Health, gender and poverty in Latin America

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June 2007

Background paper prepared for the Women and Gender Equity Knowledge Network of the WHO Commission on Social Determinants of Health
**Background to the Women and Gender Equity Knowledge Network**

The Women and Gender Equity Knowledge Network (WGEKN) of the WHO Commission on Social Determinants of Health was set up to draw together the evidence base on health disparities and inequity due to gender, on the specific problems women face in meeting the highest attainable standards of health, and on the policies and actions that can address them.

The work of the WGEKN was led by two organizational hubs – the Indian Institute of Management Bangalore (IIMB) and the Karolinska Institute (KI) in Sweden. The 18 Members and 29 Corresponding Members of the WGEKN represent policy, civil society and academic expertise from a variety of disciplines, such as medicine, biology, sociology, epidemiology, anthropology, economics and political science, which enabled the work to draw on knowledge bases from a variety of research traditions and to identify intersectoral action for health based on experiences from different fields.

**Acknowledgments**

This paper was reviewed by at least one reviewer from within the Women and Gender Equity Knowledge Network as well as by two external reviewers. Thanks are due to these reviewers for their advice on additional sources of information, different analytical perspectives and assistance in clarifying key messages.

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*This paper was written for the Women and Gender Equity Knowledge Network established as part of the WHO Commission on the Social Determinants of Health. The work of the network was funded by a grant from the Swedish Ministry for Foreign Affairs through the World Health Organisation, the Swedish National Institute of Public Health and the Foundation of Open Society Institute (Zug). The views presented in this paper are those of the author and do not necessarily represent the decisions, policy or views of IIMB, KI, WHO, Commissioners, the Women and Gender Equity Knowledge Network or the reviewers.*
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HEALTH, GENDER AND POVERTY
IN LATIN AMERICA

Policy Briefing

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Montevideo – Rio de Janeiro
June 2007
I- INTRODUCTION

The objective of this paper is to examine the connections between health reform processes, gender relationships, reproductive policies and poverty policies in five Latin American countries.

Across Latin America and the Caribbean there have been extensive reforms of the health sector in the last decade. Although conceived as a means to increase equity in the provision of services and to satisfy the health necessities of the population, considerations of gender inequities have been barely touched upon.

These policies, although to a great extent standardized by international financial institutions, had quite distinct impacts by sub region and countries. However, a common characteristic across countries is the limited incorporation of a gender perspective to address crucial dimensions such as health determinants, access to services and financing.

II. GENDER INEQUITY IN HEALTH: SOME CRITICAL ASPECTS

In addition to consistently articulating aspects relating to the sexual division of labor and gender power differentials, gender analysis in health also requires the analysis of sex disaggregated epidemiological data as well as the assessment of the characteristics of existing health system in terms of accessibility, finance and management, which implies the necessity of:

- The opportunity to be in good health and not become ill or disabled, or die, due to preventable causes;
- Access to health care according to need;
- Financing of services according to payment capacity;
- Division of responsibilities and power in the provision of health services and care.

III. HEALTH SECTOR REFORM IN THE REGION

In Latin American countries, health reform processes were a key component of broader state reform agendas and in particular of social security and pension systems. The reforms aimed at reshaping social security and health models that have gradually evolved throughout the 20th century, which were mostly tripartite as the public, social security and private subsystems played different roles with different levels of integration, types of finance and provision, and degrees of coverage. (Mesa Lago, 2005). In seven countries (Argentina, Bolivia, Colombia, Chile, El Salvador, Peru, Dominican Republic) health reforms followed the structural reform of pensions, as both programs are connected within the social security system. In four countries health reform preceded pension reform (Brazil, Costa Rica, Mexico, Nicaragua) and in four other countries (Guatemala, Honduras, Panama, Paraguay) health reforms have been undertaken but not pension reforms, at least not structural ones. In Uruguay there the pension reform has been underway for some time, but the health system was not structurally altered.
This paper presents the characteristics of reform in five countries: Argentina, Brazil, Chile, Mexico and Uruguay.

IV. PLANS AND PROGRAMS TO COMBAT POVERTY IN LATIN AMERICA

Since the mid 1990s social protection programs aimed at the poorest sectors of the population began to be implemented in several countries of Latin America. The objective of these programs is the provision of support for families to improve their living conditions and exit the cycle of poverty and/or overcome a severe short-term income crisis situation. In addition to these social protection objectives such programs promote investment in human capital by making their support conditional on the beneficiaries taking responsibility for children’s attendance at school and/or access to health services for specific interventions. In some cases where the programs emerged in the context of deep economic crisis, the transfer is linked to some labor commitment on the part of the beneficiaries.

These programs have the following characteristics in common:

- They are subsidized programs that operate through direct monetary transfer for families to improve their consumption levels.
- They define as their goals: poverty alleviation and investment in human capital.
- Most programs are of a conditional nature and incorporate an education component as well as a health and nutrition component.
- Input from national economies is moderate, not exceeding 0.35% of GDP.
- They specifically focus on poor or extremely poor sectors.
- Women are usually the main recipients of transfers either because this is stipulated in the program’s rules of operation or simply because this is what happens in practice.
- They claim to be different from previous transfer programs in that the beneficiaries of these current programs have to take responsibility for fulfilling an agreement or contract with the program.
- Several of these programs declare that they operate within logic of rights: the right to social insertion.
- These programs are financed, or supported and encouraged, by multilateral financial, which plays a strong supporting role for countries in their design, operation and evaluation.

Gender impact of antipoverty programs

Transfer recipients are usually women, either because the programs so specify in their rules or because this is simply what happens in practice. This implies that women are the ones in the household who request, manage and receive benefits.

In addition, the programs do not always ensure that education and health systems function properly and are accessible, but simply mobilize a demand for them. This raises important questions in respect to the quality of educational and health services, as if access and quality is not ensured, the mere transfer of income may not always allow people to escape from the vicious circle of poverty.

It should also be noted that when and where links are established with health interventions they are restricted to child maternal health and nutrition, leaving aside other critical sexual and reproductive needs such as contraceptive assistance, HIV/AIDS, STD and cervical cancer screening, gender based
violence, or even other relevant women’s health demands as in the case of mental health and chronic diseases. This absence is particularly striking when in practically all countries where income transfer programs are being implemented, either policies are in place to address these needs, or they have motivated civil society mobilization for many years.

A range of implications for policy and programs arise from a gender perspective on health and poverty:

Attention to women’s non-reproductive health needs: poverty lays women vulnerable to a range of health problems, some but not all associated with reproductive health. Conditions which may be associated with poor women’s work, increase vulnerability to a range of health problems, as does poor nutrition.

Non-health sector strategies: Non-health sector strategies are needed to address socio-economic and legal issues (e.g. legality of abortion, rights of girl child, gender based violence), which also affect gender inequality.

Primary health care interventions should assess the costs and benefits of interventions to women, as well as children, with particular attention to time constraints.

Community participation initiatives must ensure that the perspectives of poor women are included.

VI. CONCLUSIONS

The recent impetus achieved by health sector reforms policies throughout the region has given rise to an intense debate in governments, civil society, and multilateral agencies about the actual and potential effects of these policies on health equity and human development. However, this concern has focused almost exclusively on regional and income disparities without taking into account the differential impact of these policies on women and men. The absence of this concern in the public debate has translated into a lack of policies to correct the gender inequities associated with these reforms that cannot be addressed through the same measures employed to reduce the gaps between regions or income groups.

Certain effects of health and poverty reduction policies’ have been measured in recent years that are very positive: vaccination and other interventions have lowered infant mortality; polio has been eradicated from Latin America. Some countries, such as Chile and Cuba, have health indices similar to those registered in Northern countries. But in most of Latin America the reduction of public investment in health and privatization has clearly led to a widening gap in access to quality health care.

When health and poverty reduction policies implemented in the five countries are examined through the lens of gender, the results are rather paradoxical. On the one hand, positive trends must be acknowledged: the adoption of poverty reduction policies and within that of income transfer programs that are directly benefiting women; the legitimatization of sexual and reproductive health frameworks and discourses, despite strong conservative resistance; the expansion and consolidation of research and policy debates on both health and gender and gender and poverty.
On the other side, a series of disjunctions are easily identifiable, such as sheer disconnections between health and poverty reduction policies and most principally lack of conceptual clarity and inconsistencies in respect to the gender dimensions and implications of existing policy frameworks. Despite the longstanding recognition of a poverty-health link in conceptualization, research and policy debates, the case studies suggest that in terms of policy frameworks and effective implementation what tends to prevail is disconnection and fragmentation.

At least two hypotheses may be raised to explain these disjunctions. The first is that the health and poverty policy arenas are very different in terms of the actor’s involved, privileged conceptual frameworks, and disciplinary traditions. This means that each policy agenda constitutes relatively closed domains that do not intersect easily, neither at societal or institutional levels, not to mention the competition for resources by different policy areas that is intensified under conditions of fiscal stringency. The second hypothesis is that the difficulty of conceptualizing and implementing comprehensive policy frameworks encompassing health – there including gender aspects and sexual and reproductive health – is also related to the “focalization” frame adopted by these programs and the extreme selectivity policies implemented in recent years.
HEALTH, GENDER AND POVERTY
IN LATIN AMERICA

Executive Summary

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Montevideo – Rio de Janeiro
June, 2007
Executive SUMMARY

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I- INTRODUCTION

The objective of this paper is to examine the connections between health reform processes, gender relationships, reproductive policies and poverty policies in five Latin American countries.

