affecting the organization, funding, and management of health systems (*3*). In theory, health sector reform is intended to improve the health status of populations by promoting and enhancing access, equity, quality, sustainability, and efficiency in the delivery of health care services to the largest possible number of people (*4*). Unlike in Europe and the USA, where reform efforts have been spurred principally by a desire to contain health care costs (*5*), reform of the health sector in most LAC countries has grown out of an attempt to expand coverage and establish equity in the provision of health care services, while controlling health care spending by governments, nongovernmental organizations (NGOs), and donor agencies (*2*).

In practice, the clearest results of reform in the LAC region are a range of new national policies, an increase in national public spending on health care (from 6% of GDP in the early 1980s to over 10% in some countries in the late 1990s), and improved coverage for some parts of the population as a result of new social insurance schemes (although these are often not reaching those who are most in need). Less clear results are improvements in efficiency, increased equity, and improved quality of care at the service delivery level (*6*).

Reform strategies vary widely across the LAC region, but usually include decentralization — from national to provincial, state, or district levels — of decision-making power, budget allocations, and

management of service delivery; a shift of service provision from the public to the private sector; reorganization of service delivery (e.g. through the integration of previously vertical service elements); establishment of financing and payment schemes (such as sliding-scale fees for service, contracting, and insurance plans); and the shift of donor financing from isolated projects to resultsoriented, sectorwide support (*7*).

Health sector reform must be viewed broadly as more than a technocratic or managerial process. They are part of a political transformation involving broad-based discussions on the most legitimate strategies for moving forward. In some instances, health reform is part of a democratization process that is redefining the role of government and the public sector in many countries (*2*). The transformation depends on increased participation of a larger range of social and political actors in the development of health and other policies with the central objective of making the health sector more client centred and financially sustainable.

Table 2. **Progress of health sector reform in Latin American and Caribbean countries**

Incipient	Intermediate	Advanced
Dominican Republic	Bolivia	Argentina
Ecuador	Mexico	Brazil
El Salvador	Nicaragua	Chile
Peru		Colombia
Paraguay		

Source: Ref. *2*.

Table 3. **Status of reproductive health in Latin American and Caribbean countries**[a]

Poor	Moderate	Good
Bolivia	Dominican Republic	Argentina[b]
Ecuador	Colombia	Brazil
El Salvador	Mexico	Chile[b]
Nicaragua		
Paraguay		
Peru		

[a] *Source:* Ref. *2*.

[b] Total fertility rate (TFR) and contraceptive prevalence figures were not available for Argentina and Chile. However, based on population growth, it was possible to infer that contraceptive use and/or induced abortion were common practices.

What is reproductive health?

The reproductive health approach, which was globally adopted in 1994 at the ICPD in Cairo (*8*) and reaffirmed and strengthened at the FWCW in Beijing in 1995 (*9*), articulates a critical shift of focus in health and population policies and programmes — from a primary emphasis on achieving country-level demographic targets, largely through family planning programmes, to a focus on improving the quality of life for individuals, primarily through the promotion of human rights and the provision of a comprehensive range of reproductive health information and services. Tenets of the reproductive health approach include the integration of reproductive health services, provision of client-centred, gender-sensitive, high-quality health care, universal access, and free and informed reproductive choice guided by a human rights framework (*10*).

The growing strength and coordination of women's movements in different countries and regions, Latin America in particular, were responsible for the paradigm shift which was articulated in Cairo and other global forums (*11*). Increasingly, women are banding together to criticize the overemphasis on control of female fertility — especially such abuses as forced sterilization and lack of informed consent — and the exclusion of women's other health needs and general well-being (*12*). It has been internationally recognized that the absence of equal status for women is clearly linked to the denial of their reproductive rights and is, at least in part, responsible for their poor reproductive health (*13*).

To change this situation calls for the use of a gender perspective to guide reproductive health policy-making and service delivery (*14*). The effects of power imbalances between women and men must be examined and equitable responses must be developed by empowering women and involving men in issues related to reproductive health (*15*). A gender-sensitive reproductive health approach looks beyond the confines of clinical medicine and address women's status and the underlying causes of poverty and poor health.

