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

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Integration of reproductive health services within the framework of the health sector reform

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Introduction: Integration as a polysemous concept in the field of health care

During the last twenty years, the concept of integration in health systems has been part of at least three major world strategies aimed at introducing modifications in the form health care is provided. Such strategies are the Alma Ata Conference (1978), the health sector reforms launched in Latin America in the early 1990s, and the bases for action resulting from various international initiatives, basically encouraged by the claims of the women’s movement. Clearly, the most important is the International Conference on Population and Development held in El Cairo in 1994 (Lush et al., 1999.) Another foremost reference is the Safe Motherhood Initiative of 1987, which ten years later was ratified and upgraded to World Initiative and endorsed by more than 100 countries (World Bank, 1993; WHO, 1997.)

A brief review of these contexts is presented below, bearing in mind that the various meanings of the word “integration” should be analyzed in light of the nature of the groups and main goals promoted for each of the world initiatives. It is necessary to spell out what kind of integration is promoted in each case in order to be able to analyze the confronting positions and generate research and advocacy proposals.

Lush states, “In 1987, the Alma Ata Declaration made an international commitment to comprehensive primary health care as part of a broader political and economic development agenda” (Lush, 1999, p. 771.) As a tool to attain “Health for all by the year 2000”, the Alma Ata Conference promoted the strengthening of Primary Health Care (PHC) through the creation of health centers and facilities to increase accessibility of the population to first level care. The purpose of these health centers and facilities was to provide integrated services and act as “gateways” to higher complexity levels within the health care system.

In the PHC model, the concept of integration meant the provision of comprehensive care to the population, which was captured by the system through its various and ideally well-distributed gateways. Comprehensive care presupposed an optimization of the encounter such that the person could benefit from different prevention and basic care strategies. This would result in a better use of time for both the health care team and the user. The outcome would be high-quality care and a cost-effective service provision.

Public health was the paradigm of the Alma Ata Conference to sustain the strategy of primary health care. This proposal was largely fostered by public health specialists who espoused an equitable coverage. Alma Ata was the dream of public health specialists, who considered that the “epidemiology of risk factors” was the major discipline guiding thought and action. This approach has been questioned on several grounds (Luz, 1988; Almeida Filho,1989; Castiel, 1994; Ayres, 1997.) By way of example, one of the ten sections of the document issued by the Safe Motherhood Initiative bears the title “Every pregnancy faces risks.” The document states that even though maternal risk is defined as the probability to die or suffer a serious complication resulting from pregnancy or childbirth, it is practically impossible to predict what woman specifically will develop life-threatening complications.
Also health system reforms include integration as a strategy. As mentioned earlier, the reforms were launched in the region in early 1990s by international and multilateral financing organizations, with the purpose of providing more cost-effective health services (Solimano, 1999.) Within the framework of the reform, integration is related to two further tools: decentralization and promotion of new relations between the public and private sub-sectors.

At the local level there should be an integration of national vertical programs and local programs. Like decentralization, program integration should eradicate structure duplication, hold back bureaucracy, curtail budgets, etcetera.

Likewise, one goal of integration is to improve coverage by providing more comprehensive services. By stimulating alliances among the public, private, social security, and not-for-profit private sub-sectors, the reform proposes a new equation that leads to expand coverage of the population and improve cost-effectiveness.

While at Alma Ata the prevailing ideology was that of public health specialists, the health sector reforms are grounded on an economic logic. At the same time, even though both seek to upgrade health care provision for the poorer populations, the role of resources in the reform (cost reduction) is not a minor issue.

The claims of the feminist movement, which have also nurtured the idea of integration, were articulated in the El Cairo Conference. The rights-centered reproductive health approach was adopted in the International Conference on Population and Development and reflects a new global consensus policy with regard to the relationship between policies on population and the rights concerning sexual and reproductive health.

Primary concern for user care is one of the main components of the rights-centered approach, which stresses free and informed consent and the respect of the users’ rights. This approach comprises access to clean, well-equipped facilities, with technically competent and well-supervised personnel, user involvement in the design and evaluation of programs, and integration of various services to properly address specific health requirements (Family Care International, 1999.)