Across Latin America and the Caribbean there have been extensive reforms of the health sector in the last decade. Although conceived as a means to increase equity in the provision of services and to satisfy the health necessities of the population, considerations of gender inequities have been barely examined.

These policies, although to a great extent standardized by international financial institutions, had differentials impacts by sub region and countries. However, a common characteristic across countries is the limited incorporation of a gender perspective to address crucial dimensions such as health determinants, access to services and financing.

II. GENDER INEQUITY IN HEALTH: SOME CRITICAL ASPECTS

The adoption of a gender perspective in health requires a conceptual frame that consistently articulates aspects relating to the sexual division of labour and gender power differentials within a specific population and analyses the epidemiological profile of this same population as well as an assessment of the characteristics of existing health system in terms of accessibility, finance and management. It therefore implies the identification of gender inequities in respect to the following dimensions of health equity:

- The opportunity to be in good health and not become ill or disabled, or die, due to preventable causes;
- Access to health care according to need;
- Financing of services according to payment capacity;
- Division of responsibilities and power in the provision of health services and care.

A. Gender equity in access to health services

Gender equity in access to health services requires that:

- Health care resources are allocated according to the differential needs of women and men;
- Members of each sex receive services corresponding to their differing needs;
• Services are paid for according to the economic capacity of each person and not according to differential needs or health risk assessments based on sex differentials.

B. Gender equity in health service management and finance

In order to achieve gender equity in the financing of health care it is necessary to promote a system to which both women and men contribute according to their economic capacity and not according to their need or risk assessment, as it happens with private systems. And, above all, it is important that the social costs of reproduction do not fall only on women, or on women and their partners, but rather that they are borne by the social group as a whole through a solidarity system.

In health service management, gender equity involves not only the issue of equal pay but also the egalitarian distribution of responsibilities between women and men, the acknowledgement and accounting of the economic contribution to health promotion and care made by women’s unpaid work, the recognition of the under-representation of women in local and national power structures, and a just division of the real costs of health service provision between family, community, state and market.

From these elements the following challenges are identified: to eliminate avoidable differences between men and women in their state of health; to allocate resources according to need; to create a payment system based on people’s economic capacity; and to ensure an egalitarian division of responsibilities and power.

III. LATIN AMERICA: ANALYSIS CONTEXT

The Social Watch 2006 Report\(^1\) estimates that for women’s reproductive health the goal of dignity for everyone, as agreed by governments in the framework of the MDG’s, will be achieved in the region by 2065.

Several regional studies indicate that in comparison to men, women suffer the following labour and social security disadvantages:

a) more than 50% of them are not part of the paid labour force;
b) they have a higher unemployment rate than men;
c) a majority of them work in low paid jobs or they receive less pay for the same work (average female income is 70% of average male income) and consequently have less ability to pay private health insurance premiums or other health service related costs and so have access to lower quality plans than men.
d) as heads of households they suffer a greater incidence of poverty, and complications during pregnancy, birth and the postnatal period are more frequent in groups that live in conditions of poverty and suffer from malnutrition;
e) they are over-represented in jobs that do not provide social security coverage, such as informal or domestic work;

\(^1\) See www.socialwatch.org
f) direct access to health insurance is affected by the discontinuity caused by pregnancy and child rearing, which often forces women to leave their job and thus lose their sickness and maternity insurance coverage;
g) frequently women have indirect coverage when they are a dependent of a man who has insurance, however they can lose this in the event of widowhood, abandonment or separation.

Available information on health determinants in Latin America and the Caribbean also shows disparities between men and women in terms of social and political participation and in their access to housing, education, information, income, social protection, food, basic sewerage services and drinking water. Disparities are also apparent in other aspects, such as available leisure time, risk of sexual and domestic violence and participation in domestic and community work. All these factors manifest differently according to sex and therefore determine different living conditions, health risks and degrees of access to resources and services for women and men. Unacknowledged and unshared labour in the home constitutes an additional work burden for women and exposes them to specific work risks. Also, gender related violence is one of the most serious public health problems.

IV. HEALTH SECTOR REFORM IN THE REGION

A. Contemporary Health Sector Reform Trends

The main aim of HSRs proposed in the late 1970’s was to ensure the reduction of fiscal deficits in order to control inflation and supposedly improve national savings. This implied a drastic reduction in public funding for health, and “privatization” in a variety of forms: adoption of user’s fees in public health services, expansion in the number of private providers or pre-paid health insurance schemes. Though these conceptual foundations are still alive and active, it is critically important to acknowledge that the health reform guidelines pushed by the World Bank and other powerful international institutions have changed since the first framework was made public in the late 1970’s. By the mid 1980’s the detrimental effects of the stringent reduction of public investment in health and education, as well as of privatization, were already evident. From then on a series of systematic critiques of the poor health and education outcomes of the SAPs was developed, publicized and used to pressure the World Bank and IMF. This pressure had an impact, albeit minor, on the global health reform agenda. In 1993, the World Bank launched the report “Investing in Health”. After almost fifteen years of implementing the SAP health model, the World Bank recognized that the outcomes were not positive and that public investments would be required to improve critical health indicators – such as infant and child mortality, HIV-AIDS and other epidemics – in the developing world and transition economies. This “breakthrough” led to a new global policy agenda that became known as the “reformed health reform”. But this did not mean a revival of the publicly funded universal models of the 1950’s and 1960’s. Instead, under the new guidelines, public funds were to prioritize the basic needs of the poorer sectors – the so-called basic packages – while higher income groups would still pay for their health costs. (Mesa Lago, 2005; Standing, 2000; Standing, 1997)

The report also used a new method to define which diseases or health interventions should be prioritized in the allocation of public funds. The method, known as Disease Attributed Lost Years (DALY), measured the impact of disease burdens on the productivity of individuals. In addition, greater visibility and priority was given to decentralization strategies and the report also mentioned

that in some contexts the existence of social accountability mechanisms had improved access to and the quality of health systems.

In the late 1990’s, as new proposals for debt relief gained legitimacy, a second important shift was observed in health investment in Southern countries. Sector Wide Approaches (SWAPs) were adopted as part of the Highly Indebted Poor Countries Initiatives (HIPC) and, later on, of Poverty Reduction Strategies Programs (PRSP). This meant that the basic elements of the reformed health reform – managerial changes, decentralization strategies, basic packages for the poorer sectors, new rules governing priority setting and community participation – became part of the overall negotiations around the conversion of debt payments into health investments.

In the case of most Latin American countries, health reforms adopted from the 1980’s one have been undertaken as part of a general State reform. In most cases these reforms were strongly influenced by international finance bodies. In isolated cases such reforms were limited to a revision of the health system. In seven countries (Argentina, Bolivia, Colombia, Chile, El Salvador, Peru, Dominican Republic) health reforms followed on from the structural reform of pensions, as both programs are connected within the social security system. In four countries health reform preceded pension reform (Brazil, Costa Rica, Mexico, Nicaragua) and in four other countries (Guatemala, Honduras, Panama, Paraguay) health reforms have been undertaken but not pension reforms, at least not structural ones. In Uruguay there have been pension reforms but no real reform of the health system. The new wave of reforms aimed at reshaping social security and health models that have gradually evolved throughout the 20th century, which were mostly tripartite as the public, social security and private subsystems played different roles with different levels of integration, types of finance and provision, and degrees of coverage. (Mesa Lago, 2005)

Most of the reforms have all or some of the following objectives, although with significant differences in some cases:

(a) to decentralize and de-monopolize service provision by the public and social security subsystems through the use of multiple insurance and/or service provision companies, with a crucial role for the private subsystem and greater independence and self-management for hospitals;
(b) to separate the functions of governance/regulation, insurance and management, finance and service provision;
(c) to introduce free choice of provider for insured parties or users;
(d) to widen coverage, extend primary care through a basic package of services and improve service quality;
(e) to promote equity by reallocating resources to reduce the gap between regions and municipalities and to focalise fiscal subsidies on the poor;
(f) to increase the efficiency, autonomy and accountability of the health system, especially hospitals;
(g) to change traditional financing from a fixed budget to reimbursements for the provision of services and from supply subsidies to demand subsidies;
(h) to reduce public expenditure and recuperate costs through co-payments and regular payments for usage rights.
(i) to promote greater civic participation and control.
By and large the principle of solidarity and income redistribution has been ignored, or has received scant attention, in reform processes. Many public/social security systems in the region are criticised for their lack of true solidarity as they do not provide coverage for a significant part of the population but do provide fiscal subsidies to insured middle-income sectors that do not need them. The language of health sector reform, as expressed by international agencies and Governments, has changed over the decade from the early 1990s. The “first generation” of reforms was overwhelmingly supply side driven and focused on and within the health sector. In the “second generation,” many of those basic elements remain firmly in place, but the emphasis has shifted more to the demand side and the language has broadened towards anti-poverty interventions and intersectoral approaches to health. In many developing countries, this agenda has been heavily donor driven and linked to economic adjustment and liberalisation. (Standing, 2000). But a similar menu has been pursued in most reforming countries, including some northern ones. This first generation has been distinguished by a number of serious shortcomings. The focus was purely on system level change (such as reforming the functioning of Ministries of Health) with no associated monitoring of outcomes for health and impact on service delivery.

