Initiative for sexual and reproductive rights in health sector reforms: Latin America

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Health Sector Reform and Reproductive Health
Community participation and accountability in Latin America

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Reproductive health goes beyond the universe of individual life since public policies agendas, non-governmental organizations and the demands of women’s movements are framed within it. The participation of organized groups of women and the act of international agencies that promote reproductive and sexual rights have been a key aspect in the spreading of the achievements made at the International Conference on Population and Development, Cairo, 1994, sponsored by the United Nations (Oliveira & Rocha, 2001).

In order to understand the concept of community participation, and of service accountability mechanisms, and their articulation with the improvements made in the field of reproductive health in Latin America, it is necessary to consider the larger processes which have been taking place in the region over the last decades, so as to contextualize the data obtained in the case studies, and basically, in order to learn those lessons which facilitate more influential research and action proposals.

Latin American researchers agree, to a certain point, on the fact that, though the local scenarios are heterogeneous, the political and economical history of the region in the last decades has two elements in common: democratization movements, and the impact of structural adjustment programs (Fleury 2000). In almost all of the region countries, structural adjustment policies applied on the State and on resource allocation, have been characterized by a cutting down of social expenses, threatening the universal condition of the achievements made in the field of health, which are now seen as an element for the construction of citizenship (Oliveira & Rocha, 2001).

Community participation in Latin America

Some authors have analyzed the concept of participation taking into account the previously mentioned elements. Thus, Briceno León (1998) revises the different meanings the concept of participation has had in the field of health, and points out the changes suffered by the idea of participation as a result of the radical transformation undergone by the Latin American society in the past forty years. The author begins by describing the concept of participation in the context of the Cold War and points out four modalities: participation as ideological manipulation, as cheap labor costs, as a facilitator of medical action, and as subversion. Then, he moves on to revise participation in the context of the ideologies crisis and emphasizes two modalities: participation as a grassroots’ movement, and as popular initiative. Finally, he explains the shapes participation takes in the context of the adjustment programs, which he describes as a complement of the State and as privatization.

The implementation of adjustment programs in the region produced radical changes in the concept of community participation: it went from being a despicable word (basically due to is “subversive” connotation), to being a sort of panacea of health programs. Here, participation is
situated in the context of the State transformations, particularly regarding its size reduction and changes in its responsibilities.

As the State becomes smaller, it leaves aside execution and its responsibilities are restricted to orienting and leading. Thus, the care and prevention tasks are transferred to the civil society. This process is simultaneous to that of decentralization: i.e. the transference of responsibilities from the central governments to the provinces, departments or states, based on the assumption that local instances would be more appropriate to identify the needs and would facilitate the participation of the population or of organizations (See section on decentralization).

Following a similar line of thought, Caledón and Noe (2000) analyze health sector reforms and social participation in Latin America. They point out that the promotion of participation as a strategy to improve health may consider people as simple beneficiaries or receptors of health care. This meaning of the concept of participation is based on a vertical relationship, in which the opportunities for people's participation are scarce. This is valid for those countries in which the health public sub-sector has had a preponderant role.

Another modality is participation in health promotion: those who encourage it see participation as the population's voluntary support to certain social development programs and projects established by the health services. There is a vertical relationship between the public agent and the people, who are seen as a facilitating instrument or resource for the actions of the State. Instead, community participation is the organization of community into committees or groups to support social programs (a type of participation promoted by international organizations as one of health reform basic strategies). Its purpose is to identify resources in the community, and to train the population so as to make it become an active agent in its development.

Finally, the authors put emphasis on a modern view of participation, which sees people both as citizens and as users of a health system, and before which the health system must render accounts for quality and opportunities of service and for the efficient use of the resources. This poses the need for participation mechanisms that allow people to exercise their right to health protection. To enforce people's rights requires certain civil mechanisms of control. At the same time, mechanisms of control need certain condition in order to be really efficient and to promote equity. As Smulovitz (1997) points out, even when citizens know their rights and there are no legal restrictions, the possibility to exercise such rights will be conditioned by a set of institutional factors, which can either enable or hinder it.

