THE CONTRIBUTION MADE BY WOMEN'S AND FEMINIST MOVEMENTS TO EQUITY IN HEALTH: THE CHILEAN EXPERIENCE

A case study commissioned by the Health Systems Knowledge Network

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Background to the Health Systems Knowledge Network

The Health Systems Knowledge Network was appointed by the WHO Commission on the Social Determinants of Health from September 2005 to March 2007. It was made up of 14 policy-makers, academics and members of civil society from all around the world, each with his or her own area of expertise. The network engaged with other components of the Commission (see http://www.who.int/social_determinants/map/en) and also commissioned a number of systematic reviews and case studies (see www.wits.ac.za/chp/).

The Centre for Health Policy led the consortium appointed as the organisational hub of the network. The other consortium partners were EQUINET, a Southern and Eastern African network devoted to promoting health equity (www.equinetafrica.org), and the Health Policy Unit of the London School of Hygiene in the United Kingdom (www.lshtm.ac.uk/hpu). The Commission itself is a global strategic mechanism to improve equity in health and health care through action on the social of determinants of health at global, regional and country level.
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Introduction

This document offers an historic overview, stretching from the final years of the military dictatorship (1988-1989) to the present, of the action of women's and feminist movements on behalf of health. The interest in recording the work of the women's movement in the field of health has arisen because it is considered to have been the forerunner of the progress currently being made in respect of gender equity within the Chilean health system.

A review of publications, working documents of a number of organizations (principally the Forum-Network on Health and sexual and reproductive rights and the Chilean Network against Domestic and Sexual Violence) and interviews with those who were active founders and participants in the most important moments of the women's health movement has been used to highlight certain milestones and strategies, chosen because of their direct impact on public policies and government programmes or their significant role in developing a public debate over certain topics.

Some background information

Chile is divided into 13 administrative regions and has a population of 15 773 500 (2002 Census). It has a transitional population structure, in which the population is gradually ageing (on account of a decline in fertility and mortality rates) and the epidemiological profile is changing, with cardiovascular diseases, cancers and accidents being the new causes of mortality; these causes are closely linked to individual and social behaviour within a system marked by individualism, competitiveness and inequality.

Thirty years ago, a neo-liberal economic model was introduced and consolidated; it was based on a broad opening up of the economy to international competition and the export of natural resources. It achieved high rates of macroeconomic growth (the average annual rate of growth during the decade 1990-2000 was 5.6%) with a high concentration of wealth and considerable inequalities. During the same period, Chile underwent a process of political transition and economic continuity during the changeover from a military dictatorship to the restoration of a democratically elected civilian Government.

Social inequality is compounded by gender inequality, expressed inter alia by the low level of women's participation in the labour force, a wide wage gap between women and men.

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2 I should like to express my thanks to Fanny Berlagoscky, Josefina Hurtado, Rosa Espínola, Mireya Zuleta, Soledad Rojas and Valentina Martínez, for their contributions, interest and willingness to collaborate in this task.
3 In 2001, the crude fertility rate was 2.0 children per woman (Demographic and vital statistics yearbook, INE). The fertility of Chilean women has fallen considerably over 40 years. However, there are differences on account of age, level of education and between rural and urban women.
4 The poorest 20% receive 3.9% of national income, while the richest 20% receive 56.5%. (ALAMES - PIDHDD. 2005, figure from Mideplan 2003). According to the Gini index, Chile and Brazil count among the Latin American countries in which inequality is greatest (UNDP 2004).
5 In 2000, 39.3% of women belonged to the labour force. MIDEPLAN, Government of Chile. CASEN survey. 2000.
performing similar jobs, the feminization of poverty - with a high percentage of women heads of households living in poverty and casual employment characterized by flexibility, informality and instability. According to the 2000 CASEN survey, 27.9% of working women are without a contract of employment, a situation that more often affects women and men workers in the lower-income quintiles.

Other changes that have a major impact on women’s lives and health are those connected with family composition. There has been a fall in the number of marriages, an increase in the number of annulments and a marked increase in the number of children born out of wedlock; in 2001, they accounted for 51% of total births and in the same year slightly more than 10% of total live births were recognized by the mother alone.

As regards health, in 2003 the maternal mortality rate was 12.1 per 100 000 live births, although avoidable causes such as abortion still count among the main causes of maternal death. Mortality rates from breast cancer and cervical cancer are also high, ranking second and fourth respectively – among deaths from malignant tumours.