More recently, international agency language and approaches have shifted quite significantly. Partly, this has been due to a tacit acknowledgement of the relative failure of reforms in a number of countries to deliver any obvious improvements on the demand side. However, widening gaps between rich and poor in health status and health care access have raised serious questions about the content and direction of reforms. Both governments and donors are stressing the importance of partnerships between key stakeholders, although the concept of partnership remains underdeveloped. These are taking various forms: the public-private partnerships between governments and different elements of the private sector, and partnerships between governments and a variety of civil society groups such as NGOs and other community based organisations.

This paper presents the Reform’s characteristics in the five countries: Argentina, Brazil, Chile, Mexico and Uruguay.

**B. Health Sector Reforms and Gender**

Common to most countries, and that is the case in the five cases studied, has been the limited insertion of a gender perspective in approaching crucial issues such as health determinants, access to services, finance and employment in the health sector and social participation in health. Current observation reveals that it is not possible to continue repeating that sector reform has the potential to make an impact on reducing inequities if the differing needs and conditions of men and women are not taken into account from the beginning in its design, implementation, financing and monitoring.

The lack of coordination and articulation between the different subsystems that provide health care (public, social security and private) generates a heterogeneous provision of coverage that prevents the formation of a common vision for health systems and is detrimental to an efficient use of resources and the achievement of acceptable levels of equity in service access and use.

**B.1 Gender inequities in health access and care revealed by the countries studied**
Gender equity requires that health resources and services are allocated and received according to the needs of each sex and are paid for according to each individual’s economic ability without reference to differing gender related risk assessments.

Gender related differences in access and attention can be explained by internal and external factors: the characteristics of the health system itself and the general socio-economic context in which it functions (Pollack, 2002).

The charging of user fees for health care has spread in the region, in some countries even for basic and emergency services. Several studies have confirmed that such fees, together with inefficient exemption mechanisms, have resulted in the exclusion of those who are unable to pay. Although there are few studies on the impact of these payments according to sex, there is evidence that women suffer proportionally more due to their greater use of services both for themselves and their children, and the responsibility that they have to provide health care in poor households (UNRISD 2005).

**B.2 Health reform, finance and insurance mechanisms and specific gender inequities in the financing of health services**

Health sector reforms in Latin America during the 1980’s and 1990s have implied structural changes of which two most critical were the separation of health service finance and provision and the reform of the health social security system resulting in insurance companies gaining access to health funds raised through formal employment. The outcomes of these reforms can be clustered in relation to three core aspects: modalities of managing and financing, insurance schemes and basic packages.

i. State run public systems with fiscally funded public insurance schemes

In several countries reforms have modified State run public systems (Chile, Colombia and Argentina, amongst others) through health system and service provision decentralisation processes from national to provincial and municipal management and through the transformation of public hospitals into self-managed bodies in competition for public and private insurance funds with private entities. This decentralisation has resulted in municipalities being responsible for basic or primary health care while responsibility for more complex services lies at provincial and national levels, which has affected reference and counter-reference systems. (Onyango 2001)

It should be emphasized that up to now there are no public gender equity policies for the regulation of private sector and social security in health activities and one of the most significant changes in public health policy over recent years has being the passage to private hands of previously public services and finance.

The Health Ministry in Chile made the only pioneering attempt at inspection and regulation. It can be said that gender sensitive policies related to the change in the State’s sphere of operation are only applied to primary health care with the situation becoming more complicated when passing to more complex attention, and there are serious consequences in terms of integral service provision.

Another important aspect for measuring gender inequity in public fund systems is an examination of what expenditures they do not cover.

ii. Insurance schemes for workers in the formal sector
Since the reforms started, in most countries of the region, insurance schemes for workers in the formal sector have been divided into two types: a) those of solidarity funds, b) those of risk insurance companies. There is a tendency for funds from the former to be transferred to the latter. It is important to highlight some aspects of this tendency’s gender related consequences.

Risk insurance companies, even the best regulated, work on the classic basis of commercial risk and thus the size of coverage premiums depends on a potential expenditure assessment according to sex, age and number of dependents of the insured person. In Latin America the effects on gender inequity of the risk insurance model has been well studied in Chile, which has the most mature experience of neo-liberal reform in the region.

iii. Basic insurance, micro-credits and catastrophic disease funds for the “deserving” poor.

Such programs have been fostered by various international bodies in Third World regions and are being promoted in some Latin American countries. From a gender perspective it can be shown that their potential beneficiary group is predominantly made up of women, given the prevailing poverty distribution generated by the well known feminisation of poverty phenomenon, which is already in itself a gender inequity effect of great dimensions. In regard to basic insurance, the main question from this perspective is to identify whether it covers and responds to gender related differing needs. It is also important to critically analyse the equity effects of credits or saving plans for the poor proposed by international financers to solve health problems.

iv. Evaluation of Health Sector Reforms’ gender impact in Latin America

Although an evaluation of the true gender impact of health sector reforms remains a key pending agenda, indicators are available to explore its effects in some specific areas: human resource policies, types of finance for the provision of women’s and men’s differential health needs, gender equity in the quality of care, impact by sex of economic reforms on the ways in which people become ill and die.

v. The evolution of sexual and reproductive health policies in the framework of health sector reforms.

A way of looking at the relation between health sector reform and gender is to analyse the evolution of sexual and reproductive health policies and their relation to reform processes, if nothing else because the sexual and reproductive health has been throughout the years a key component of the wider gender equality agenda and main are of civil society mobilizations.

In Mexico, women’s health agendas were forcefully mobilized in the 1980’s by feminist and left-wing critiques of the population control policies that had been implemented since the previous decade. In contrast, in Uruguay and Argentina women’s movement activists mostly had to face up to and challenge explicit or implicit pro-natalist stances, such as the prohibition of sterilization (in both cases) and of commercialization of contraceptives (in the latter). In Brazil the new feminist discourse on reproductive self-determination was constructed in opposition to both neo-Malthusian proposals and the pro-natalist ideology of the Catholic Church and other sectors.

Moving into the 1990’s, in Latin America greater political stability and the positive impacts of Cairo and Beijing are clearly the factors most worthy of mention and analysis. In Brazil the UN conferences clearly re-activated the 1980s women’s health policy agenda, particularly with respect to the provision of abortion in the two cases permitted by law (rape and when the women’s life is at
risk). In Bolivia, Mexico and Uruguay the main bulk of the policies that were still in place during the 2002-2004 period emerged, by and large, out of the intersection between national policy initiatives under discussion since the late 1980’s and the international breakthroughs of 1994 and 1995. In Argentina developments followed a different pattern since throughout the 1990s, while the feminist movement strongly engaged with the S&R H&R agenda, Carlos Menem’s government maintained, both at home and in international arenas, an extremely regressive position with respect to S&R H&R issues, in particular abortion. This would require great persistence from women’s organizations to keep the agenda visible and alive in the public arena.

But in the other countries, despite the democratic vitality and advances observed during this period, problems can also be identified. The international commitments made by governments did not always translate into consistent national policies. Fiscal restrictions and state reform processes also created important policy constraints. Electoral and administrative changeovers often gave rise to a pattern in which policy progress was erratic: two steps forward, one step back.

V. PLANS AND PROGRAMS TO COMBAT POVERTY IN LATIN AMERICA

The study of poverty from the point of view of gender has gained importance since the 1990s. Studies within this framework “examine gender differences in the poverty-generating results and processes, particularly focusing on the experiences of women and asking whether they form a disproportionate and growing contingent among the poor. This emphasis implies a perspective that highlights two forms of asymmetries that become intersected: gender and class.”

Since the end of the 1990s social protection programs aimed at the poorest sectors of the population began to be installed in several countries of Latin America. In this study we will focus on income transfer programs that have been implemented in the region and the relation between these programs and health.

The objective of these programs is the provision of support for families to improve their living conditions and exit the poverty cycle and/or overcome a severe short-term income crisis situation. In addition to these social protection objectives such programs promote investment in human capital through making their support conditional on the beneficiaries taking responsibility for children’s attendance at school and/or health services. Where they are programs of employment in crisis situations, the support is linked to some labour commitment on the part of the beneficiaries.

These programs have the following characteristics in common:

- They are subsidy programs that operate through direct monetary transfer for families to improve their consumption.
- They determine objectives of support, poverty alleviation and investment in human capital.
- Most programs are of a conditional nature and incorporate an education component as well as a health and nutrition component.
- Input from national economies is moderate, not exceeding 0.35% of GDP.
- They specifically focus on poor or extremely poor sectors.
- Women are usually the recipients of transfers either because this is stipulated in the program’s rules of operation or simply because this is what happens in practice.

• They claim to be different from previous transfer programs that transferred resources to beneficiaries who received them in a passive way in that the beneficiaries of these current programs have to take responsibility for fulfilling an agreement or contract with the program.
• Several of these programs declare that they operate within logic of rights: the right to social insertion.
• These programs are financed, or supported and encouraged, by multilateral banking, which plays a strong supporting role for countries in their design, operation and evaluation.

Gender impact of antipoverty programs

Transfer recipients are usually women, either because the programs so specify in their rules or because this is simply what happens in practice. This implies that women are the ones in the household who request, manage and receive benefits.

Although the process of empowerment resulting from women being the resource administrators is considered to be positive, it can also be seen from another angle as it places on women’s identity an association that categorises them as “being for others”. In this way women continue to be “intermediaries for well-being or for the social organization of care” as well as carrying responsibility for care of the family group. As is well known, this has repercussions for their use of time and generates an overload of work, stress and responsibility.