From this perspective, reproductive health care services should include:

- Information, education, and services related to family planning.
- Prenatal, delivery, and postnatal care.
- Child health care.
- Prevention and treatment of sexually transmitted diseases and reproductive tract infections.
- Treatment of complications arising from unsafe abortion practices and, where legally available, provision of safe abortion.
- Prevention and treatment of infertility.
- Information, education, and communication activities regarding sexuality, reproductive health, and responsible parenthood.
- In the absence of further services such as treatment and diagnosis of cancers of the reproductive system and HIV/AIDS, referral mechanisms for the appropriate services should be set up (ICPD, 1994; WHO, 1998.)
After the El Cairo Conference, new epidemiological scenarios as well as scientific developments and legal frameworks came into existence. Their incorporation is indispensable to complete the conceptual agenda for the integration of reproductive health within the context of health system reforms.

The growing impact of HIV/AIDS, the heretosexualization of the epidemic, the implementation of voluntary testing promotion policies (UNAIDS, 2002), and the appearance of the ACTG 076 protocol are a watershed in three basic practices of reproductive health care: the usual practices of provision of contraceptives, prenatal control, and breast-feeding had to be modified in light of HIV infection through unsafe sexual relations and vertical transmission.

1. **Contraceptives**: In the contraception encounter it is necessary to communicate the existence of AIDS to presumably non-infected people and alert them to the inefficiency of the more widely used contraceptive methods (hormones, intrauterine devices, tubal ligation) as barriers to sexually transmitted diseases and AIDS. The condom should be promoted as second or only method. Dialogue between the consulting person and his or her partner(s) about sexually transmitted diseases should be encouraged and voluntary testing for HIV diagnosis strongly recommended. Lastly, bargaining strategies for male (or female where available) condom use should be provided. In the case of women or couples living with AIDS, a hierarchical model (Gollub, 1996; Forbes, 1995) of contraceptive methods should be provided where condoms are not the only option. A hierarchical model is a spectrum of possibilities ranging from maximum protection (using condom always) to other alternatives that do not guarantee protection against STD/AIDS but do prevent pregnancy. Each particular situation should be addressed in this case (Weller, 2001.)

2. **Prenatal care**: Pregnant women and their partners should be encouraged to perform voluntary HIV tests. It is noteworthy that although women may not be infected their partners might be, in which case infection of women should be avoided, especially during pregnancy. The significance of this measure is reflected in the United Nations Declaration of Commitment in its first special session devoted to AIDS since the advent of the epidemic: “By 2005, reduce by 20% and, by 2010, by 50%, the number of babies infected by HIV by ensuring that: 80% of pregnant women in antenatal care receive information, counseling and other prevention services; [and] HIV-infected women and babies receive treatment to reduce mother-to-child transmission” (United Nations, 2001, para. 54.)

3. **Breast-feeding**: HIV-infected women should be encouraged to use breast milk substitutes as an alternative to prevent infant infection through breast-feeding.

Finally, recent research underlines the relationship between sexually transmitted diseases and the increase in vulnerability to HIV/AIDS: “The links between STIs and HIV transmission were confirmed in 1995, when a trial of STI treatment at the primary care level in Mwanza district in rural Tanzania reduced HIV incidence by 40%. [...] As a result, policymakers became enthusiastic about implementing STI management programs in primary care...” (Lush, 2002, p. 71.)

With the same target of integrating prevention and treatment of sexually transmitted diseases and HIV in prenatal care into prenatal care and family planning services, epidemiological studies using “sentinel sites” (AIDS Coordination, 2001, 2002) have shown that in spite of ideological and cultural resistances to the care of women, they should be considered vulnerable to sexually
transmitted diseases and AIDS. “These data indicate that many women served by maternal and child health and family planning programs should no longer be considered at low risk, and that efforts to reach them through these programs are justifiable on a public health basis” (Askew y Maggwa, 2002.)

Types of integrations related to reproductive health practices

This section focuses on the types of integrations reported in the existing literature, followed by examples of integrations found in the bibliography on Latin America.