Interactions between health sector reform and reproductive health: synergies, conflicts, and challenges

Theoretically, the priorities of reproductive health advocates resemble those of health sector reform in a variety of ways. For example, both groups advocate improved health status through equitable access to high quality care, integrated approaches to primary health care, and decentralization of authority through participatory processes which involve the public in setting priorities on health care spending, service design, and delivery (*4*). Furthermore, both movements tend to incorporate principles of democratization (e.g. decentralization and community participation) and share the goal of fostering human development in more efficient and equitable ways (*16*).

However, key questions remain about the effects these movements are having on one another in practice and, especially, as to whether the consequences of current health sector reform strategies are creating opportunities rather than barriers for reproductive health in the LAC region. Experience from a number of countries suggests that

the implementation of these two policies is complex, and that elements of health reform have not always facilitated — and may not be able to facilitate — the realization of the reproductive health agenda (*16*).

One of the major challenges currently facing health managers is how to implement together health sector reform and the reproductive health approach so that the objectives of both are effectively achieved (*15*). As countries implement health sector reform, they need to guarantee that health systems improve the quality and accessibility of reproductive health services, and recognize that these services are an important base upon which to build and improve primary and secondary health care (*7*).

There are risks, however, that while reform efforts focus on such central issues as financing, reorganization of service administration, and decentralization, the specific technical and financial inputs required for reproductive health will be neglected. Another risk is that efforts to integrate family planning programmes and expand them to a broader reproductive health approach may — instead of improving the whole health system — result in another type of vertical programme (*7*) and/or undo the successful outcomes of previous vertical programmes.

Another potential conflict between health sector reform and reproductive health arises from applying a laissez-faire economic model to the provision of health services. When health care comes to be viewed as an economic "commodity" and the task of providing it as a business guided by market forces, there is a risk that cost savings and/or profit to the system — rather than a focus on quality improvement, enhanced access, and consideration of the social, cultural, and economic dimensions of health problems — will drive the reforms (*2*). In this context, reproductive health services could suffer, with further marginalization of key target groups such as women and adolescents.

There is evidence that, on a global scale, the targets set for reproductive health funding, which were agreed to at the ICPD in 1994, were falling far short of the minimum requirements five years later (*17*). Progress is also stifled by the fact that some donors and governments have failed to move beyond the rhetoric of reproductive health, which they demonstrate by continued funding of discrete projects and services more for purposes of internal measurement and accountability. These macro trends have important implications for the further progress of implementing a comprehensive reproductive health approach in the context of health sector reform and must be further analysed and reversed.

Of concern is the dearth of critical information on the impact of health reform efforts on the reproductive health care movement. Much of the current knowledge base comes from theoretical projections or isolated anecdotes about what is actually happening in practice. There is, therefore, an urgent need for more and better research related to these interactions (*2*).

Decentralization, changes in health services financing, and the role of the private sector

The above were the themes of three regional workshops, which were held, respectively, in Mexico City, Quito, and Brasilia between June and August 1999. The highlights of the discussions are outlined below (*2*).

Decentralization

Decentralization, or the transfer of authority and management from central to local levels (*18*), can, in theory, support the comprehensive reproductive health approach. Client-centred care requires responsiveness to the needs and demands of service users. Among the advantages of decentralization are that it puts authority in the hands of managers, often at the district level, who tend to be better acquainted with local conditions than persons at higher levels (*16*). Decentralization can mean greater flexibility in how resources are allocated and used. It can also promote capacity-building by ensuring that training and other investments are adapted to local needs. In addition, district managers and planners are closer to the communities they serve, increasing the potential for extensive community inputs on decisions about service design, delivery, and evaluation (*19*).

One of the greatest challenges posed by decentralization is that it requires greater technical and management capability at all levels of the health system, and strong, efficient structures to link local and district-level systems to the national level (*16*). So far, the overall effectiveness of decentralization efforts is mixed, and most LAC countries are finding the process difficult to carry out well. Recent assessments from the literature show poor outcomes in terms of successful transfer of decision-making capacity and improved equity (*20*). Country-level experience in the region shows that success or failure of decentralization depends on how the process is designed, the pace of implementation, and the capacity and maturity of the health system when such reforms are undertaken (*2*).