The health system is in the throes of a neo-liberal reform concerned more with institutions than health, with a marked bent towards privatization and limitation of State participation. The reform focuses on changes in the organizational and operational structure of the public health system, the health-care model, funding, coverage, regulation of the Isapres (health maintenance organizations), in priorities and guarantees and relations between the different actors. However, as far as reducing gender inequalities is concerned, more has been achieved by “legislative progress over paternal leave after childbirth, sexual harassment and divorce, and by the amendment to the former law on domestic violence.”

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6 Women are paid wages that are 36% lower than those of men with the same level of education; with 13 or more years study women earn on average 52% less than men. MIDEPLAN, Government of Chile. CASEN survey. 2000.
7 “According to the World Bank, the Chilean labour market is 2.5 times more flexible than the Latin American average and almost twice as flexible as the most developed economies (OCDE)”. Escuela Continental, Chile document. Alames – Chile.
10 Chile is one of the few countries in the world in which abortion is criminalized by the law whatever the circumstances. It was still 13% in2003. Op. cit: 66.
11 In 2001, 13.2 deaths per 100 000 women were from breast cancer, and the mortality rate from cervical cancer was 8.7 per 100 000 women. Op. Cit:68.
The women's health movement and its contribution to reducing gender inequities in health

Birth of the movement

During the years of the military dictatorship, the women's movement was noteworthy for its particular strength and capacity to resist repression and poverty, as well as for putting forward gender-specific demands denouncing the violence and discrimination practised by the military regime against women. For their part, the representatives of the health sector lacked the political will to change their theoretical outlook and practices, imbued as they were with the conservative cultural beliefs characteristic of Chilean society, largely determined by the Catholic Church, which still acts as a veritable overseer of political decisions concerning women's health, despite the secular nature of Chile. This conservative trend also affected the left in Chile, from where many of the women active in the movement have come, and which provided no significant support or alliances for efforts to develop gender issues.

Differences also developed within the women's and feminist movement over political strategies, between those in favour of working within the movement independently from institutions and those who preferred to influence public policies from within the universities, non-governmental institutions or via direct participation in the State, which to some extent undermined their action within civil society. These differences are significant in order to understand the nature of the women's health movement, which has been emerging since the end of the 1980s, and the lessons, criticism, obstacles and challenges it has faced in its more than 20 years of existence.

During the early years of the transition to democracy, the women's health movement, which was made up of NGOs and women's welfare organizations with roots in the women's and feminist movement, laid down lines of political action focusing on a number of issues which they considered to be of strategic importance; these included health and gender violence. These organizations based their political and technical action on the knowledge developed, on their propositions for comprehensive health, citizenship and democracy, on human rights - including sexual and reproductive rights - and on their commitment to bringing about change in order to improve peoples', and especially women's health.¹⁴

The most important points of reference for these movements were the thematic networks grouping organizations, health groups, NGOs and persons working or active in these areas. January 1989 saw the founding of the Foro Abierto de Salud y Derechos Reproductivos (Open Health and Reproductive Rights Forum) in the metropolitan and fifth regions, which later expanded to 6 other regions in 1994, and 1991, that of the Red Chilena Contra la Violencia Doméstica y Sexual (Chilean network against Domestic and Sexual violence). Both of them belong to Latin American networks.¹⁵

¹⁵ The Red de Salud de las Mujeres Latinoamericanas y Del Caribe (RSMLAC) (Latin American and Caribbean Women's Health Network), which promotes the establishment of national networks, as in the case of the Forum in Chile, is particularly important.
Over these years, the Forum has been active in the field of sexual and reproductive health, where it has focused on the topics of care quality from the gender and rights perspective, maternal mortality, abortion, bioethics, AIDS, adolescents' sexuality, pregnancy and sexual violence affecting adolescents, while at the same time promoting participation by civil society and transparent accountability by means of campaigns, research projects, publications, training schools and further training, and by disseminating and publicizing information to the mass media and a range of sectors of society and institutions.

Women's right to take decisions about their own bodies, and by extension about all aspects of sexuality and reproduction, is the basic tenet of the organizations that belong to the Forum. Consequently, the right to safe and legal abortion and the adoption in Chile of the principle of voluntary motherhood, have been the cornerstones of its action. A significant milestone was the 1993 campaign - against the background of the recent abrogation, in 1989, by the military Government of therapeutic abortion – during which the Symposium “Laws for Women's Health and Lives: Let's discuss therapeutic abortion” was organized at the Diego Portales conference centre. The symposium was attended by contributors from Latin American countries and almost 600 participants, including health professionals, social scientists, activists from the women's movement and government and health officials, with the aim of forming an alliance to restore the civil right taken away from women.