- Maternal-child health and family planning integration: this is based on the linkage between provision of contraceptive methods and traditional pregnant women and children health care. It does not necessarily involve a change in paradigm in terms of the implementation of the reproductive health principles promoted by the El Cairo Conference, even though the incorporation of rights, gender, and equity may be part of the integration goal.

- Family planning and sexually transmitted diseases and HIV/AIDS integration: being related to the impact of HIV/AIDS epidemic, this kind of integration is comparatively new and aims at:
  - Preventing sexually transmitted diseases and HIV/AIDS through educational programs implemented at family planning services.
  - Promoting the use of and/or delivery of condoms along with other contraceptive methods with a view to encouraging double protection.
  - Promoting, advising and/or performing voluntary HIV/AIDS tests to users of family planning services.

- Maternal-child health and sexually transmitted diseases and HIV/AIDS integration: this kind of integration is also rather new and basically addresses the need for HIV diagnosis to prevent mother-to-child transmission. Laboratory tests for detection of syphilis may also be included in order to prevent congenital syphilis in children. Furthermore, integration involves coordination with health care providers at higher complexity levels for referring people requiring treatment of one or both diseases.

- New populations and available family planning or STD and HIV/AIDS services integration: through community-oriented strategies coordinated with a base institution, these initiatives aim at approaching or integrating males, adolescents, sexual minorities, sex workers, injection drug users, etcetera, to family planning or STD/AIDS detection services. On the basis of the paradigms discussed in the previous section, it could be stated that from the perspective of the Alma Ata model this type of integration may be understood as an “increase in accessibility”; from a more economicist perspective it could be construed as an “increase in users” that would contribute to improve the performance of for-profit and not-for-profit private institutions; and according to the paradigm of rights promotion it could be seen as “citizenship construction” since it enables access of populations traditionally excluded by the public health systems.
Integration also refers to the links among effectors within the sub-systems (public/private.) Such links may comprise various kinds of services among the parties such as training agreements between "expert" NGOs and municipalities, provision of contraceptive methods, supply of educational material, transfers of public funds to NGOs for the provision health care services to rural or traditionally unprotected and hard to reach populations such as sex workers and injection drug users. Also included are referral and counter-referral procedures among these sub-sectors.

In some cases, “integration” does not only refer to the incorporation of new practices to existing routines but to the redesigning of the work methodology. This is especially applicable to the attempts to transform equipment and services by incorporating the El Cairo guidelines which, as already mentioned, advocate the rights, equity and gender perspective.

Evidence of documented integration experiences in reproductive health in Latin America

A. Integration of family planning and sexually transmitted diseases and HIV/AIDS

Brazil, Honduras and Jamaica

In 1992, the International Planned Parenthood Federation, with USAID financing, carried out a pilot project in BENFAM/Brazil, ASHONPLAFA/Honduras, and FAMPLAN/Jamaica with a view to incorporating strategies for HIV/AIDS prevention into everyday family planning activities. This strategy involved training personnel belonging to those NGOs in order to instill a broader concept of sexuality and reproductive health that included HIV/AIDS and sexually transmitted diseases in the model of care provision and service.

Training included the supply of information and counseling and advising skills on HIV and sexually transmitted diseases. Specifically, it dealt with familiarization with sex-related terminology; demystification of prejudices against sexuality; notions about sexual development; definitions of sexual and reproductive health; sexual life and risk perception by the user; gender, power and sexual relations; safe sex; family planning from a sexual and reproductive health perspective; and sexually transmitted diseases.

Several authors have discussed these initiatives. Barnett (1997) notes that personnel’s training was an important first step toward the integration of sexually transmitted diseases and family planning services. According to him, in this way providers encouraged the use of condoms and double protection and abandoned the conception of the condom as a reinforcement method or as an alternative in the absence of other contraceptive means.

On the other hand, Scott and Becker (1999) examine the case of FAMPLAN (Jamaica.) As part of an initiative designed to train personnel in the prevention of HIV/AIDS and sexually transmitted diseases, this NGO implemented a program in all health care and community services in order to promote changes in sexual behavior, condom use, and consent to the treatment of these diseases. Training also underscored the need to change the services’ approach such that they did not limit themselves to the mere distribution of contraceptive
methods but also adopted a broader attitude toward reproductive health that allowed for the sexual lifestyle of the user and his or her context.