Mexico, like many countries in the LAC region, has a legacy of centralized decision-making and top-down management infrastructure. As a result, political resistance to the redistribution of power is strong, capacity at lower levels of the health care system to manage decentralization is weak, and the process takes time and is often fraught with challenges. The experience in Mexico emphasizes the need to move slowly, giving people and systems time to adjust to radically different philosophical and administrative approaches to policy design and service delivery (*2*). Policy changes towards decentralization must be supported by clear and widely disseminated terms of accountability and a system-wide programme to build the requisite technical and administrative skills. In addition, mechanisms must be in place to facilitate information-sharing and

coordination among the different levels of the health system in both the public and private sectors. Standardized norms for high quality service provision, including reproductive health, must be developed, disseminated, and implemented, with systems in place to monitor and regulate the quality of care in both public and private sectors.

Decentralization has been conceptualized very broadly in terms of policy, financing, administration, and programming at the country level. The process is intended to be part of a larger shift towards democratization. In Paraguay, as in Argentina, a central problem is that there is no national population policy or reproductive health policy to guide the implementation of these critical services in the context of health sector reform (*2*). Progress has therefore been limited. The main challenges include a lack of technical, administrative, and financial management expertise and limited awareness of reproductive health problems as public health priorities at the local level. In addition, officers at the central level are facing difficulties in decentralization owing to inadequate experience, reluctance to make decisions based on consensus, and inability to relinquish centralized control (*2*).

Common experience in the LAC region shows that development of "comprehensive" service packages is a difficult process requiring a balance of national and local health priorities with available resources. Such processes have serious implications for the delivery of reproductive health services. In decentralized health systems, for example, the importance of reproductive health must be emphasized at each level and in each location. In some cases, reproductive health has fallen down in the local priority list, further restricting access to these vital services for the most vulnerable segments of the population (*2*). Furthermore, decentralization policies have often not been supported by an adequate infrastructure. There appears to be limited coordination between the various public and private sector bodies tasked with implementing health sector reform and the reproductive health approach, which sometimes leads to fragmented progress and missed opportunities to improve the whole health system.

Health services financing

One of the major thrusts of health sector reform is securing sustainable funding for services. In some LAC countries, such as Colombia, this has meant a shift from the supply-side to demand-side subsidies. This strategy strengthens the client's capacity to choose providers and creates greater market competition (*2*). A second strategy is cost recovery. User fees and other methods of recovering some of the costs of health care are increasingly common in public sector health systems. In many developing countries, users of reproductive health care already pay a variable share of the costs of the care they receive. While the amount of income accumulated through user fees tends to be small, if these fees are retained and reinvested at the service facility they can provide revenue for improving general quality of health services (*15*). In addition, clients tend to demand a more responsive service when they pay for it directly, especially if local communities are involved in the design and application of user fees (*21*). Some health facilities in LAC countries are attempting to balance user fees and subsidized care, with the fees being charged on a sliding scale, the poorest clients paying less than those with greater financial means.

User fees can be applied to improve service efficiency and quality in a variety of ways. For example, they can be leveraged to encourage clients to use the lowest possible level of care by charging those who go directly to higher-level facilities, such as hospitals, for services that could be provided at a health centre. Implementation of such fees helps to ensure that mainly those who really need the higher-level facilities and staff will use them. Furthermore, user fees can be applied to influence the demand for certain services. Services with high individual or social benefits, such as STD prevention, can be provided free or at low cost to encourage their use. Services with largely private benefits, such as pregnancy testing and ultrasound, might carry higher fees. User fees, however, must be implemented with care. Experience in the LAC region shows that while user fees for public services have mobilized resources for the health system and specific health facilities, in many cases, neither the poor nor certain critical services have been adequately protected from the marginalizing effects of a heavy cost to the client. One result can be a reduced utilization of services by the people who need them most (*2*).