In November 2006, in a second attempt, two deputies supported by the Humanas Corporation, a feminist-oriented consultancy, prepared a draft law on therapeutic abortion during the first twelve months of pregnancy; the proposal was declared inadmissible by the Chamber of Deputies, which refused even to discuss it. Although abortion has never been on the political agenda of the Coalition Governments, not even the present one, Chilean society is more open and willing to legislate, as has been shown by several opinion polls\(^\text{16}\) and by the recent statement by a major health professionals' organization, the national confederation of municipal health workers (CONFUSAM), in favour of abortion.

Another of the points of reference for the women's health movement has been the Chilean Network against Domestic and Sexual Violence. This network is made up of social organizations and women's/feminist NGOs that have developed health care models to provide basic mental-health care and legal guidance and worked with self-help\(^\text{17}\) and self-awareness groups; provision of shelters; training for a range of social and institutional actors; helping to draft both the initial and the current legislation on domestic violence, together with other strategies at a time when neither society nor the Government had any response to the problem.

From 2001 onwards, in Latin America and in Chile, the Chilean Network against Domestic and Sexual Violence launched the campaign: “Protect women's lives: no more deaths” whose purpose is to raise awareness of killings of women. It was against the background of this campaign that the first research was carried out to highlight the problem and offer a tool that has proved effective in influencing public policies.

\(^{16}\) According to the national opinion poll: How women see the decriminalization of abortion, 61.9% of them consider that it is urgent to restore therapeutic abortion, while 34% believe that it is not. A total of 75% agree that abortion should be legalized if the mother's life is endangered, while 21.5% disagree. Humanas corporation, University of Chile. 2006.

“...from inside the Network, since 2000 the problem of killings of women has been
taken up, starting in Mexico and via the Latin American network. This study marks a
clear change in that it has revealed, pinpointed how this problem is the result of gender
violence...this marked a turning point; in 2004, it was not on the political agenda and we
put it there...it is taking practical shape with the provision of shelters, with the
recognition that there is clearly a problem of under-reporting, that crimes are not broken
down by the sex of the victims, that we know who killed but not who they killed or what
their relationship with their killer was...” (Interview with Soledad Rojas\textsuperscript{18})

The campaigns have served as tools for raising awareness and for achieving an impact;
they have been used in the past by the women's and feminist movement to pose the
problem on the basis of critical gender concepts and focuses, symbolized by dates that
restore the historic memory of women's movements throughout the world and in Latin
America.\textsuperscript{19} In the area of women's health, the most important campaigns take place on 28
May, “International Day of Action for Women's Health” and 28 September, “Day for the
Decriminalization of Abortion in Latin America and the Caribbean”. The campaigns
promoted by the Forum “I am a woman and I have rights”\textsuperscript{20} and “I am a woman, I want to
be healthy and I demand humane care”, were milestones in the defence of the right of
women to health, with as their key theme the quality of care, which served as the
foundation for a long-term effort directed at health providers:

“...we attained our objective of getting everyone to see us as women and human beings
sharing the same problems. In some respects, this effort affected public health policies
because quality of care is a topic that has been taken up by the Ministry, they are
training their staff to produce satisfactory indicators for quality of care and this is the
fruit of a long-term effort...” (Interview with Mireya Zuleta\textsuperscript{21})

During the 1980s, the national “democracy in the country and at home” movement, which
was inspired by the broad feminist movement, stressed the political nature of what were
considered to be private everyday personal matters and demanded that the State assume
its responsibility, with the objective of “driving dictatorship out of the home”\textsuperscript{22}. It was
against this background that the concept of domestic violence was developed by those
combating violence against women.