Integration was reported to have improved the quality of family planning services because the personnel were properly trained to advise users regarding HIV/AIDS and STD prevention. Another reported outcome of the initiative was a more active involvement of males, who started to resort to the services to obtain information and protection against these diseases.

Also Dehne et al. (2000) analyze the integration experiences of prevention and treatment of STDs into the family planning programs from various world initiatives such as that of BENFAM in Brazil. The study evaluates the impact of integration taking into account: 1) user satisfaction; 2) acceptance of contraceptive methods; 3) changes in behaviors that bear some kind of STD risk; and 4) use of condoms.

With regard to the impact of integration on user satisfaction levels, the number of counseling sessions on sexually transmitted diseases increased and service quality improved according to the users. The authors point out that there is not clear evidence of the impact of integration as far as acceptance of contraceptives is concerned. This is due to the coincidence of the implementation of integrated services with the introduction of out-of-pocket payments which, the authors note, prevented the analysis of integration impact per se. In regard to changes in sexual behaviors, even though many family planning services point to the success of prevention campaigns in the mass media and the increase in the supply of condoms by community agents, there is little empirical evidence that these have prompted any changes in the sexual behavior of the population. Lastly, the outcomes of integration indicate a 50 per cent rise both in the use of condoms and in the level of knowledge of STDs and HIV/AIDS since the implementation of integrated care programs.

According to Becker and Leitman (1997), the lessons that could be derived from the initiative of applied integration in BENFAM, ASHONPLAFA and FAMPLAN are:

- The importance of an institutional commitment that provides a facilitating environment for the dialogue with users about sexuality and new forms of care.
- The health team attitude with regard to users' sexuality does not change immediately with training. Changes take place gradually and with the aid of supportive supervisors as well as with the existence of opportunities for providers to share their experiences.
- Family planning service provision focused on sexuality brought about a significant increase in the use of condoms by the users. After the initiative, this method was one of the main contraceptive options offered by the three NGOs.
- Groups for the debate of sexuality issues were welcome, especially among women. The meetings were conducted by qualified facilitators, who made available an appropriate atmosphere for women to be able to talk about sexuality, gender inequalities and power relationships.

Colombia

Vernon et al. (1990) and María Cristina Calderón (2001) examine transition to the integration of other reproductive health services and forms of health care in the case of PROFAMILIA, a Colombian NGO affiliated with the International Planned Parenthood Association.
In their study “Incorporating AIDS Prevention Activities into a Family Planning Organization in Colombia”, Vernon et al. examine integration of HIV/AIDS into family planning. In 1987, PROFAMILIA implemented two research projects to evaluate the impact of: 1) informative talks on HIV/AIDS prevention and the use of condoms; 2) distribution of condoms to specific groups of the population; and 3) mass dissemination campaigns on HIV/AIDS prevention, especially focused on the use of condoms.

Informative talks and the supply of condoms proved highly positive as they could be performed concurrently with family planning activities developed by the NGO (communication, education and sale of contraceptives), without interfering with them. Dissemination campaigns also had a positive impact as they enabled the appearance of the condom in the mass media with a good reception by the population.

Subsequently, María Cristina Calderón presented the case of PROFAMILIA at the meeting “Sexuality and sexual rights in Latin America: Advocacy, community work and research”, organized by the Ford Foundation in Buenos Aires in 2001. Calderón, coordinator of the PROFAMILIA Reproductive Rights and Gender Consulting Office, presented the results of the researches and activities carried out by this NGO regarding integration. Even though PROFAMILIA focused their activities on contraception-reproduction, the work with young people initiated in 1990 resulted in the introduction of notions related to eroticism, pleasure and sexual orientation. This new approach gave rise to the following research:

- **Double protection: A connection between sexuality and eroticism**

  This research comprised interviews with women and PROFAMILIA service providers. Female users identified with reproductive and care giving roles. They also denoted little bargaining capacity with their partners as far as disease protection was concerned, in the belief that exposure to risk of sexually transmitted diseases pertained exclusively to men. Thus, the major reason for consultation at PROFAMILIA was related to contraceptive methods rather than prevention of sexually transmitted diseases. Female users were also reluctant to talk about their sexuality.