In order to meet the ICPD's goal of universal access to reproductive health services in a health sector reform environment, "safety net" systems must be in place (e.g. free services, subsidized care, insurance schemes, and sliding-scale fees) so that economically and otherwise deprived women, men, and adolescents continue to receive high-priority and high-quality services, including prenatal care, skilled attendance during delivery, STD screening and treatment, and family planning information and services (*15*).

Key questions being asked by many LAC countries are how to increase the contribution of private for-profit and non-profit sectors to the national health care system and what will be the effect. In general, very little is known about the current and potential role of the for-profit sector, and many issues arise related to the management and regulation of those services. In some LAC countries, a mix of private and public service delivery and financing is evolving but it is still too early to know if an appropriate and effective balance can and will be struck (*2*).

Health sector reform in Colombia began before the ICPD's 1994 statement on the global shift towards reproductive health. However, universal coverage for basic health care, including reproductive health, has been one of the end goals of sector reforms from the beginning. Health sector

reform has led to more financial resources for health care, an emphasis on more efficient use of resources, decreased donor dependence, broad-based support for health promotion and preventive care, and special attention to underserved groups. All of these sector-wide trends have had positive impacts on the delivery of reproductive health services in Colombia (*2*).

Colombia's broader health coverage through universal primary health insurance has created a greater demand for and use of services, thus expanding the range of providers and clients. Competition among providers in both the public and private sectors was intended to create positive pressure on organizations to streamline, improve the quality, and be more innovative in the design, management, and financing of basic health care services.

In Ecuador, there is a law that the provision of maternity care (prenatal care, delivery, and postnatal care) shall be free of charge (*2*). Despite the law, charges for obstetric services continue to be levied on clients in both the public and private sectors. The financial contributions made by clients are critical to maintain and improve the current level of service quality. An ideal system is one that fosters a public/private mix, in which part of the costs for obstetric services are paid by clients subsidized by a public insurance plan. Awareness was expressed that insurance plans carry financial risk and may not be sustainable over the long term. A number of NGOs in Ecuador are currently working with the Ministry of Health to experiment with alternative health care financing models. Of great concern is the development of a flexible system that will not stifle access to vital reproductive health and other services in the poorer parts of the country (*2*).

The role of the private sector

Shifting the financing and/or delivery of health services from the public to the private sector is another key component of health sector reform in many countries. In most LAC countries, the oldest and still the biggest provider of health services remains the public sector. But many countries show that services are provided by an increasingly diverse range of institutions. The number of private for-profit clinics, hospitals, and pharmacies has increased rapidly in many LAC countries, accompanying the growth of urbanization. In addition, more non-profit NGOs are joining the health sector to provide reproductive health information and services. However, experience with these types of changes is uneven across the LAC region (*2*).

NGOs in LAC countries have a long history of being instrumental in providing family planning and other reproductive health services. Their tendency toward non-partisanship, flexibility, and objective to serve those most in need have propelled them to address vital public health issues, such as unsafe abortions and adolescent reproductive health, which are often politically or ideologically too sensitive for other types of providers to take on.

However, many NGOs that provide key reproductive health services are facing increasing pressure from donors to achieve financial sustainability, which, in turn, is forcing some to charge clients escalating prices for care. Indeed, a number of NGOs are relying increasingly on user fees to cover much of their operational costs. Some have adopted a strategy of charging fees for services that people are willing to pay for, and using the revenue generated to subsidize services for which the clients' ability to pay is lower. The danger is that by charging even subsidized fees for services, NGO programmes could shut out the people for whom they are often the only accessible providers of high quality reproductive health services. Nonetheless, NGOs in the LAC region are playing a major role in implementing the comprehensive reproductive health approach. Their experience and ability to advocate and address critical areas of reproductive health and social well-being are placing them at the forefront of policy and programmatic changes in many LAC countries and ensuring that reproductive health becomes and remains a national priority (*2*).