Women's participation

When thinking about participation and reproductive health, some milestones regarding the women's movement in the region have to be considered. As stated by Rostagnol (2001), at the beginning of the 80’s, women’s health was already part of the movement agenda in Europe and in the United States, but not in the Southern Cone, where the priority issues were the resistance to dictatorships and the achievement of democracy, as well as the search for options to face the crisis resulting from adopting adjustment policies. The author states that, despite all this, some issues related to reproductive health also raised interest.
In 1981, the First Latin American Feminist Meeting gave visibility and autonomy to the feminist and women’s movement. In 1984, women from the Southern countries took part in the IV International Women and Health Meeting. Reproductive rights were one of the main topics, and the Women’s Global Network for Reproductive Rights was created, with headquarters in Amsterdam. That same year, the Latin American and the Caribbean Women’s Health Network was established, with headquarters in Chile. The purpose of this network is to provide information to feminist and women’s organizations, as well as to local and regional health service providers, by creating a documentation center and publishing a magazine. Also during that year, the International Women’s Health Coalition, with headquarters in New York, and Catholics for a Free Choice, with headquarters in Washington, established affiliate offices in the region. It is also necessary to point out the contributions made by financing agencies that support, either directly or indirectly, some of the activities carried out by these groups of women and organizations.

At the beginning of the 90’s, some important changes took place as a result of a preponderance of globalization over local peculiarities. In Latin America, though many countries had began with the health reform at the beginning of the decade, the reform related to sexual and reproductive health became stronger as countries adopted the Action Program promoted by the International Conference on Population and Development (United Nations, 1994).

The International Conference on Population and Development promoted a greater involvement of non-governmental organizations (NGOs) in reproductive health issues, and also called civil society to play a more active role in the design and implementation of programs so that the needs of local population health (including those referred to sexual and reproductive health) were met. By encouraging governments to promote community participation, the Action Program supported the process of decentralization from nationally managed health programs to private providers and NGOs.

It is important to emphasize that the participation process in Latin America takes place within a context of extreme democratic weakness in which the possibilities for civil participation are quite limited. According to Bronfman (1998), the decentralization and participation processes in Latin America, though related, did not strengthen one another: decentralization has been imposed by governments as part of the reform process instead of being an answer to the demands of the people.

Available evidence regarding participation and reproductive health in Latin America

Most of the literature on national experiences is based on the documents developed by the Policy Project2 (2000). The following examples refer to reports on the work carried out by this institution in Bolivia, Peru, Mexico and Guatemala. In all cases, the main purpose of the Policy Project was to reinforce the participation process in order to help improving the decentralization of the health sector and to create a favorable environment for the development of reproductive health.

The report on Bolivia points out that despite the favorable political-institutional environment granted by the Popular Participation Law (1994) and by the Administrative Decentralization Law

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2 The Policy Project was created by the U.S Agency for International Development. This project began to be implemented in September 1995 by "The Futures Group International" in cooperation with "Research Triangle Institute" (RTI) and "The Centre for Development and Population Activities" (CEDPA)
(1995), civil society lacked the strength needed to become involved in the decision-making process, thus hindering the possibility of carrying out a participatory decentralization process.

The report shows that the main obstacles to this process were related to the insufficient knowledge regarding the rights and obligations granted by law, as well as to the lack of abilities and skills needed to participate in the decision-making process. As regards reproductive health, the report states that neither the community nor the local authorities considered these issues a priority to be included in government programs. Besides, advocacy groups, the main actors when fostering the inclusion of these issues in the local agendas, were too weak and had little contact with each other.

Given this context, the efforts of the Policy Project were aimed at developing the participation of civil society and training community leaders and town council officers, who also received technical and financial support. Efforts were specifically aimed towards making citizens aware of the rights and obligations granted by the participation and decentralization law. It also made community members and decision-makers aware of the policies needed and of their impact on reproductive health. Women’s organizations received financial support and training in political participation (Pinto et al, 2000).

The report on Mexico describes the results of the implementation of a participatory methodology for multi-sector strategic development at the local level. Between 1997 and 2000, the National Aids Council (CONASIDA) developed a decentralization plan to transfer part of its functions to the local level. As part of the new functions, local states became responsible for: coordinating activities between the public, private and social security sector; developing guidelines in collaboration with each state commission of human rights, and training health personnel to improve the quality of HIV/Aids services.

The Policy Project began working in Mexico due to the difficulties found by the decentralization process in those activities related to HIV/Aids prevention and treatment. On the one hand, the decision-makers, the ones responsible for distributing the financial resources, lacked funds and knowledge on the topic. On the other hand, the strong conservative context resulting from the influence of the Catholic Church and of some political groups, made it very difficult to analyze the HIV/Aids epidemic in depth. As an answer to these difficulties, in 1988 the Policy Project began implementing a local level strategic planning program to foster the development of multi-sector planning groups.