Conceptually such programs are criticised for associating rights that are a matter of citizenship, with access to social services, which is a matter of coverage. They are also said to have design and management defects that inhibit the possibility for linkage with socio-community dynamics in the locality where beneficiary families live.

In addition, the programs do not intervene in the supply of education and health services but only in the demand for them, which raises the question of the quality of social services and could create a vicious circle of poor services for the poor.

From a gender perspective these programs should take responsibility for the generation of greater equity by intervening to encourage the break up of the division of labour and access to power by sex, by promoting social responsibility for reproduction activities, promoting a social organisation of care with collective responsibility that does not depend on overburdening women with work and responsibility.

In connection with this Daeren (2004) highlights the need to investigate opportunities available to women who are not targeted by such programs, are not mothers, are not of reproductive age or are part of a non traditional family. The programs “exploit” the social image of women as devoted to the service of others while studies show that women who participate in such activities are interested in obtaining training and access to financial assets and services in order to facilitate their insertion in productive activities and increase their income.

Income transfer programs are gaining ground in the social agenda, which is worrying for several reasons. The first and most important one being because they fail to combine protection and well-being. They remain on a threshold of assistance to the poorest without incorporating key issues of development such as citizenship, empowerment and capacity building.

Secondly, because they discard considerations relating to the social division of responsibilities for the construction of a society with higher equity levels, proposing instead focalised protection
dynamics that do not involve solidarity criteria at a social level. Thirdly, because they are supported by a hypothesis attributing benefit to investment in social capital, which in fact has proved its limitations in terms of social policies when the linear assumption is made that the inheritance of a social position linked to birth can be broken through education or training. Fourthly, because they wrongly associate rights, that are a citizenship matter, with access to social services, which is a coverage matter. Fifthly, because they have design and management defects that inhibit linkage with socio-community dynamics in the locality where beneficiary families live and because they do not link with the social protection system as they promise.

A focus on poverty in women’s health provides an opportunity to broaden the idea of what constitute women’s health needs away from the current focus on reproductive health. Thinking about women and poverty can draw attention to health problems arising from the wide scope of women’s activities and how gendered patterns of disease and health risk are affected by socio-economic position. However it is important to recognise that women’s health problems and access to health care are affected not only by poverty, but also by gender inequality.

A range of implications for policy and programmes arise from a gender perspective on health and poverty:

**Attention to women’s non-reproductive health needs:** poverty lays women vulnerable to a range of health problems, some but not all associated with reproductive health. The conditions which may be associated with poor women’s work increase vulnerability to a range of health problems, as does poor nutrition.

**Non-health sector strategies:** Non-health sector strategies are needed to address socio-economic and legal issues (e.g. legality of abortion, rights of girl child) which affect gender inequality.

**Primary health care interventions** should assess the costs and benefits of interventions to women, as well as children, with particular attention to time constraints.

**Community participation initiatives** must ensure that the perspectives of poor women are included.

**VI. CONCLUSIONS**

The recent impetus achieved by health sector reforms policies throughout the region has given rise to an intense debate in governments, civil society, and multilateral agencies about the actual and potential effects of these policies on health equity and human development. However, this concern has focused almost exclusively on geographical and income considerations without taking into account the differential impact of these policies on women and men. The absence of this concern in the public debate has translated into a lack of policies to correct the gender inequities associated with these reforms that cannot be combated with the same measures employed to reduce the gaps between geographic locations and socioeconomic strata.

Certain trends have become palpable within much of Latin America. Some have been favorable: vaccination and other interventions have lowered infant mortality; polio has been eradicated from Latin America. Some countries, such as Chile and Cuba, have health indices similar to those
registered in the north. But in most of Latin America a retreat commitment to public subvention of health care and a move forwards for its privatisation have led to a widening gap in access to quality health care.

When health and poverty reduction policies implemented in the five countries are looked through a gender lens the results are rather paradoxical. On the one hand, positive trends must be acknowledged: the adoption of poverty reduction policies and within that of income transfer programs that are directly benefiting women; the legitimatization of sexual and reproductive health frames and discourses, despite strong conservative resistance; research and policy debates on both health and gender and gender and poverty have expanded and consolidated.

On the other side, however, a series of disjunctions are easily identifiable, such as sheer disconnections between health and poverty reduction policies and most principally lack of conceptual clarity and inconsistencies in respect to the gender dimensions and implications of existing policy frames. This section examines this disjunctions and inconsistencies.

Despite the longstanding recognition of a poverty-health link in conceptualization, research and policy debates, the case studies suggest that in terms of policy frames and effective implementation what tends to prevail is disconnection and fragmentation.

The Argentinean and Uruguayan case provide a different angle to the same disjunction. In both cases the 2000-2001 crisis created a window of opportunity for sexual and reproductive health agendas. However, even so the conceptualization of poverty reduction strategies runs in parallel of how health policies and in particular sexual and reproductive health policies are being reframed.

Different patterns emerge in Chile and Mexico. In the first case a sustained anti-poverty program that has started in the early 1990’s was converted into an income transfer program in 2000. In parallel a consistent strategy for maternal mortality reduction has been adopted. It is not clear, however, if these two policies were or not organically connected and more importantly, as relevant as maternal mortality may be, a gender sensitive policy is more than that. In the case of Mexico, a similar contradiction is to be found in terms of the broader gender and sexual and reproductive health policies are being reframed.

At least two hypotheses may be raised to explain these disjunctions. The first is that the health and poverty policy arenas are very different in terms of the actor’s involved, privileged conceptual frames, disciplinary traditions. To that the well know problem to make two distinct policy domains – with different traditions and cultures - to positively interact must be added. Not to mention the competition for resources by different policy areas that is intensified under conditions of fiscal stringency. The second hypothesis is that the difficulty of conceptualizing and implementing comprehensive policy frameworks encompassing health – there including gender aspects and sexual and reproductive health – is also related to “focalization” and selectivity policies adopted in recent years.

Gender Equity

Gender equity requires that health resources and services are allocated and received according to the needs of each sex and are paid for according to each individual’s economic ability without reference to differing gender related risk assessments. In most countries of the region the percentage of women...
affiliated to the social security system is much lower than that of men. Policies for gender inequity reduction have to relate to its causes, whatever the nature of the health system.

In regard to the external causes it is necessary:

- to promote productive and stable jobs for women;
- to invest more in their training both at national level and in the corporate sphere;
- to rigorously apply the principle of equal pay for equal work;
- to require that companies of a certain size provide day-nurseries
- to establish a fiscally subsidised low fee public program of day-nurseries.

In regard to inequity causes internal to the health system, the following measures are recommended:

- that social security requirements are extended to cover those types of employment principally engaged in by women, such as domestic service, informal self-employed work, etc.;
- to guarantee that maternity coverage continues during periods of unemployment;
- to allow the reduction of pre-natal maternity leave and the extension of post-natal leave to give mothers more time to take care of their newborn babies;
- in countries where the wife or partner of an insured man only receives maternity coverage and not sickness coverage, the latter should be made available to her in exactly the same form as it is available to the man (and equally, a husband or partner dependent on an insured woman should have the same sickness coverage);
- to provide optional coverage for house workers (“housewives”) as is already done in some countries but providing a fiscal subsidy incentive to low income groups;
- to allocate more health resources to women than to men
- to invest more in prevention and to make the provision of a basic package obligatory in the entire health system (public, social security and private) taking into account the needs of women;
- to prohibit the practice of “skimming off the cream” by gender engaged in by private insurance companies;
- the collective determination of premiums, compensating for higher risk women through transfers from men and from women who have passed the fertile age, for this purpose a compensation fund could be created.

In terms of gender equity policies it is clear that the greatest differences by sex in the use of services occurs during the reproductive years, which is exactly when non solidarity insurance plans discriminate most against women. The data quoted in this article leads to the conclusion that in order to achieve the objective of service access equity a greater understanding of gender needs in the provision of health services is required.
I- INTRODUCTION

The objective of this paper is to examine the connections between health reform processes, gender relationships, reproductive policies and poverty policies in five Latin American countries.

Across Latin America and the Caribbean there have been extensive reforms of the health sector in the last decade. Although conceived as a means to increase equity in the provision of services and to satisfy the health necessities of the population, considerations of gender inequities have been barely taken into consideration.

In the mid 90’s, most of the countries in Latin America and the Caribbean initiated reforms of their health systems and extension of their social security programs as part of the process of State reforms. Policies centered primarily on institutional and financial changes in the health systems. Their central axes have been the privatization, the decentralization and the separation of functions between the provision and the regulation of services.

These policies, although to a great extent standardized by international financial institutions, had quite distinct impacts by sub region and countries. However, a common characteristic across countries is the limited incorporation of a gender perspective to address crucial dimensions such as health determinants, access to services and financing. The present situation reveals that it is not possible to consistently asses the effects of health sector reforms in respect to inequities if the specific necessities and conditions of men and women are not taken into account from the beginning in design, implementation, financing and monitoring of these reforms.