  With respect to providers, many of them misunderstood the concept of “double protection” as “protection of both members of the couple” or “the need for a contraceptive reinforcement.” Those who were acquainted with double protection considered it was a strategy targeted at specific populations such as unmarried persons, adolescents and “risk groups.” Although the reason given by providers for not elaborating on the issue of sexuality was lack of time, it could be seen that they did not have enough information or that it was a taboo subject.

- **Double protection in adolescents**

  From the study it appeared that sexuality in adolescents was based on the adult’s conception of what “should be” or was expected of them. It also revealed a high degree of care to prevent pregnancy along with a low perception of sexually transmitted diseases. Among other interesting findings, it could be observed that in the cases of STDs and HIV/AIDS, young people mistook prevention for treatment.

- **Project on sexual orientation to adolescents**
This project, still underway when it was presented, promoted sexual orientation as a right. The aim was to produce a work model based on the experience of the community work carried out by Princeton University with homosexual young people and by PROFAMILIA.

**Argentina**

In Argentina, Weller (2001) analyzes the relationship between HIV/AIDS prevention and contraception. His research inquires about the use of condoms in women from various social sectors taking into account that young and poor women are the most vulnerable to unwanted pregnancies and HIV/AIDS infection. The specific goal was to study the behavior of the Responsible Reproduction Program users at a health center in the city of Buenos Aires before the incorporation of HIV/AIDS prevention.

Results show that condoms were used as the first method by 31 per cent of women with higher primary education and by 22 per cent by women with lower primary education. Condoms had been adopted by women with higher primary education who had used some contraceptive method before their first pregnancy. It was also the first method reported by the younger population. Intensity in its use changed over time: 57 per cent had used condoms at least once in 1990-1993, and 70 per cent had used them at least once in 1998-1999.

One of the main conclusions of the study is that even before the implementation of integrated services, a great part of the population who resorted to the health center had already acquired a HIV/AIDS prevention behavior. However, differences among user populations were observed. Women with a higher primary education had used condoms more intensively, while the poorer had used it less frequently.

The following recommendations arise from the study:

- To work on the health care team members’ representations and preconceptions, especially as they relate to vulnerability to HIV/AIDS.
- To integrate information on contraception and HIV/AIDS prevention in the various exchange instances with the users: contraception encounter, education groups, talks in the waiting room, etcetera.
- To reinforce knowledge on condom use, emphasizing its correct utilization for safe results.
- To alert users to the need to discuss with their partners the use of condom and provide arguments and guidelines in case of any conflict in connection with the proposal by the female user to her partner.
- To promote HIV testing in stable couples as an alternative to the use of condom, stressing the importance of subsequent fidelity by both members, and the use of condoms in case of occasional sexual relations outside the couple.
- To alert to the risk of sharing syringes in connection with the entrance of the virus to the couple.
- To be flexible and respectful about the method chosen, as the use of condoms should not be imposed. The need for “double protection” may be reinforced by supplying condoms along with the contraceptive method chosen. Educational material on AIDS prevention and correct use of the condom may also be included.
B. Maternal-child and family planning integration

Chile

In the report “Integrated Maternal and Infant Health Care in the Postpartum Period in a Poor Neighborhood in Santiago, Chile”, Alvarado et al. (1999) analyze the impact of an integrated program for maternal-child care during postpartum implemented in a health care center located in an extremely poor neighborhood between 1991 and 1992. The main components of the program were education, maternal-child care, support to mothers, and women’s active involvement.

The analysis of the program’s impact took into account the use of contraceptives, breast-feeding practices, child growth and health, and qualitative assessment of the degree of user satisfaction. The goal of the evaluation was to determine if there were any differences with a control group comprised by women sharing the same socio-demographic conditions and characteristics, but who sought care at a public hospital near the health center. The evaluation revealed that the integrated program for maternal-child care during postpartum was successful compared with the results obtained in the control group. Specifically, differences were observed in the higher use of contraceptives and in the longer breast-feeding times. Likewise, differences were found in favor of the health center with regard to children’s growth and health and women’s satisfaction.