The results show that the support given to local actors involved in HIV/Aids prevention strengthened the coordination between the public and private sector, helping create associations among groups from different fields. These actions made it possible to face the difficulties posed by the different conservative interests and to promote the decentralization process (Alfaro et al, 2000).

The report on Peru shows that the capacity of local governments to develop reproductive health programs according to the needs of the population was weakened by the local governments

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The Popular Participation Law was passed in 1994. The Administrative Decentralization Law was passed in 1995 transferring decision-making and financial control to local governments, and giving citizens the legal right and the responsibility to actively participate in the decentralization process.
lack of knowledge on sexual and reproductive health issues, by the public sector inability to recognize the importance of the civil society participation, and by the limited capability of local groups of women to lead advocacy actions. In this context, the Policy Project decided to work with local groups of women, training them on advocacy issues and providing them with the technical and financial support for designing and promoting campaigns on reproductive health, violence against women, political participation and citizenship. The work was done mostly with the National Network for the Promotion of Women's Health (RNPM), providing it with training and tools on policies and advocacy. The purpose was to help identify the needs of the community and to formulate proposals to public officers. Among the results, the following are pointed out: the strengthening of a women's network capable of working in the defense and promotion of sexual and reproductive health and rights, the incorporation of the sexual and reproductive health issue in the municipal programs, and the development of new sexual and reproductive health programs for young people.

The report on Guatemala poses the need to strengthen and promote the new Peace Agreement, signed after 40 years of civil war. This agreement constituted a favorable scenario not only for the development of civil society, but also to strengthen groups of women by acknowledging their rights. The very little experience civil society had on participation, and the strong conservative context that opposed to the promotion of sexual and reproductive health led the Policy Project to work with a women's network providing them with training on advocacy, with the skills needed to take part in the decision-making process, and with information on sexual and reproductive rights, gender equity and integral health. The activities were specifically oriented towards facilitating the development and establishment of civil society advocacy networks and organizations. They were encouraged to participate in the policy-making process so as to articulate their actions with the identified needs and to set priorities in the health sector.

In her publication “Encrucijadas entre el Estado y la sociedad civil en Salud Reproductiva” (Crossroads between the State and Civil Society on reproductive health), Susana Rostagnol (2001) analyzes the relationship between the women’s movement and the State as regards sexual and reproductive health in Uruguay. In her article, she analyzes a period of time between the mid 80’s and the beginning of the 2000. She explains that in the 80’s, during the re-democratization period, the women’s movement, including feminism, became public. Though sexual and reproductive health issues were not central to the women's movement agenda, they were an object of collective thought. The first democratic governments adopted structural adjustment policies, which resulted in a reduction of social benefits. The women's movement had several responses to this situation.

The 90s were characterized, among other aspects, by a greater implementation of the neo-liberal model, by the State reduction, and by new forms of relationships between State and civil society, as well as by the strong influence of the United Nations Conferences, particularly Cairo, which gave women’s situation a place in the international political agenda. The author highlights

4 The following were among the main points of the agreement:
1. Guaranteeing women the right to get organized and to participate at the same level as men in all levels of the decision making process.
2. Guaranteeing equal rights for men and women, especially at the rural and domestic environments.
3. Strengthening the active participation of the local governments and of the communities in the planning, implementation and execution of local programs and services.
4. Guaranteeing women access to an integral health and appropriate medical services without being discriminated
different women’s participation modalities in the ‘90s, depending on their social integration and considering the effects of structural adjustment programs.

Thus, those women from popular sectors, the ones most affected by the effects of unemployment and by cutbacks in social benefits, had different participation modalities in response to the crisis. Some entered the labor market, some created popular economy organizations, and some began participating in different social security programs providing basic services to the population. From the very beginning, structural adjustment programs tried to lower the costs by the intensive use of workforce. This fell into the hands of women, who were already carrying out many activities. In some popular economy organizations women developed productive activities, while others were in charge of distributing food and packed meals (community or popular food shelters). They also became health agents in other organizations, learning to give shots and to provide basic care.

Women from the middle social sectors, who were not so dramatically affected by the structural adjustment measures, promoted issues related to women’s condition, to the role of socialization in gender construction and to participation in the labor-market, among others. At the beginning of the ‘90s, many of these women, who were organized around health and reproductive rights issues, occupied public positions or were appointed in legislative positions at the different levels of the country’s political organization.