The economic globalization of which Chile is a part has brought with it processes of socio-
political globalization, which have broadened the range of reference points for human
rights and democratic models. Here, events such as conferences and conventions
promoted by the United Nations and other global organizations have gained prominence,

\textsuperscript{18} At present, national coordinator of the Chilean Network against Domestic and Sexual Violence.
\textsuperscript{19} On 28 September, we commemorate the enactment of the “Free womb” law in Brazil in the eighteenth
century; On 25 November, International Day for an End to Violence against Women, we commemorate the
murder of the Mirabal Dominican sisters by the Trujillo dictatorship in 1962.
\textsuperscript{20} “This lasted 5 months and was celebrated on 48 days in different sectors of Santiago, towns and nearby
villages and involved some 1700 women, 332 peasants belonging to organizations (...) in the Fifth, Seventh
and Metropolitan Regions, including cities and towns such as Santiago, Valparaíso, Viña Del Mar, Quillota,
Concepción, Coronel, Talcahuano, etc.” Review of the Forum-Network on Health and Sexual and
Reproductive Rights Chile A.G. Number 1/2003.
\textsuperscript{21} Founder of the Forum-Network on Health and Sexual and Reproductive Rights, of the Chilean Network
against Domestic and Sexual Violence and Director of the Women's Home - Valparaíso 1986 - 2003.
\textsuperscript{22} Carena Pérez, exhibition for the launch of the “resource Guide for Action”. Chilean Network against
providing feminist and women's movements with elements and information as a basis for demanding changes at the national level on behalf of human rights and forming a major strategy for social mobilization and for strengthening the debate between civil society and the State. Accordingly, the women's health movement defines as one of its key strategies the development of tools to enable citizens to control health policies; such tools include indicators to measure progress, stagnation or retreat from expectations based on the commitments made by the State. The World Conference on Women, (Beijing 1995)\textsuperscript{23} the International Conference on Population and Development (Cairo, 1994)\textsuperscript{24}, and the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), provide the principal framework for surveillance and monitoring of policy relating to women's rights. The most recent undertaking, which brings together numerous nongovernmental bodies, academia and civil society, is the Observatory of Gender Equity in Health, sponsored by PAHO.

During this overview of the main contributions made by the women's health movement, we identified milestones - which we defined as such on account of their outstanding importance and impact on society and on public policy - ascertained by consulting the existing literature and on the basis of the opinions of some of the women who played a leading role in these processes. They are described below:

1. National Convention on Women's Health. This process, which was encouraged by the Forum, was intended to produce a diagnosis and propositions for women's health from women and via a "citizenship" approach to health. The convention was an opportunity for women to discuss their own health, to define their priorities and to draw up proposals for action and for policy implementation. The first priority was quality of care in sexual and reproductive health and the concept of quality of care in the broader sense. For women, treatment, quality of services, the patient-physician relationship, (users and citizens), availability of proper equipment and facilities as well as of suitable health professionals, were fundamental. Attention continued to focus on quality of care in sexual and reproductive health through the follow-up and monitoring of the agreements of the Cairo Conference.\textsuperscript{25}

\textsuperscript{23} One example is the fulfilled commitments indicator (ICC) developed by FLACSO and the Women's Initiative Group, on the basis of the global Platform of Action of the Beijing Conference, the Cairo Global Plan of Action, the National Equal Opportunities Plan for Women 1994-1999 (SERNAM) and the Political Proposals for Equal Opportunities for Rural Women (SERNAM, 1997). PAHO. Observatory of Gender Equity in Health. Report 2005.


\textsuperscript{25} One of the five axes of follow-up was quality of care in sexual and reproductive health services. Op. cit.
A later version of this exercise in civic participation has been the organization since 2002 - with the support of PAHO - of four women's health parliaments, bringing together more than 1000 women, which have addressed analysis of health reform and put forward proposals from the gender perspective.

As a result of these efforts, and in line with global progress over women's rights, in 1994 the Ministry of Health decided to transform the traditional Maternal and Perinatal Health Programme into a women's health programme, with the aim of decentralizing reproductive health care to cover other aspects of women's life cycles and to progress towards a concept of comprehensive health, with the gradual inclusion of the gender perspective (Women's Health Programme. Ministry of Health, 1997. p.7). However, after several years of this programmatic change,

“It has to be pointed out that several years after the Women's Health Programme began to be implemented, despite the maintenance of the positive indicators traditionally used to evaluate reproductive health care...there is still a wide gap between rhetoric about the programme and actual practice in its implementation” (Maturana, C. 2004: 83)

2. Quinacrine. In 1994, the Forum intervened in experimental research into sterilization with quinacrine, undertaken by Dr. Jaime Zipper in two hospitals in Santiago and another in Valdivia in southern Chile, involving a group of 700 to 1000 women. The Forum collected information from other countries on the potential carcinogenic risks for women's health of this method of sterilization, and found that the research was being done without proper informed consent. Thanks to the Forum's persistence, and its willingness to confront the authorities, including the research team, the project was finally called to a halt.