C. Public sector and NGOs integration

Abramson (1999) analyzes the cases of five countries contracting non-government organizations as state’s providers of health care in general and primary care and preventive practices in particular. These initiatives were aimed at extending coverage, improving quality and monitoring the cost of health care services. The cases examined were: COOPESALUD and the Costa Rica Social Security Institute; PROFAMILIA and the Ministry of Health of Colombia; FUNDEMI/Talita Kumi and the Ministry of Health of Guatemala; the Local Committees of Health Administration (CLAS) and the Ministry of Health of Peru; and PROFAMILIA and the Public Health and Social Care Office (SESPAS) of Dominican Republic. The main findings in each country are summarized below.

Colombia

In 1993, as a result of the reduction of funds from external patrons from 30 per cent to 5 per cent, PROFAMILIA decided to offer their services to the public sector. One year later, given the decrease in the coverage of family planning and reproductive health services by the public sector and the scarce provision of these services by the private sector, PROFAMILIA endeavored to capture uncovered populations. This institution sought new financing sources, which resulted in their association with the national Ministry of Health to provide such services as family planning, prenatal control, control of the newborn and postpartum family planning, as well as the prevention of violence, the promotion of sexual and reproductive health, early detection of breast and cervical-uterine cancer, and counseling and research.
Costa Rica

In 1994, the government of Costa Rica contracted cooperative organizations for the provision of health care services in order to expand the availability of service providers so as to cover the unmet needs of the population and reduce public expenditure. In this respect, under the premise of promoting health sector reform, the state implemented a model in which the purchase and provision of services was shared with the private sector. This led the Costa Rica Social Security Institute to contract the services of COOPESALUD, who committed to provide comprehensive health care services to populations from selected areas of the country.

Guatemala

The Peace Agreements entered into by the five Central American countries included the commitment to reduce infant and maternal mortality by 50 per cent and to allocate 50 per cent of the public expenditures in health to the prevention of diseases. Within this framework, the national authorities, the Minister of Health, and the heads of the Comprehensive Health Care System of Guatemala decided to give priority to increasing coverage and improving the quality of health services to rural populations with less access. Due to the lack of appropriate infrastructure and human resources the services of the non-government organization Talita Kumi were engaged for the provision of comprehensive primary care, especially addressed to maternity and childhood, and focused on emergency and prevention.

Peru

The Peruvian government also resolved to increase health coverage of rural populations by creating the Local Committees of Health Administration (CLAS). Mainly with state funds, these organizations endeavored to manage and develop a local health care program focused on primary health care, healing and preventive care, and health promotion.

Dominican Republic

Similar to Colombia, the Dominican Public Health and Social Care Office (SEPAS) and PROFAMILIA, the main family planning provider of the country, associated to cater both for the state’s need to expand coverage of reproductive health and family planning services, and PROFAMILIA’s to diversify their financing sources.

C. Integration of family planning services with other development activities

Peru

CARE International is a development agency who entered into association with the Peruvian government in order to improve social conditions. In 1992, they worked with the Ministry of Health to expand access and improve the quality of family planning services. This initiative covers one million people from five regions of the country and has two components: a) supporting the health services administered by the Ministry of Health for the provision of family planning, and b)
working with this Ministry to train, monitor, and manage 950 voluntary promoters devoted to the provision of family planning services. The initiative provides for the integration of family planning services with projects designed by other sectors such as food assistance (PRODIA, Integrated Project for Food Assistance; and NIÑOS, a project for the provision of nutritional supplements to children); productive micro enterprises (WOMAN, a project designed to generate women’s income; and PERU, a project for rural and urban economic development); and natural resources (Water and Health Project; and ANR, Agriculture and Natural Resources Project.)