NGOs are playing a vital role in Peru to educate current and potential clients about their right to high quality reproductive health and other services. The involvement and empowerment of clients, through civil societal and actual consumer inputs in health service design, delivery, and evaluation, is helping to make clients more aware and more demanding of the services they receive. As a result, the health system is becoming more responsive and accountable to clients' needs. Movimiento Manuela Ramos, a Peruvian national NGO, plays such a role by working with approximately 200 community-based organizations around the country to foster and support the improvement of reproductive health services and ensure that the public health system incorporates women's perspectives into health care delivery and institutionalizes women's participation in the design and implementation of government health services (*2*).

Despite progress in such collaboration, the experience of Manuela Ramos highlights some of the ways it can be difficult for NGOs and the government to work together. There has been government resistance concerning the amount of donor support the NGO has received independent of the Ministry of Health. Further tensions resulted during the 1996–97 sterilization campaigns. The NGO found that the most successful collaboration took place at the local and regional levels, where agreements with specific time-frames and actions were signed. More recently, however, the Ministry sought input from Manuela Ramos with regard to strategies that allow service users to prioritize their own health needs. The NGO is hopeful that such collaboration will lead to sustained mechanisms that guarantee the clients' abilities to hold the Ministry of Health accountable for its actions and lead to more appropriate client-centred services (*2*).

Brazil is undergoing a relatively harmonious transition through health sector reform with a strong

emphasis on reproductive health. Pivotal factors in making reproductive health a priority are the impact of the feminist movement pushing the ICPD-Cairo and FWCW-Beijing agendas at both national and local levels and a strong political will (*22*). In terms of health sector reform, in spite of an economic austerity climate, the government has approved additional health financing, advanced basic health approaches through a combination of family health and community-based strategies, and accelerated the decentralization of health services. In this environment, reproductive health care is increasingly integrated with municipal-level primary health services, and the quality and range of available services are improving (*2*).

Growth in the size and influence of civil society in Brazil since the 1980s has facilitated the positive change. Increasingly democratic processes have lengthened the policy decision-making process, but also given voice to the advocacy community and allowed for public debate of reproductive health and human rights issues. Open political debate is persuading other key actors to adopt the agenda. The ability of the advocacy community to interact with the Ministry of Health and Congress, as well as to move into policy-related positions, has worked in favour of achieving reproductive health goals in Brazil (*22*).

Conclusions and recommendations

The gap between comprehensive rhetoric and selective practice has resulted in limited change to health systems in many LAC countries. Decentralization, integration, private sector involvement, and other processes related both to health sector reform and reproductive health have generally not been well coordinated, and such fragmentation has resulted in overlapping policies and lagging programmes. Policy and programme development have also been hindered by inadequate human and financial resources, uneven allocation of responsibility between different levels of the health system and service components, a lack of communication between programme staff, and limited political and organizational commitment to improving health service quality and equity.

In order to implement together effective health sector reform and reproductive health care, managers and providers at all levels need training and strong support to ensure universal access to a comprehensive package of high quality primary health care services that includes reproductive health (*7*). Vision from the top is critical, but it must be matched with leadership and a sense of ownership of the processes at the local level.

Strategies to improve reproductive health in a health reform environment

Engage in continuous dialogue at the regional and country levels. Developing a shared vision of how health sector reform and reproductive health can be successfully undertaken together will require mutual respect for the importance of both movements and a desire to work together for the benefit of the whole health system. Given that each country's situation is unique, mechanisms for communication and collaboration will vary. It is most important that sustainable systems are developed and utilized to share and use information regularly and effectively. Formalized South-South collaboration can serve as a valuable mechanism for sharing experiences among countries with varying levels of progress (*2*).

Employ participatory processes for monitoring progress. The importance of establishing clear programme goals and agreed measurable indicators of requirements from the outset should not be underemphasized. One of the main shifts in approach under reform is that progress in implementing programmes focuses on results rather than inputs (*2*). For this to work, key stakeholders (community and women's groups as well as reproductive health managers and providers) should be involved in the goal-setting and indicator selection process, as well as the management and evaluation of health services (*7*). To help ensure that the radical changes in organization and management of both health sector reform and reproductive health are carried out effectively, it may be useful to establish management units with representatives of both movements to oversee the transformation process. In addition, the guidance of experts in such areas as organizational capacity-building, personnel systems, and financial management may be useful to assist in the assessment of existing capacity for these functions and to help in strengthening such capacity when necessary (*7*).