...sterilization using quinacrine was fundamental, we drew attention to a very important strategy... no-one was investigating it, not even in the health services... the procedure was being carried out in the south-west health services without any follow-up, ...we denounced the experiments being done with quinacrine without any follow-up of the women on whom it was being used ...some of them even became pregnant, others had difficulties with their children and finally the research was stopped, first at the San José hospital and then at Sótero del Río...” (Interview with Fanny Berlagoscky)

3. Sexual and Reproductive Rights. The idea that sexual and reproductive rights are inalienable and indivisible human rights was one of the cornerstones of the women's health movement acting in coordination at the international level.

“Women's and feminist movements have developed arguments whose purpose is to recover their freedom of action in the sphere of sexuality and reproduction. They have established sexual and reproductive rights as fundamental components of human rights and have thus reformulated the traditional division between public and private matters

26 Founder of the Forum-Network on Health and Sexual and Reproductive Rights.
and given new significance to the notion of the universality of rights, as well as to equality and liberty. 27

The importance of this is reflected in the change that took place within the Health Forum itself, which in 2002 was renamed as the “Forum-Network on Health and Sexual and Reproductive Rights”. During all those years, the Forum undertook training and activities to raise awareness intended for health institutions and the women’s movement.

One of the most significant products of the legal approach, as regards the adoption of the notion of sexual and reproductive rights, has been the drafting of the Framework Law on Sexual and Reproductive Rights; however, it has not yet been adopted and is still with the Health Committee of the Chamber of Deputies. It is seen as a bold civic initiative, as it represents the fruit of a collaborative endeavour involving civil society and parliamentarians on behalf of the rights of women.

Among the changes favourable to the adoption of sexual and reproductive rights in the sphere of sexual and reproductive health we may mention the gradual approval of hospitals to permit fathers to attend and participate in childbirth, 28 the change in the standards applicable to surgical sterilization, which is defined as a right for women and men, and which requires informed consent. Finally, we may mention the recently published “National standards on regulation of fertility”, which are a significant step forward for the incorporation of the gender perspective:

“These standards explicitly incorporate the gender perspective, and thus seek to correct the inequalities between men and women as regards their capacity to exercise control over and decide in respect of their sexual and reproductive health, as well as to increase men's participation and responsibility in this area, bringing it to the same level as that currently assumed exclusively by women.” (MINSAL.2006).

4. Gender violence. The Chilean Network against Domestic and Sexual Violence took an active part in the promulgation of the first law on domestic violence because at the time it was the only entity that had acquired any knowledge and experience of addressing violence against women. Consequently the promulgation of the law is considered to be an achievement, even if it does not correspond to the proposals made by the movement.

“...let's take an example, the law on domestic violence... at the time, I belonged to the Chilean network, as a member of the national coordinating body, and we did a huge amount of work within the inter-ministerial committee on domestic violence, we worked to improve the law and of course, we advocated classifying it as a criminal offence, ... we were in favour of many other things that we failed to achieve. Nevertheless, I believe that this policy would have been worse without the contributions made by the feminist movement (…) When the law was amended (2005) there was not the same participation by the feminist movement...in contrast with the earlier phase, when we participated in the committee that drafted the law, during this phase, things were much more disorganized, our contributions far more dispersed” (interview with Valentina Martínez)

28 In 2001, one out of ten hospitals were classified as "patient-friendly", meaning inter alia that they encourage and permit men to attend childbirth; in 2001, 20% of fathers did so, and in 2002 31%. (Op. cit: 42)
This legal framework made it possible to implement programmes of comprehensive care for women experiencing violence, albeit under the category of domestic violence, which conceals the specific inequalities affecting women and offers a fragmented response to the problem:

“...in spite of the significance of this progress, the institutionalization of domestic violence – rather than gender violence – reflects a fragmented approach to the problem by institutional thinking and practice and to the subjects concerned; this approach prevents us from identifying the links between the diverse expressions of violence against women as expressions of a single phenomenon” (Maira, G; Olea, P; Santana, P; Rojas, S. Resource Guide for Action: Services dealing with violence against women. Chilean Network against Domestic and Sexual Violence. 2006: 7)