As proposed by Fraser (1997) gender equity cannot be identified through one particular value or norm, for example equality or difference. It is a complex notion that includes the following normative principles (Fraser, 1997):

The anti-poverty principle requires prevention of poverty. Due to gender inequalities poverty acquires particular characteristics for women. Although the principle’s criteria can be met in various ways these are only acceptable if they respect the following principles:

The anti-exploitation principle requires preventing the exploitation of vulnerable people. At least three exploitable dependences to which a woman is more exposed are elaborated: exploitable dependence on one member of the family, exploitable dependence on an employer and exploitable dependence on State officers. Social policy, instead of transferring women from one dependency to another, should simultaneously prevent all three.
The *income-equality principle* requires equality in real per-capita incomes by reducing the income difference between men and women. This principle is crucial because women perform a great deal of unpaid work and many women suffer from “hidden” poverty due to unequal resource distribution within the household. This principle involves the prevention of both unequal payment for equal work by women and men, and under-valuation of a woman’s work and capacities.

The *leisure-time equality principle* requires equality in the division of leisure time. This is very significant as women who do unpaid work suffer to a great extent from a lack of leisure time. It involves measures geared to preventing a double working day being required from women and only a single one from men.

The *equality of respect principle* requires that a woman is acknowledged as a person and that her work is recognized. It excludes provisions that regard women as objects and undervalue them, and is incompatible with welfare programs that trivialize or ignore their contribution to social well being.

The *anti-marginalization principle* requires promoting a full and equal participation by women alongside men in all spheres of society and the generation of the necessary conditions for such participation. This necessitates, amongst other things, the provision of day nurseries, care for the elderly, and the dismantling of male chauvinist work culture and political arenas that are hostile to women.

The *anti-androcentrism principle* requires reconstructing andocentric institutions so that women are not required to behave like men, or adapt to institutions designed for men, in order to enjoy similar levels of well being. This implies change in attitude and behavior in both men and women.

All these principles must be simultaneously and consistently taken into account for gender equity to be achieved. As debates around the notion of equity are very extensive at the moment, it is important to approach this concept methodologically and conceptually with the recognition of three dimensions that must be taken into account when speaking of gender equity: equiphony, equipotency, and equivalence.

*Equiphony* is the possibility of speaking up or having a voice – not only to make use of one’s voice, but also to be assured that one’s word has as much value and impact as that of other social actors. It means not only access to the use of words, but also the recognition and valuing of the words one speaks.

*Equipotency* is equality in access to and exercise of power. This is a point that often generates conflict as it implies the contestation of existing orders and gender power differentials.

Finally, *equivalence* means that the activities performed by men and women have equal value and must be equally recognized both in social and economic terms. One domain that cannot be ignored is the sphere of social reproduction and its intrinsic relation to the sphere of production. Equality of labor refers as much to the economic value of activities performed by women in the workplace as in the reproductive realm (households). It implies the recognition of two interconnected dimensions of labor: work that is financially compensated and work that is not compensated.

Bearing this definition in mind, advocating for gender equity in health implies more than demanding that men and women receive equal share of resources and services. It means advocating for resources to be assigned and distributed according to the particular needs of each sex and taking into consideration the specificity of social and economic contexts (Gomez, 2001).
II. GENDER INEQUITY IN HEALTH: SOME CRITICAL ASPECTS

In addition to consistently articulating aspects relating to the sexual division of labor and gender power differentials, gender analysis in health also requires the analysis of sex disaggregated epidemiological data as well as the assessment of the characteristics of existing health system in terms of accessibility, finance and management, which implies:

- The opportunity to be in good health and not become ill or disabled, or die, due to preventable causes;
- Access to health care according to need;
- Financing of services according to payment capacity;
- Division of responsibilities and power in the provision of health services and care.

With regard to the health status of a specific population the objective of gender equity is that no remediable differences should exist between men and women in their opportunities for good health, and that all gender based injustices affecting how they become ill, disabled or die should be eliminated. For example, statistics show that living in conditions of poverty has a greater impact on women than men in terms of life expectancy and state of health. This is observed, for instance, in the differentials in life expectancy between high and low income groups. In the high-income groups women’s life expectancy surpasses men’s by several years, while in lower income groups this differential is significantly lower.

C. Gender equity in access to health services

Gender equity in access to health services requires that:

- Health care resources are allocated according to the differential needs of women and men;
- Members of each sex receive services corresponding to their differing needs;
- Services are paid for according to the economic capacity of each person and not according to differential needs or health risk assessments based on sex differentials.

The central aspect of health care that must be analyzed from a gender perspective is the impact of the sexual division of labor and of gender power imbalances on the ability of women and men to access resources for direct payment for services or to contribute to public or private insurance plans. Extensive evidence shows that women utilize more health services than men. However, greater use does not necessarily constitute an expression of social privilege. The differences observed in the use of health services by men and women reflect distinct socialization patterns affecting symptom recognition, illness perception and behavior in seeking medical attention as well as structural and institutional factors that may facilitate or hinder access to health services.

Women have a greater objective need for health services than men. In addition to problems that women have in common with men, female reproductive functions generate specific health care needs related to contraception, pregnancy, birth and post-natal care. Also, when compared to men, women present higher sickness and disability rates throughout their lives and, due to their greater longevity, they have a greater probability of suffering chronic illnesses associated with age.
Studies developed across cultures, geographical regions and socio-economic strata reveal that women, much more than men are able to recognize their health impairments and needs. Though this greater awareness may reflect objective epidemiological realities, it is also linked to culturally constructed gender experiences and perceptions that impinge on the ability of persons to identify illness as well as the freedom to or inhibition to express it.

The distinct socialization of women and men, therefore, influences their attitudes and behavior in seeking health care. For instance, women’s predominant role as health “care takers” improves their ability to detect symptoms of disease and become better acquainted with formal and informal processes of health care. Whereas men, as some studies have suggested, tend to view illness and the seeking of health care as an expression of weakness that contradict the dominant model and image of male strength, courage, self-sufficiency and control. However, the contribution of these acquired factors to behavior in seeking care is extremely difficult to measure.

Even more important, is acknowledgement that most studies, which have addressed gender differentials in access to and use of health care, have not devoted attention to the structure and functioning of a health system as another key factor that could explain these variations. When this perspective is further developed and adopted, gender based differentials in regard to access and use of health services appear also to be related to gender biases in health care provision and finance systems that tend to favor one sex or the other. For instance, the medicalization of biological processes, and financial subsidies for certain types of services (contraception, for example) explain why health systems may be more accessed and used by women than by men.

Gender has not yet been integrated into the analysis of health services and up to now has been limited to a consideration of needs associated with the biological differences of each sex. Very little consideration has been given to the relationship between sex and variables not related to biological needs, which also have the potential for producing inequities in health such as: health service models, health insurance coverage and modalities, income levels, degrees of autonomy in decision-making and family responsibilities.

Few studies have concluded, for instance, that health reforms privatizing services, or that have introduced non-solidarity payment systems, have worsened pre-existing gender inequities: women need more services than men but have to pay more because their risk assessment is greater and this problem is aggravated by the lesser economic capacity of women; in some cases private insurance companies limit expenditures by avoiding providing insurance for women. In addition the burden of responsibility for bringing up children falls even more on women than before as an increasing proportion of them lack a partner with whom to share it (30% of households in the region are headed by a woman).

D. Gender equity in health service management and finance

In order to achieve gender equity in the financing of health care it is necessary to promote a system to which both women and men contribute according to their economic capacity and not according to their need or risk assessment, as happens with private systems. And, above all, it is important that the social costs of reproduction do not fall only on women, or on women and their

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partners, but rather that they are borne by the social group as a whole through the creation of solidarity system or networks.

In respect to the management of health systems and services, gender equity involves not only the issue of equal pay but also the egalitarian distribution of responsibilities between women and men, the acknowledgement and accounting of the economic contribution to health promotion and care made by women’s unpaid work, the recognition of the under-representation of women in local and national power structures, and a just division of the real costs of health service provision between family, community, state and market.

Women suffer greater effects when public services are reduced as the burden of work then tends to be transferred onto them. In order to address these distortions, measures must be adopted which eliminate avoidable differences between men and women in their state of health. In addition, financial resources for health must be allocated according to need and the payment systems must be based on people’s economic capacity. Policies must also address the unequal division of responsibilities and power. Lastly, consideration should also be given to designing mechanisms that will respond to crises, which will arise in health service systems when they are no longer able to respond to an increased incidence of chronic disease as the population ages. As a consequence of changes in gender roles, many women will no longer be exclusively at home to provide the necessary care to others and this will affect the sustainability of health care. Alternatively, they will continue to take on these tasks but at a significant cost to their physical and mental health (Durán, 1999).

III. LATIN AMERICA: SOME BASIC INDICATORS

A number of studies performed in the region indicate that, in comparison to men, women experience a wide range of labor and social security disadvantages:

- More than 50% of them are not part of the paid labor force;
- They have a higher unemployment rate than men;
- A majority of them work in low paid jobs or they receive less pay for the same work (average female income is 70% of average male income) and consequently have less ability to pay private health insurance premiums or other health service related costs and so have access to lower quality plans than men.
- As heads of households they suffer a greater incidence of poverty, and complications during pregnancy, birth and the postnatal period are more frequent in groups that live in conditions of poverty and suffer from malnutrition;
- They are over-represented in jobs that do not provide social security coverage, such as informal or domestic work;
- Direct access to health insurance is affected by the discontinuity caused by pregnancy and child rearing, which often forces women to leave their job and thus lose their sickness and maternity insurance coverage;
- Frequently women have indirect coverage when they are a dependent of a man who has insurance, however they can lose this in the event of widowhood, abandonment or separation.