Continue building on the important role of NGOs. Changes in financing and decentralization are creating a new environment for NGO activity. Care must be taken to ensure that NGOs continue to serve those most in need and that the quality of the services they provide is monitored and regulated. Many NGOs possess valuable experience and have developed viable strategies for addressing sensitive reproductive health issues and groups with particular needs, such as women and adolescents, in the LAC countries. Both the public and private for-profit sectors can benefit by involving NGOs in their reproductive health activities (*2*).

Strengthen local level capacity. In order for democratic processes to function effectively, client input on health services design and delivery must be sought and incorporated. Local-level managers and providers need the skills to solicit and use such input, as well as capacity to develop mechanisms to address gender-sensitivity in policy and programme development, institutional and professional accountability, and quality improvement (*2*).

Work with international aid organizations to achieve commitment. Work with international aid organizations is required to achieve commitment and

develop practical mechanisms to operationalize support for national health sector reform strategies with reproductive health as a priority. Donors and social development banks can undermine reform efforts by refusing to follow the mandates established at the country level (*2*). External funding and/or technical support for reproductive health in a reform setting could lead to such distortions if donors and programme managers do not coordinate their efforts in reproductive health with those of the broader health reform programme. On the other hand, donors who adopt a broad view of sector-wide development can play an important supporting role by helping to ensure that reproductive health issues are given priority (*7*).

In order to fill the information gaps relating to how health sector reform is impacting on reproductive health care in practice, there is an urgent need for more extensive quality research. Specific areas to be addressed in terms of decentralization include examining the interaction between central and local authorities to determine the allocation of funds, assessment of priorities, development and application of quality norms and standards in reproductive health; assessing the capacity of local health care units to respond to the specific requirements of reproductive health (e.g. awareness of rights, informed consent, gender-sensitivity, client-centredness, etc.); and developing a better understanding of the specific needs of population subgroups such as indigenous populations, adolescents, and migrants. Critical research themes related to financing include assessing the ability and willingness of clients to pay user fees and how the fees impact on both demand and access to reproductive health services in the public and private sectors; identifying mechanisms for the collection and reinvestment of user fees at the service delivery level; and evaluating health care financing alternatives in a decentralized system. In terms of the role of the private sector, it is important to assess the effectiveness of regulatory systems to monitor the performance of private institutions, and learn from the experiences of public and private institutions to successfully combine strengths (public/private mix) in the provision of reproductive health care, including contracting-out and other cross-subsidy schemes.

Implementation of health sector reform and the reproductive health approach can and should be mutually reinforcing, which is often not the case. Both require complex and sometimes conflicting changes at all levels of the health care system. These changes can threaten the interests of major stakeholders, who then react by working against the advancement of these agendas. It is essential that full communication, coordination, and collaboration be established between those working towards broader health sector reform and those working to ensure the provision of high quality reproductive health services in order to foster a harmonious and mutually beneficial transition. The better these movements work together, the more likely that both health reforms and reproductive health initiatives will bring about the cost-effective and equitable use of resources and universal improvements in health status which both are seeking. ■

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Résumé

Comment renforcer le lien entre les réformes du secteur de la santé et l'organisation des services de santé génésique en Amérique latine et dans les Caraïbes

A la suite de l'intérêt porté à ces questions au niveau international, de nombreux pays d'Amérique latine et des Caraïbes s'occupent en même temps de réformer leur secteur de la santé et de globaliser les prestations de santé génésique. Compte tenu de la charge individuelle, économique et sociale considérable que représentent les problèmes de santé génésique dans les pays à revenu faible et moyen d'Amérique latine et des Caraïbes, la garantie d'un accès universel à des services de santé génésique de qualité devrait idéalement être un objectif prioritaire des réformes du secteur de la santé. Outre qu'elles leur ouvrent des perspectives nouvelles, de telles réformes invitent à améliorer la viabilité et l'efficacité des prestations de santé génésique. Mais, malgré l'existence d'un terrain commun aux réformes du secteur de la santé et à l'organisation des services de santé génésique, le résultat final n'est pas garanti.