5. Emergency contraception. Since 1997, several women's and feminist organizations, essentially grouped within the Health Forum, demanded the distribution free of charge through the public health system and the sale in retail pharmacies of emergency contraception (EC), in the form of an ad hoc EC product “Postinor” (0.75 mg. levonorgestrel), thus sparking off an intense public debate because the Catholic Church and conservative politicians were opposed to it and pro-life groups attempted to block it through the courts.29 The then Under-Secretary of State for Health (name) Infante was even dismissed. This struggle has come up over and over again. Currently, EC is distributed in primary health care facilities in which the local authorities (municipality) authorize it; consequently it depends on the political opinion of the mayor, and there have been instances in which the drug has been returned to the Ministry. The question of extending this right to girls under the age of 14 years without the consent of their parents, under a proposal by the Ministry of Health to support the victims of sexual violence, is the subject of a legal debate. In addition, its purchase in chemist's shops is restricted, as a prescription is required. The women's health movement played a major role in this debate, the outcome of which is seen by many as a victory.

“EC marks a victory for the feminist movement...the first poster that was displayed in the Ministry is the one we made for the EC project in 2002, it was put up by the Under-secretary and a year later he proposed that the Ministry should propose EC as standard, which is why they threw him out ...there's something on which we certainly had some influence...it took the Government three years to take it up again...we took up the issue of EC in 1997...” (Interview with Fanny Berlagoscky)

6. Health Reform. During the early stages of health reform, when the Government of Ricardo Lagos presented the key legislative projects of the reform, the women's health movement made a huge effort to provide and disseminate information among women, to

29 In 2001, a group of organizations filed an application for protection against the Ministry of Health and the Public Health Institute (ISP) for having authorized a laboratory to market and distribute the drug “Postinor” in Chile. In response, various women's and medical organizations attempted to join the application in order to be heard. However, their request was rejected by the Santiago Court of Appeal... this led to a complaint to the Inter-American Human Rights Commission for denial of justice. In the end, the application for protection was accepted, and the distribution of “Postinor” was banned...However, ISP authorized the sale of the drug by another laboratory under the name “Postinor-2”...” Maturana, Camila. Sexual and Reproductive Rights in Chile: Ten years on from Cairo. Forum-Network on Health and Sexual and Reproductive Rights and Latin American and Caribbean Women's Health Network. 2004: 878.
undertake analyses and put forward proposals,\textsuperscript{30} denouncing the absence of a gender perspective and the promotion of a process of privatization of health and liberalization of the State, whose main victims would be women, because they are the system's main users, both as patients and staff. Even when the Government was developing gender rhetoric for the reform,

“Although at the beginning of the health reform process in 2000, the Ministry of Health set up an advisory group on gender issues, which produced a document entitled “Cross-cutting from the gender perspective in health reform policy in Chile”, this focus was not then explicitly and systematically applied to the proposed legislation” (PAHO. Observatory of Gender Equity in Health. Report 2005).

The perspective was subsequently applied in a number of health programmes, but it is expected that the current reform will rely on the unpaid contribution by women, as no transparent and proper effort has been made to address how measures such as the reduction in the length of stay in hospital, earlier discharge, strengthening community health and other measures being envisaged by the reform for health-care models, will affect women.

**Lessons learnt**

There is no doubt that two decades of mobilization by this sector of civil society, which is made up of social organizations and women's and feminist NGOs, have had an impact in terms of gaining recognition for women as subjects of specific rights in the sphere of health, and brought about changes in attitude both within Chilean society and in its institutions. This opinion is shared by all of those who have participated in the movement. However, we also share a number of criticisms when we evaluate the scope and depth of the changes achieved by the action of this sector of civil society.

At the imponderable cultural level, thanks to the public debates and the establishment of bodies providing social and political training and participation, it has been possible to disseminate a concept of health that is associated with the living conditions of women, and to assure a central place for their right to self-determination for their own bodies, their sexuality and reproduction and to a life free from violence, and for the idea that sexual and reproductive rights are an integral strategic part of the right to health.