OPS-UNFPA-UNIFEM (2005), CEPAL (2005)
Available information on health determinants in Latin America and the Caribbean also shows disparities between men and women in terms of social and political participation and in their access to housing, education, information, income, social protection, food, basic sewerage services and drinking water. Disparities are also apparent in other aspects, such as available leisure time, risk of sexual and domestic violence and participation in domestic and community work. All these factors manifest differently according to sex and therefore determine different living conditions, health risks and degrees of access to resources and services for women and men. Unacknowledged and unshared labor in the home constitutes an additional burden for women and exposes them to specific work risks. Also, gender based violence has been recognized as major infringement of human rights and a serious public health problem across the region.

Information as shown in the Table 1, indicates that, in most countries health expenditures are higher than 8 percent of GDP (which can not be considered exactly low). In fact, in two of them (Nicaragua and Uruguay) these investments surpass 10 percent. Also, with a few exceptions (Guatemala, Peru, Ecuador and Mexico) public investment in health can be considered minimal (less the 3 percent of GDP) and in a number of countries – including Bolivia and Nicaragua - public expenditures are higher than private. This suggests that inequities in health cannot be solely attributed to lack of financial resources or to privatization.

Table 1: National Health Expenditure as a percentage of GDP (2005)

<table>
<thead>
<tr>
<th>Country</th>
<th>Public Expenditure</th>
<th>Private Expenditures</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>4.7</td>
<td>3.7</td>
<td>8.4</td>
</tr>
<tr>
<td>Bolivia</td>
<td>5.8</td>
<td>2.9</td>
<td>8.7</td>
</tr>
<tr>
<td>Brazil</td>
<td>3.2</td>
<td>5.3</td>
<td>8.5</td>
</tr>
<tr>
<td>Chile</td>
<td>4.4</td>
<td>3.9</td>
<td>8.3</td>
</tr>
<tr>
<td>Colombia</td>
<td>5.3</td>
<td>2.6</td>
<td>7.9</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>5.2</td>
<td>3.4</td>
<td>8.6</td>
</tr>
<tr>
<td>Ecuador</td>
<td>2.2</td>
<td>2.4</td>
<td>4.6</td>
</tr>
<tr>
<td>El Salvador</td>
<td>3.5</td>
<td>4.7</td>
<td>8.3</td>
</tr>
<tr>
<td>Guatemala</td>
<td>1.8</td>
<td>4.7</td>
<td>6.5</td>
</tr>
<tr>
<td>Honduras</td>
<td>3.1</td>
<td>2.5</td>
<td>5.6</td>
</tr>
<tr>
<td>Mexico</td>
<td>2.7</td>
<td>3.3</td>
<td>6.0</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>6.8</td>
<td>4.7</td>
<td>11.5</td>
</tr>
<tr>
<td>Panama</td>
<td>4.4</td>
<td>2.2</td>
<td>6.6</td>
</tr>
<tr>
<td>Paraguay</td>
<td>3.5</td>
<td>4.9</td>
<td>8.4</td>
</tr>
<tr>
<td>Peru</td>
<td>2.8</td>
<td>2.1</td>
<td>4.9</td>
</tr>
<tr>
<td>Uruguay</td>
<td>4.7</td>
<td>5.6</td>
<td>10.3</td>
</tr>
<tr>
<td>Venezuela</td>
<td>4.1</td>
<td>2.7</td>
<td>6.8</td>
</tr>
</tbody>
</table>


Specifically in regard to reproductive health the Social Watch 2006 Report estimates that the ICPD goal of reproductive health to all that was reaffirmed in the MDG framework, will be achieved in the region by 2065.

Graphic 1: When MDG Goals will be achieved

When specific reproductive and sexual health related data is examined (Table 2 and Table 3), significant disparities across countries can be identified, and most importantly, some basic indicators demonstrate that much yet remains to be done to ensure higher health standards for Latin American women.

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8 See www.socialwatch.org
Table 2: Women’s Health and Reproductive Health: Selected Indicators

<table>
<thead>
<tr>
<th>Country</th>
<th>Overall fertility rate (children per woman)</th>
<th>Percentage of women who gave birth by age group</th>
<th>Percentage of births that took place less than 24 months after the previous birth 1996/2003</th>
<th>Percentage of births that are the fourth child or over 1996/2003</th>
<th>Estimated mortality rate (per 100,000 women)</th>
<th>Incidence of anaemia (percentage of women)</th>
<th>Reported maternal mortality ratio (per 100,000 live births) 1997/2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>2.4</td>
<td>6 2</td>
<td>-</td>
<td>14 30</td>
<td>24 18</td>
<td>46.1</td>
<td></td>
</tr>
<tr>
<td>Bolivia</td>
<td>3.6</td>
<td>8 6</td>
<td>28 39</td>
<td>-</td>
<td>-</td>
<td>28 20</td>
<td>230.0</td>
</tr>
<tr>
<td>Brazil</td>
<td>2.2</td>
<td>7 2</td>
<td>29 22</td>
<td>11 13</td>
<td>42 20</td>
<td>45.8</td>
<td></td>
</tr>
<tr>
<td>Chile</td>
<td>2.3</td>
<td>4 2</td>
<td>-</td>
<td>13 15</td>
<td>20 8</td>
<td>16.7</td>
<td></td>
</tr>
<tr>
<td>Colombia</td>
<td>2.6</td>
<td>8 3</td>
<td>27 18</td>
<td>15 10</td>
<td>40 23</td>
<td>98.6</td>
<td></td>
</tr>
<tr>
<td>Costa Rica</td>
<td>2.2</td>
<td>8 2</td>
<td>-</td>
<td>10 11</td>
<td>28 19</td>
<td>32.9</td>
<td></td>
</tr>
<tr>
<td>Cuba</td>
<td>1.6</td>
<td>6 1</td>
<td>-</td>
<td>18 21</td>
<td>57 35</td>
<td>39.5</td>
<td></td>
</tr>
<tr>
<td>Ecuador</td>
<td>2.7</td>
<td>7 4</td>
<td>-</td>
<td>16 7</td>
<td>40 20</td>
<td>81.1</td>
<td></td>
</tr>
<tr>
<td>El Salvador</td>
<td>2.8</td>
<td>9 3</td>
<td>-</td>
<td>20 4</td>
<td>40 20</td>
<td>120.0</td>
<td></td>
</tr>
<tr>
<td>Guatemala</td>
<td>4.2</td>
<td>11 6</td>
<td>32 43</td>
<td>9 2</td>
<td>39 35</td>
<td>153.0</td>
<td></td>
</tr>
<tr>
<td>Honduras</td>
<td>3.5</td>
<td>10 5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>32 26</td>
<td>108.0</td>
</tr>
<tr>
<td>Mexico</td>
<td>2.4</td>
<td>6 3</td>
<td>-</td>
<td>11 8</td>
<td>26 14</td>
<td>63.9</td>
<td></td>
</tr>
<tr>
<td>Nicaragua</td>
<td>3.6</td>
<td>14 4</td>
<td>26 33</td>
<td>18 7</td>
<td>40 34</td>
<td>95.6</td>
<td></td>
</tr>
<tr>
<td>Panama</td>
<td>2.7</td>
<td>9 2</td>
<td>-</td>
<td>13 11</td>
<td>39 29</td>
<td>71.3</td>
<td></td>
</tr>
<tr>
<td>Paraguay</td>
<td>3.7</td>
<td>7 5</td>
<td>38 41</td>
<td>22 11</td>
<td>35 20</td>
<td>182.1</td>
<td></td>
</tr>
<tr>
<td>Peru</td>
<td>2.8</td>
<td>5 4</td>
<td>20 31</td>
<td>20 11</td>
<td>39 36</td>
<td>185.0</td>
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</tr>
<tr>
<td>Uruguay</td>
<td>2.3</td>
<td>7 2</td>
<td>-</td>
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a: the ratio is not calculated if the relative standard error is more than 23%. In Uruguay the absolute number is 18

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<tr>
<th>Country</th>
<th>Registration of AIDS cases, annual incidence (per 1,000,000) 1999/2002</th>
<th>HIV/AIDS incidence (%) in age group 15 to 49 2003</th>
<th>Percentage of HIV/AIDS infected 15 to 49 year-olds that are women 2003</th>
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IV. HEALTH SECTOR REFORM

Contemporary Health Sector Reform Trends

The main aim of health sector reforms as designed and proposed in the late 1970’s by international financial institutions, in particular the World Bank, was to ensure the reduction of fiscal deficits in order to control inflation and supposedly improve national savings. This implied a drastic reduction in public funding for health, and “privatization” in a variety of forms: adoption of user’s fees in public health services, expansion in the number of private providers or pre-paid health insurance schemes. (Standing, 2000). Though these conceptual foundations are still alive and active, it is important to acknowledge that the health reform guidelines have changed since the 1970’s. By the mid 1980’s the detrimental effects of the stringent reduction of public investment in health and education, as well as of privatization, were already evident. From then on a series of systematic critiques of the poor health and education outcomes of structural adjustment programs (SAPs) were developed, publicized and used to pressure the World Bank and IMF. These pressures had an impact, albeit minor, on the global health reform agenda. In 1993, the World Bank launched the report “Investing in Health”.