Afin de mieux faire comprendre comment mettre à profit les réformes en vue d'une amélioration des prestations de santé génésique et le lien qui existe entre les deux processus, le Conseil de la Population en Amérique latine et aux Caraïbes a organisé en 1999 trois ateliers auxquels ont participé des fonctionnaires, des représentants d'organisations non gouvernementales et des universitaires de douze pays de la région. Ces ateliers ont révélé que les objectifs de l'action de santé reproductive et des réformes du secteur de la santé étaient parallèles en ce sens que les deux visent à promouvoir un accès équitable à des soins de qualité par l'intégration des soins de santé primaires et la participation de la population à la définition des priorités du secteur de la santé pour ce qui concerne les dépenses de santé, la conception des services et leur fonctionnement. Pourtant, le risque est réel de voir les réformes

obéir essentiellement à des impératifs financiers et/ou politiques et non à la nécessité d'améliorer la qualité des prestations en réponse à un droit fondamental de la personne humaine. Si tel était le cas, les réformes pourraient compromettre voire entraver les progrès des soins de santé primaires, santé génésique comprise.

Les participants à ces ateliers ont relevé l'émergence, dans toute la région, de trois faits importants aussi bien pour la santé génésique que pour les réformes du secteur de la santé : la décentralisation, l'instauration de nouveaux modes de financement des services de santé et l'intervention du secteur privé. Ils se sont demandés si la décentralisation pourrait favoriser une approche globale, axée sur les individus, de la santé génésique en donnant le pouvoir à des instances locales généralement mieux familiarisées avec les besoins de la population. Parmi les problèmes associés à la décentralisation, figurent le manque de compétences techniques et gestionnaires, la difficulté qu'éprouvent les instances supérieures à renoncer à exercer un pouvoir central et une expérience limitée de la participation active. Les nouveaux modes de financement des soins de santé ont été évoqués. Si la recherche de l'autonomie financière au sein du système de santé est essentielle, elle n'est peut-être pas sans danger pour la santé génésique. En effet, si les soins de santé en viennent à être considérés comme un bien économique, le risque est que les réformes soient conduites surtout pour réduire les coûts au détriment de l'amélioration de la qualité. Une telle orientation pourrait avoir des conséquences négatives pour la santé génésique.

Il a été question du rôle décisif du secteur privé, en particulier par le biais des organisations non gouvernementales, dans la promotion de la santé génésique. Il a été convenu que l'on sait très peu de choses au sujet de ce secteur et des questions importantes ont été posées sur les moyens qu'a l'Etat de contrôler et de réglementer son activité. Quoi qu'il en soit, la multiplication des hôpitaux, cliniques et pharmacies privés qui accompagne l'urbanisation dans la région impose que soient explorées les possibilités dans ce domaine.

Si l'on considère que seuls des changements limités ont été apportés aux systèmes de santé dans beaucoup de pays d'Amérique latine et des Caraïbes et que les exemples de progrès dus aux réformes sont rares, il y a encore loin de la théorie à la pratique. Les processus intervenant dans les réformes du secteur de la santé et dans l'organisation des services de santé génésique ont souffert d'une mauvaise coordination. Par ailleurs, l'absence de volonté politique, combinée au manque de ressources et à des moyens techniques et gestionnaires insuffisants, n'a pas favorisé l'élaboration de politiques et de programmes appropriés. Il est à l'évidence nécessaire de concevoir et d'institutionnaliser les mécanismes nécessaires au dialogue, de mettre en œuvre des processus de participation active pour suivre les progrès accomplis et de conduire d'autres études sur les interactions entre les réformes du secteur de la santé et l'organisation des services de santé génésique.