The author points out that this fact led to a representation crisis, for it created a gap between the represented women and their representatives, or between the women who occupied political or public positions and groups of women and organizations. Each of those areas is ruled by different logics. Many times, women participating from non-political levels do not feel represented by women in politics, but also the women who are acting in the public sphere do not feel supported by the women’s movement.

In the case of Ecuador, Lola Villaquirán (1999) analyzes an inter-institutional coordination management experience to develop the process of formulation and approval of the Reform Law on Free Maternity Care with the participation of the National Congress Health Committee, the National Health Council, the Ministry of Public Health, the World Bank Project on Health Services Modernization and the Center for the Promotion of Responsible Parenthood. According to the author, during the process of formulation and approval of the law mentioned, the National Women’s Council (CONAMU) played a very important role in directing the demands and expectations of the women’s movement and in monitoring the implementation of the law.

The women’s movement requested the following:

1) To subsidize demand and not only supply, as it had been the case until then. This was based on several studies showing that the quality of services was a patients’ permanent complaint, and was, in time, a reason for the increase in the use of private services. Thus, subsidy to demand would be one of the elements that would force service providers to improve the quality in the face

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5 The purpose of the law is to improve the access of women and children; to guarantee an integral reproductive health care; to integrate at a local level the services, municipalities and community organizations in the management of resources, and to strengthen the participation of civil society in the decision-making and local control of service quality.
of competition, so as to attract users and funds. This will give women the opportunity to attend those services which they considered to be more convenient.

2) The need to define a basic care package not only for women but also for younger children.

3) The incorporation of local governments to act as:
   a. Co-responsible for the promotion and prevention of women’s health, especially as regards transportation in the case of pediatric and obstetric emergencies in isolated areas.
   b. Responsible for the administration of the funds allocated for the performance of the law.

4) The creation of users’ committees with power to issue a “Satisfaction Certificate”. This Certificate would be an instrument to evaluate and rank services providers. The position of the different services in the ranking would affect the amount of funds they receive.

The National Health Council was not satisfied with the contents of the law. It basically criticized the compromise to keep on subsidizing supply, and the lack of guarantees for campesino women and women from popular organizations to participate in the local committees that managed the funds. It also mentions that the proposal to issue quality satisfaction certificates as a prerequisite for the allocation of funds to each service provider was not approved.

Two studies in Colombia highlight as an obstacle for participation the lack of knowledge and/or of perception that poor women have about their rights. In the first one, Ana Cristina González Vélez (2002) describes three kinds of obstacles that the population, not affiliated to the General Social Security Health System find when trying to solve their sexual and reproductive health problems. Such obstacles are: economical (people do not have money to spend in health), institutional (the system is based on a traditional view of maternal-child health, thus, it does not include contraceptive methods or preventive actions in terms of STD/AIDS), and socio-cultural. The latter are described as the impossibility of those women not affiliated to the General Social Security Health System to become citizens aware of their rights for they lack the knowledge about the mechanisms to participate in the health care system and about the places where they can obtain information or make a complaint.

The second study, developed by Serra et al (2002), describes the differences in needs and use of medical consultation when in the presence of a health problem, and in the equity of access to health services according to gender. The study is based on information from two national surveys carried out before and three years after the reform (1994-1997). Their results show an improvement in access to health services, mostly for those people affiliated to the contributive regime (formed by those who pay monthly fees from their salaries to cover their health insurance). No major inequities in access to health services are found. However, men, especially those between ages 5 and 14, have less access to health services than the rest of the population. Just like in the study previously discusses, this study evidences how people from low-income sectors are totally unaware of their rights within the General Social Security Health System.

In the case of Brazil, R. Parry Scott (2002) makes an in-depth and thorough analysis of the first experiences carried out in the country on participation by community agents in the field of reproductive health. By the end of the ‘80s, and as a result of a change in the traditional health programs approach, with a wide hegemony of medical professionals, new approaches were outlined as part of the dialogue initiated between the State and NGOs and social movements. These approaches were aimed at promoting health actions in some population segments (women, third age, etc.) with a view that goes beyond the limitations of programs traditionally organized by illnesses. This change of view encouraged the creation of different programs, one of them addressed to women...
(PAISM) and one to adolescents (PROSAD). It is important to point out that these programs were inspired and developed by the women’s movement and feminist ideas, and therefore included benefits related to reproductive health among their main components. Besides, the programs were implemented in close collaboration with the NGOs.