After almost fifteen years of implementing the SAP health model, the World Bank recognized that the outcomes were not positive and that public investments would be required to improve critical health indicators – such as infant and child mortality, HIV-AIDS and other epidemics – in the developing world and transition economies. This “breakthrough” led to a new global policy agenda that became known as the “reformed health reform”. This did not, however, mean a revival of the publicly funded universal models of the 1950’s and 1960’s. Instead, under the new guidelines, priority in public funding was to be given to the basic needs of the poor – the so-called basic packages – while higher income groups would still pay for their health costs. Greater visibility and priority was given to decentralization strategies and the report also valued participation and the existence of social accountability mechanisms as novel strategies to improve access to and the quality of health systems.

The report also launched a new framework to guide the definition of priorities for health interventions and investments: the Disease Attributed Lost Years (DALY), which fundamentally measures the impact of disease burdens on the productivity of individuals. Though the adoption DALYs can be said to have rationalized parameters for priority setting in health, its economically driven nature created inevitable biases. For instance in terms of the S&R health agenda its impact was clearly contradictory. On the one hand, DALY calculations demonstrated that priority should be given to neonatal and infant mortality – which implies increasing investments in pre-natal care and obstetric interventions and led to high prioritization of HIV-AIDS prevention and (later on) treatment. However, the DALY framework did not favor greater investments in other critical issues, such as maternal mortality, access to contraception, abortion or gender-based violence.

In the late 1990’s, as new proposals for debt relief gained legitimacy, a second wave of policy guidelines were designed that are key to understanding the logic of health investment in Southern countries, particularly those that are highly dependent on foreign aid. The so-called Sector Wide Approaches (SWAPs) were adopted as part of the Highly Indebted Poor Countries Initiatives (HIPC) and, later on, of Poverty Reduction Strategies Programs (PRSP). Through SWAPs the basic elements of the “reformed health reform”: managerial changes, decentralization strategies, basic packages for low income groups, new rules governing priority setting and community participation, all became part of the overall negotiations around the conversion of debt payments into health investments.
Another way to look into this trajectory is to examine the main goals of reforms as stated in the documents adopted by international institutions and governments, which have changed substantially. While the “first generation” of reforms was overwhelmingly supply side driven and mainly focused on the health sector per se, the “second generation” has shifted more to meet the demand for services, even when this would imply the adoption of fees. Concurrently the language has broadened towards anti-poverty interventions and intersectoral approaches to health. This re-orientation was partly due to a tacit acknowledgement of the relative failure of reforms in a number of countries to deliver any obvious improvements on the demand side. However, as time elapsed, the widening gaps between rich and poor in terms of health status and access to health care also started to raise serious questions about the content and direction of reforms (Standing, 2000).

The Latin American Experience

In Latin American countries, health reform processes were a key component of broader state reform agendas and in particular of social security and pension systems. In seven countries (Argentina, Bolivia, Colombia, Chile, El Salvador, Peru, Dominican Republic) health reforms followed the structural reform of pensions, as both programs are connected within the social security system. In four countries health reform preceded pension reform (Brazil, Costa Rica, Mexico, Nicaragua) and in four other countries (Guatemala, Honduras, Panama, Paraguay) health reforms have been undertaken but not pension reforms, at least not structural ones. In Uruguay pension reform has been underway for some time, but the health system was not structurally altered (Mesa Lago, 2005).

Until the 1980’s reforms, in practically all countries of the region, health systems were based on a tripartite model, in which the public, social security and private subsystems played different roles, operated on the basis of distinct types of finance and provision, and covered different sectors of the population. The formal work force was covered by the social security financed health system, those without access to the formal labor market had their health needs addressed by the “public health system” managed by Ministries of Health, and higher income groups were covered by private schemes. Though variations can be observed, most reforms adopted since the 1980’s have been guided by the following objectives:

(j) The de-monopolization of service provision by the public and social security subsystems through the use of multiple insurance and/or service provision companies, where the private subsystem plays a crucial role and hospitals have greater independence and self-management;

(k) The separation of the functions of governance/regulation, insurance and management, and finance and service provision;

(l) The introduction of free choice of provider for insured parties or users;

(m) Widening of coverage, extension of primary care through a basic package of services and improvement of service quality;

Since the 1980’s social security systems in the region have been criticized for not providing coverage for a significant part of the population, while channeling fiscal subsidies to insured middle-income sectors. Another aspect constantly raised by the critiques of public funded social security systems is the absence of intergenerational solidarity resulting from the gains in life expectancy, which also imply progressive increase in health costs that become a burden for younger generations.
Decentralization of health managements and service provision and, to a lesser extent, of
financing.

Promotion of health equity through the reallocation of resources in order to reduce the gap
between regions and municipalities, along with the use of fiscal subsidies to fund focused
interventions among low income groups;

Increased efficiency, autonomy and accountability of the health system, especially of
hospitals;

Re-shaping of traditional financing models from a fixed budget to reimbursements for the
provision of services and from supply subsidies to demand subsidies;

Reduction of public expenditure and strategies aimed at cost recovering through co-
payments and regular payments for usage rights.

Promotion of civil society participation in policy monitoring and design.

In general, health reforms have not created uniform conditions to ensure access to care nor have they
consistently standardized services. In fact, with a few exceptions, the three subsystems (public,
social security and private) continue to provide medical services of varying quality. In addition, the
great majority of reforms have maintained separate programs with more and better quality services
for powerful groups. Gender inequity and discrimination in access and service provision were not
addressed by the reforms, nor taken into account in the adjustment pattern for models adopted
between 1980 and 1990.

More specifically in regard to gender, women usually pay more than men for their health needs and
face enormous disadvantages as players in the formal and informal health service system. Gender
based discrimination sharply contrasts with women’s role as health providers. Abundant evidence is
available in the region to indicate that women are the main managers of family health for all age
groups: children, adolescents, adults and senior citizens. Women represent 80 percent of the paid
labor force in health services (but with little presence in decision-making positions) and perform 90
percent of voluntary community health work, in addition to being the principal protectors of their
family’s health in the home, where 80 percent of opportune detection and primary health care take
place. This means that several matters remain pending in relation to the gender dimensions of the
health reform agenda.

REFORM CHARACTERISTICS IN THE FIVE COUNTRIES STUDIED

ARGENTINA

Characteristics of the Argentinean Health System Source

In Argentina the public health system is made up of three sub-systems: a) the public network
managed by the Ministry of Health; b) the social security network comprising the Obras Sociales – a
system of health care provision established in the early 20th century by immigrant workers’
associations and later incorporated into the pre-World War II social security reform of the 1930’s; c)
the private sector providing services both through user fees and health insurance schemes. In general
terms, until the neo-liberal reforms of the 1990s the Argentinean system was modeled on the welfare
social security system widely adopted in Latin America during the political transformations of the
1930’s. The three sub-systems still co-exist today and great differences can be observed among them
in terms of the type and quality of benefits and services. The effects of the privatizing model adopted
during the 1990s are clearly reflected in the figures relating to health spending. In 2000, public investment was 2.4 per cent of GDP while private expenditure accounted for 6.1 per cent of GDP. Since then, however, as shown in Table 1, the level of public investments have substantially increased, reflecting new directions adopted by the Argentinean governments after the economic and political crisis of 2001-2002. 10

The 1990’s Reform Process

The HSR was part of a broader State reform process, implemented in the 1990’s, by the Menem administration. Proponents of the health reform stated as their main objective a correction of the distortions present in the previous “welfare model”. Their argument was that, under the guise of universality, the model had a “unionist” bias, rather than an equitable structure. While guaranteeing access to health services for the formal labor force, it excluded those sectors of the population active in the informal labor market. Although the distortion was real and needed to be addressed, under the prevailing political conditions the argument mainly served to fuel proposals designed to reduce public expenditure. In the public debate the reform agenda appeared to have mainly technical goals: a) to modify the financial logic of the system; b) to improve knowledge of factors explaining increasing health costs; c) to resolve management inefficiencies and promote technological innovation and better respond to complaints by users regarding quality of care.

As was the case with the broader state reform, the HSR was heavily influenced by the market-oriented paradigm that prevailed in the 1990’s. The main logic of the reform followed World Bank guidelines emphasizing on the one hand, “basic health packages”, and the expansion of paid services on the other. It is worth mentioning that the model adopted retained the regulatory functions and control by the state over: a) employer and employee compulsory contributions; b) establishing a solidarity principle to help cover the health needs of low income groups; c) monitoring the fulfillment of norms governing the financial sustainability of private pre-paid health insurance companies.

The most relevant outcomes of the model adopted in the 1990s were the deregulation of the Obras Sociales that constituted the historical foundation of the public health network. The new model allowed for persons to choose what institutional provider (what Obra Social) he or she wanted to contribute to. Deregulation also implied privatization of access to more complex levels of care and the creation of a basic package of care (Paquete Médico Obligatório) that all institutions must provide. Belamartinò’s (2005) analysis of the deregulation process call attention to the fact that “the implementation of “free choice” was delayed and when finally it happened it was not accompanied by sufficient information that would allow persons to make a conscious option for in respect to potential benefits and risks implied in their choice”. Deregulation also has not obliged the providers (Obras Sociales) to introduce systems of follow-up and evaluation. As a result providers did not establish proper standards for service use as defined by the contracts established between the health insurance schemes and clients. It should also be said that no procedure was defined to systematically assess costs or user satisfaction. The other relevant feature of the Argentinean Health reform is that decentralization of the public health system that covers the general population was quite radical. As of 2005 roughly 60 percent of public health funding is under the responsibility of provincial governments, which implies that the design and implementation of key programs, such as sexual and reproductive health, is defined at these levels (Macieira, el al, 2006).