Some of the key concepts introduced by the movement, such as gender, sexual and reproductive rights, gender violence and the human and civil rights of women have been incorporated into a number of health programmes and standards\textsuperscript{31}, while at the same time the gender perspective has gradually been incorporated into the health reform process, even though the measures themselves still tend to be sporadic and insufficient. The progress made in the legislative sphere provides a valuable framework for implementing programme measures and changes in health-care practice, the most significant of which

\textsuperscript{30} The movement for health reform with a gender focus has been formed. It comprises more than 20 women's social organizations, feminist collectives and NGOs. PAHO provided noteworthy support in organizing days and discussion seminars on health reform and gender.

have been in the field of domestic and sexual violence; liberalization of the law on sterilization; the constitution of sexual and reproductive health advisory services that observe the principle of confidentiality and the right to take informed and independent decisions; participation by men at different moments of pregnancy and childbirth; specific guidelines for sexual and reproductive health care for adolescents, based on international instruments recognizing their rights in this area and access to emergency contraception.

It is possible for us to list a number of government measures and initiatives which show that there has been awareness and the political will within the different Coalition Governments to incorporate some elements deriving from the gender perspective. However, the evaluation made by some sectors of the movement is that the changes are sluggish, insufficient, disconnected and unrelated to the context, and that they lead to programmes and policies which are fragmented and frequently distorted in regard to their initial purpose. The clearest illustration of this has been the evolution in the response by society and by the State to violence against women, whose conceptual framework, domestic violence, conceals the gender-based nature of power relations. The fact that the women's health movement has actively participated in some of these processes, while in others, such as abortion, there has been regression, are elements for a critical evaluation, because it puts us before our responsibilities.

The strength of conservative and fundamentalist sectors and the disorganization of the women's and feminist movement as a whole, and in the health sphere in particular, determine a situation in which we face huge challenges to set in motion processes of authentic transformation of social, and in particular gender, inequalities. From this angle, one possible interpretation is that the progress made in respect of women's health rights has been made possible by the involvement in the State of feminist women and women from the women's movement, and by the involvement of NGOs with a clearly technical orientation, rather than by the existence of a movement that acts as a partner of the State and as a social and political point of reference. This produces a double game, in which women experts place themselves under the authority of the health institution while at the same time lacking a social support base, making them dependant on State patronage and dependant on needs which do not always correspond to the strategic interests of women.

This form of political involvement as a means of influencing public policies is being called into question because of the way it weakens the women's and feminist movement's capacity to bring about social transformation, in a situation where the capacity of social movements as a whole to act as catalysts for social and cultural change is in crisis.

“Our understanding of participation has undergone changes; this policy is pretty perverse, the movement is fragmented, for different reasons: organizations can’t

32 “This year, 260 agreements have just been made with local authorities, under which specialists will put into practice a health-care methodology developed on the basis of feminist experience.” Interview with Valentina Martínez, a member of the Chilean Network against Domestic and Sexual Violence since its early years, and sometime member of its national coordinating body.
33 By 2004, 7 hospitals had provided treatment rooms that guaranteed privacy, technical quality and humane primary treatment for women who were victims of sexual violence. PAHO. Observatory of Gender Equity in Health. 2005.
34 Currently, the Chilean Network against Domestic and Sexual Violence is in the throes of a process of “re-politicization”, involving a critical review of its relationship with the State, with the feminist and women's movement and with other social actors, and of “focusing on issues” which necessarily leads to a fragmented approach to violence against women.
survive without resources, this means that on the one hand they tend to split up and on the other that the NGOs have gradually become specialized in certain topics, so it's hard to think of the movement as a more global entity in which we are all involved, we need a more common agenda...” (Interview with Rosa Espinola)

The pronounced tendency of the women's and feminist organizations active in the field of health to rely on the State for political action has also led to a lack of alliances with other social sectors; moreover, the lack of resources – which used to be provided by international cooperation - and dependency on patronage undermine the autonomy which these organizations need.

“In recent years, this has perhaps hampered the formation of a robust, sustainable and highly active health movement on the national technical and political stage, with the corresponding media impact. Despite this, thanks to the various organizations that belong to it, it has managed to have quite an impact in bringing issues to the forefront of public debate” (PAHO. Observatory of Gender Equity in Health. Report 2005: 13)

Apparently, one of the main challenges facing the movement, which has made a significant contribution to gender equity, is the need to improve its internal organization and to build alliances with other sectors, including with organizations of health workers, who hold the key to progress in issues still outstanding. It is also important to return to centre stage and to direct action towards women, grass-roots organizations and users and to encourage complementarity between the knowledge garnered from real life and that developed by academia, and to build a relationship with institutions that is based on political legitimization and empowerment.

35 Currently, national coordinator of the Forum-Network on Health and Sexual and Reproductive Rights.
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