Resumen

Reformas del sector sanitario y salud reproductiva en América Latina y el Caribe: fortalecer los vínculos

Gracias a una mayor atención internacional, muchos países de América Latina y el Caribe están reformando actualmente sus sectores sanitarios, y aplicando además un enfoque integrado a la atención de salud reproductiva. Dada la grave carga personal, económica y social que suponen los problemas de salud reproductiva en los países de ingresos bajos y medios de América Latina y el Caribe, el acceso universal a unos servicios de salud reproductiva de alta calidad debería ser teóricamente una prioridad de las reformas del sector sanitario. Además de brindar nuevas oportunidades para la salud reproductiva, esas reformas obligan a mejorar la sostenibilidad y el desempeño de los servicios de salud reproductiva. Pese a la existencia de un terreno común entre las reformas del sector sanitario y la atención de salud reproductiva, no hay ninguna garantía respecto a los resultados finales.

A fin de comprender mejor las oportunidades que brindan las reformas para mejorar la salud reproductiva, así como los vínculos entre los dos procesos, el Consejo de Población de América Latina y el Caribe organizó en 1999 tres talleres, que congregaron a funcionarios públicos, representantes de organizaciones no gubernamentales y profesores universitarios de 12 países de la región. Los talleres pusieron de relieve el paralelismo de los objetivos de la atención de salud reproductiva y de la reforma del sector sanitario, en el sentido de que ambas aspiran a promover un acceso equitativo a una asistencia de alta calidad mediante la aplicación de enfoques integrados de la atención primaria y la participación del público general en el establecimiento de prioridades sanitarias en lo relativo al gasto asistencial y al diseño y la prestación de servicios. Sin embargo, existe un grave riesgo de que las actividades de reforma sanitaria se vean impulsadas fundamentalmente por criterios financieros y/o políticos, y no por la necesidad de mejorar la calidad de los servicios como derecho humano básico. En esas circunstancias, las reformas podrían dificultar, incluso socavar, los progresos en materia de atención primaria, incluida la atención reproductiva.

Se identificaron tres temas importantes que estaban cobrando importancia en la región en relación tanto con la salud reproductiva como con las reformas del sector sanitario, a saber, la descentralización, los cambios experimentados por la financiación de los servicios de salud, y el papel del sector privado. Respecto a la descentralización, se habló de su utilidad para respaldar un enfoque integrado y centrado en el usuario de la salud reproductiva, al delegarse la autoridad en actores locales que suelen conocer mejor las necesidades de los usuarios. Entre los problemas asociados a la descentralización, cabe citar la falta de capacidad técnica

y de gestión, los intentos de las instancias superiores de mantener el control central, y la limitada experiencia en los procesos participativos. Se habló de nuevos enfoques en la financiación de la atención sanitaria. La búsqueda de la autosuficiencia financiera dentro del sistema de salud es muy importante, pero puede entrañar graves amenazas para la salud reproductiva. Si se llega a considerar la atención sanitaria como un producto económico, existe el riesgo de que el proceso de reforma se vea presidido por la reducción de costos, en detrimento de la mejora de la calidad, lo cual puede perjudicar a la salud reproductiva.

Se abordó el papel crucial desempeñado por el sector privado, en particular por las organizaciones no gubernamentales, en la promoción de la salud reproductiva y en el suministro de información y servicios en ese campo. Se reconoció que es muy poco lo que se sabe sobre el sector lucrativo, y se plantearon importantes interrogantes acerca de la capacidad del Estado para implantar medidas de vigilancia y regulación. No obstante, la enorme proliferación de hospitales, dispensarios y farmacias privados de que va acompañada la urbanización en la región hace de este sector un interesante ámbito de estudio.

Los cambios experimentados por los sistemas de salud en muchos países de América Latina y el Caribe son limitados, y no abundan los ejemplos de progresos conseguidos gracias a las reformas, de modo que el desfase entre la teoría y la práctica sigue siendo importante. Los procesos relacionados con las reformas del sector sanitario y la salud reproductiva no se han coordinado bien hasta la fecha. La falta de voluntad política, unida a los limitados recursos disponibles y la deficiente capacidad técnica y de gestión, también ha dificultado el desarrollo de políticas y programas en el nivel de ejecución. Es necesario sin duda elaborar e institucionalizar los mecanismos de diálogo, emplear procedimientos participativos para vigilar los progresos realizados, y llevar a cabo nuevas investigaciones sobre la interrelación entre las reformas sanitarias y la atención de salud reproductiva.

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