Two other programs were launched at the beginning of the ‘90s: the Community Agents Program (1991) and the Family Health Program (1994). Both programs made “problem-families” a priority. The Community Agents Program began working on reproductive health issues with important achievements. The agents were then incorporated to the new Family Health Program, which integrated reproductive health actions with other actions provided to the family as a whole. This, which could be seen as an integration process, ended up undermining the capacity of community agents to handle so many problematic issues, and made children and family health care a priority over reproductive health actions.

Apart from this first conclusion, and based on the analysis of the processes that have taken place, the author raises two questions, which undoubtedly challenge community participation:

- Are those community members who enter the health system (as community health agents) community representatives in the health system or health system representatives in the community? Which role do they play in the community? Who do they really represent?
- The decision made by regional sanitary authorities to incorporate community agents who had previously worked on reproductive health to work on “family” issues had a negative impact on reproductive health actions. Is the integration of actions the problem? or was this an action that had the purpose of undermining those achievements made by the women’s movement as regards care so as to benefit a more classical approach to maternal-child care?

Conclusions, new scenarios and new challenges

The studies discussed here allow us to exemplify the different modalities adopted by women’s participation in Latin America.

Generally speaking, the formulation of health policies in Latin America is still centralized, with very little civil society participation and little adaptation to social reality. Though the reform processes are progressing, the development of instruments that allow citizen control over resource allocation and over how the health system is working is still precarious. The following are among the main obstacles for citizens’ participation:

- The State “reduction” that has taken place in the region. If the civil rights in the 18th century can be considered “libertarian” rights, built against the power of the State or as the defense of the individual against the power of the State, 20th century social rights actually need the State to provide and/or guarantee those rights (Fleury, 1997).
- The inequality in income distribution and other forms of power.
- The incipient character of the recognition of people’s rights in public services.
- The very little information as regards these rights and the lack of mechanisms to make them effective.
• The precarious way in which the existing control mechanisms acknowledge social diversity and consider the opinion of minorities or deprived sectors, or the weak development of social organizations (Caledon and Noe, 2000).

When considering the political participation of women’s movements in the last two decades, a highly positive synergy can be seen in the strength of the proposals made at international conferences, and in the results of the different projects financed by international agencies to promote reproductive health and women’s involvement in it.

• In most of the region’s countries there are women strongly committed to the reproductive health principles and gender equity who occupy political positions both in the management as well as in the formulation of laws. Traditional public institutions have modified their activities, opening up spaces devoted exclusively to women and/or to reproductive health, at all levels of the State political organization (national, provincial, municipal).

• Most of the region countries have laws and programs which answer the concerns proposed by women’s movement more than two decades ago.

• Those actions promoted by the public spheres or by NGOs with national and/or international agencies funding have generated critical masses of women, of groups of women and networks with a greater knowledge and capacity to claim for their sexual and reproductive rights. These training sessions and meeting opportunities have gathered women who participate in political and academic areas as well as women from popular sectors.

This concentration of resources generates new scenarios as well as new challenges for the next years:

• Laws and programs are not enough to guarantee women’s rights and reproductive health. It is necessary to create new mechanisms to monitor and assess the fulfillment of the written statements. Perhaps it is necessary to recover forms of lobby and of pressure closer to those of the ’80s, with the strength of the lessons learned in the last years of participation in more formal spaces.

• The mechanisms that hinder putting into practice reproductive rights adopt more subtle and complex shapes, as exemplified by Scout (2001) in his work on transferring community agents from one health program to another.

• Both Rostagnol's (2001) and Scott’s (2001) consider the new dilemmas presented by some of the last decade achievements as regards the “representative-represented” pair. Both those women who occupy political positions and those who participate in the health system as community agents face unforeseen situations for which there are no answers yet. The step towards an instance of representativeness implies new identities, new game rules and new codes, which inevitably differentiate the “representative” from the represented group.
Some terms have apparently become contradictory, and it is necessary to create new syntheses and new participation and leadership forms which allow overcoming false dilemmas. These are: social rights versus reproductive rights, women’s participation in traditional political spaces versus women’s grassroots organizations working on social needs. Transforming these apparent contradictions into new alliances seems to be a promising road.

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