The factors listed below contributed to the success of this family- and community-based project:

- The integration of family planning services with other services known to the community, which was essential to achieve the support of the community, the local government, and the Ministry of Health.
- The election of promoters by the communities or participants in the project, which made user acceptance easier.
- The coordination of the activities carried out by the promoters with existing programs and services.
- The joint training of the regional offices’ personnel in the project’s goals and features.

Analysis and proposals

The examples found in the literature on concrete cases of integration of health care actions related to the field of reproductive health in Latin America deserve the following comments:

- The existence of integration projects prior to 1994 reveals that this concept was in force before the IV Conference on Population and Development of El Cairo.

- The integration initiatives found correspond largely to actions carried out by NGOs with international financing. This statement could be biased by the search methodology used in this study, which rests on the literature produced and available for consultation. In this respect, empirical research is recommended, preferably with the methodology of key informants, in order to gain access to integration actions in progress in the region not documented in the form of scientific papers or research reports.

- The examples described illustrate virtually all the types of integrations listed a priori in the specific literature. These reveal that there are no pure types, since one initiative may correspond to several of the types listed.

- A common feature both in the articles dealing with the concept of integration and in those where concrete cases are presented is the absence or insufficiency of properly measured outcomes regarding the impact of integrated strategies. Some hypotheses might explain this phenomenon:

  - As mentioned in the introduction of this document, integration projects have rested on proposals with a high political or ideological content: improving accessibility, cutting costs, and improving service quality from a women’s human rights perspective.
- The insufficient amounts of time for these processes have made it difficult to implement innovative policies concurrently with the generation of monitoring and evaluation outcomes.

- Impact evaluation requires a good model to account for changes. In the case of reproductive health, such a model is far from being simple. The need to find a model has led to an oversimplification and overuse of Knowledge, Attitudes and Behavior (KAB) surveys, among others.

- The concept of “intervention” in reproductive health calls for revision, as it has been imported uncritically from the traditional field of public health. Actually, reproductive health includes elements not present in other fields of public health, such as sexuality, gender relations, social and gender violence, among others. The concept of intervention might misleadingly suggest the possibility to isolate and intervene in the problems affecting the social reality. Furthermore, this interpretation could nurture individual interventions that ignore the complex dynamics at the community or even structural levels. This difficulty regarding intervention correlates with the difficulty in measuring the outcomes of specific actions.

- The proposals for integration of maternal-child health and family planning and/or sexually transmitted diseases and HIV/AIDS presuppose that older programs are well structured, which may not be the case. Thus, such presuppositions need to be revised so as to avoid mistakenly ruling out or moving forward on integration proposals.

- Empirical research on health care systems and user populations should allow for:
  1) The existence of a single care unit where practices are performed in a non-integrated way.
  2) The existence of diagnosis units whose practices do not tally with the treatments available at higher complexity levels.
  3) The existence of care units that perform outdated practices. In these cases, rather than integrating services, it is necessary to train and equip the health personnel so as to enable them to keep up with the latest advances of knowledge.
  4) The perceptions, actions and logics of the users.

On the users of health care systems

We consider that one way of overcoming the strong “ideologization” prevailing in the subject in question and advancing in the improvement of service quality for the benefit of the users is to carry out research focused on the perceptions, actions and logics of the users as well as on the realities of the actual consumers of health care services.

We agree with Cecilio (1997) who claimed that the technical model of health care—which portrays the health care system as a pyramid of rising and falling flows of users with access to differentiated levels of technological complexity within articulated referral and counter-referral processes—is centered on a rationalizing perspective whose merits would be a highly efficient use of resources and equitable and universal access. In practical terms, by assuming that events occur differently than intended under a certain technocratic rationality, the author advocates the idea that the health care system would be more adequately thought of as a circle with numerous
gateways located at various points in the system rather than at its purported “base.” He also questions the image of a top level as an expression of a certain “technological hierarchy” with the hospital located at the top. At the same time, he notes that the health care system should be organized taking into account what is more relevant to each user, so as to offer the right technology at the right time.

An interesting idea is to start giving priority to those researches that deal with the circuits effectively used by the users, in order to generate proposals for the improvement of service integration and quality targeted at “what people do” rather than at “what people should do”.

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