10 Domínguez et al (2005)
BRAZIL

HSR Background, Contemporary Processes and Outcomes

In the 1970’s, key disparities in access to health care were observed between those sectors of the population active in the formal labor market, covered by social security, and with access to relatively good health care, and those who were not in the formal market and accessed services provided by the Ministry of Health. In addition, at that point in time, the social security health network expanded by contracting private providers who preferred to invest in hospitals, resulting in a hospital-based system with less investment in prevention and primary care.

By the end of the decade public health care professionals, academics and broad-based social movements began mobilizing around an agenda that called for a total reform of the health system. This movement was fuelled by democratization and culminated in health reform principles enshrined in the constitutional reform of 1988, which defined health as a right and set out the Unified Health System (SUS) as a universal, integral and decentralized public health system, with built-in public accountability mechanisms at national, state and local levels. The implementation of these definitions was hampered by political and institutional instability that prevailed between 1989 and 1992. During the 1990’s, however, the SUS was gradually and consistently developed. The National Health Law was approved in 1991, and from 1993 on a complex management system involving commissions at federal, state and municipal levels (the Tripartite and Bi-partite Management Commissions) was established. In 1996 and 2001 operational and financial norms guiding SUS decentralization and other aspects of implementation were adopted (Normas Operacionais Básicas, NOBs).

Decentralization expanded and consolidated using a model that allowed for municipalities that established a health fund and functional health councils to directly manage all health units (secondary and tertiary levels) and not merely primary health care and prevention programs. From 1994 on, a well-defined and better-financed primary health strategy was also designed, starting with the Community Health Agents Program (Programa de Agentes Comunitários de Saúde, PACS) and then moving towards the Family Health Program (Programa de Saúde da Família- PSF). On the surface the PSF has similarities to basic packages implemented elsewhere in the region as it prioritizes poorest areas, provides basic health care and selects cases to be referred to higher levels of complexity. But it should be remembered that the PSF is part of the universal and free-of-charge health system, which does not exist in most countries.

Despite this institutional development, until 1996 the system remained financially unsustainable. To resolve this bottleneck, in 1996, under pressure from the MoH and the public health movement, a new source of health funding was created – the Financial Transactions Tax (CMPF), which charges 0.20 per cent on all bank transactions. The law stated that all funds raised through this tax should be invested in the SUS. In 1998 during the currency devaluation crisis the percentage was increased to 0.38 per cent, of which 0.20 was retained to fund the SUS while the remaining 0.18 was earmarked to compensate for the deficit in the social security budget. In 1996 a Basic Health Care Financial Ceiling (Piso de Assistência Básica - PAB), was created that allows for the transfer of a certain amount per capita (10 R$ in 1996; 15 R$ in 2006) to Municipal Health Departments. In 2001 a new

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11 The content of this section is fundamentally based in Corrêa, Piola and Arilha, 1999
set of financial incentives was developed to encourage the expansion of the PSF, basic drug delivery and certain specific interventions, including pre-natal and obstetric care, contraceptive assistance and cervical cancer screening.

Though the CPMF provided the SUS with an unprecedented degree of financial sustainability, problems remained. One of them is that constitutionally defined social security funds, which include health funds, are constantly diverted to ensure fiscal surplus. Another persistent problem is the imbalance between federal investments (roughly 65 per cent) and funds allocated to health by states and municipalities. In 1999, a new constitutional provision was adopted (PEC 20 – 1999), establishing that 20.6 per cent of the funding was to be provided by state governments and 16.4 per cent by municipalities. It also determined that the annual increase in the health budget would be determined by increases in GDP. The private sector, which provides care to roughly 30 percent of the population through a variety of health insurance schemes, remained entirely de-regulated until 1998, when a new regulatory agency – the National Supplementary Health Regulatory Agency – was established to supervise the financial performance of the private sub-sector and ensure that it also follows the SUS technical guidelines.

Since the early 2000’s no substantial change in terms of management and financing structures has been registered. But it worth noting that decentralization became a reality and PSF has effectively expanded. While in 1998, the program was being implemented in 3,166 municipalities covering 10 million persons (6.6% of the population), in 2006; it was present in 5,106 municipalities providing care to roughly 85 million persons (46% of the population).

Outcomes

The Brazilian HSR process offers a sharp contrast with what has, by and large, prevailed in other Latin American countries in that it does not conform to the market-oriented and efficiency-driven basic package model. Brazil is one of the few countries in the region where the right to health has been defined as constitutional right. It is the only country in which the universal and public funded nature of the health system is also constitutionally defined. At least three main positive impacts of 1980’s reform can easily identified: the overcoming of the fragmentation between social security and MoH outlets; the expansion of the health network and of access to health; and the gradual (though very slow) correction of the hospital-based model. This is reflected in the positive evolution of some health indicators over the last decade, including a steady reduction in infant mortality rates and HIV-AIDS-related mortality.

Even the World Bank – which has often criticized the SUS principles of universality and full reliance on public funding – recognizes its merits. A group of World Bank researchers examined data on access to health care in more than 4,000 Brazilian municipalities in relation to the quality of governance and voter preferences. One of their findings indicate that in many municipalities where levels of social-economic inequality was higher people had better access to health care: “Holding per capita income constant, municipalities with a less equal distribution of income — suggesting a greater proportion of persons relying on SUS — are likely to have more SUS clinic rooms, and especially more doctors and nurses. A one standard deviation change in the Gini coefficient increases SUS doctors by about 4% (model 4) and nurses by about 5%.”

But despite these positive outcomes, many problems remain in term of access to services and most principally quality of care. This is clearly related to the scale and decentralization of the system. SUS is a gigantic machinery delivering services to millions of people across an extremely diverse and unequal country. Decentralization has helped to reduce the gaps between managers, providers and users and favored transparency and accountability because it allows users to pressure providers and
managers, as well as to access and monitor the budgetary processes at local levels. Still, great unevenness can be identified at local levels in terms of technical capabilities, human resources. In addition, ideologies informing the conduct of health managers and providers at local levels are often in contradiction with federal norms and this inconsistency is particularly problematic in the case of sexual and reproductive health policies. Consequently, federal rules and incentives do not always ensure access to or quality of services. Not infrequently an excellent national policy translates poorly at local levels, either because human and financial resources are scarce (particularly in the smaller municipalities) or simply because it is not prioritized by local managers. Local health systems are also more prone to clientelistic biases.

In addition, tensions have not been resolved in respect to the partition of financial responsibilities between the various levels, as until today a large number of states and municipalities are not yet fulfilling the responsibilities defined by PEC 20-1999. Moreover, hospital expenditures, especially in the case of complex and sophisticated procedures (like heart surgery, kidney dialysis, transplants etc.) tend to consume the bulk of resources and have become the target of powerful lobbies operating at both Executive and Legislative levels. The competition for SUS resources by private providers and suppliers of equipment and drugs is prone to corruption and bribery at all levels of the system. Last but not least, the co-existence of the SUS and a powerful private system of health insurance and care is also a source of tension and contradictions. Bahia (2006) in analysis, asks if the SUS is in fact a universal health system, or rather a health system for the poor. 30 percent of the population is covered by the private sector, which systematically promotes sophisticated technologies and hospital based care. Whenever a new SUS “crisis” becomes visible, more room opens up for the private sector to expand its reach. This results in a permanent tension between privatizing forces that use marketing strategies to sell “quality of care and quicker access to health technologies” and the SUS’s fundamental principles of universality, public funding and maintenance of health as a right.

CHILE

Characteristics of the health sector in Chile

Health reform in Chile began in 1980 as part of a general social security reform at the worst period of the military dictatorship and took place in a context of drastic public expenditure reduction, a diminished public sector presence and increased privatization. Health service reform was based on two key elements. The first was the decentralization of public resource administration to regional services and the decentralization of primary health care, which was completed by 1988. The second element was the new definitions of the 1980 Constitution that opened the possibility for people to either pay the compulsory premium to the old state insurance system or, instead, to start paying contributions to the various Social Security Health Institutions (Instituciones de Salud Previsional, ISAPRES) that were emerging at that time. The public system operates through a social health insurance scheme administrated by the National Health Fund (Fondo Nacional de Salud, FONASA). FONASA is an equal distribution scheme, which provides the same benefits for all. It is financed by a single premium equivalent to 7% of the insured’s taxable income and by general fiscal resources of the nation.

The private health system is comprised of health insurance companies (ISAPRES) and private health providers. ISAPRES operate as health insurance systems based on individual contracts made with insured parties in which benefits provided directly correspond to the size of the premium paid.
ISAPRES cover higher middle income and high-income groups through contributions and copayments. The reform did not achieve population coverage goals. ISAPRES function as independent private insurance companies run on the principle that the more that is paid is the more received. At the end of 1994, 26 percent of the population was members of an ISAPRE. Private health services are provided by clinics, hospitals and independent professionals to ISAPREs’ users, but also to those who contribute to the public system (FONASA). These operations are framed by a “free choice” modality of access to services (Tajer, 2006).

Active and retired workers are obliged to contribute 7 percent of their taxable income to the health system. This payment can be made to FONASA, in which case the person is a beneficiary of the public system or can be made to an ISAPRE, making the individual part of the private health system. Affiliation to an ISAPRE involves payment of a premium determined by that ISAPRE, the premium being dependent on the type of insurance purchased. To obtain more benefits the worker can pay additional premiums over and above the 7 percent. The destitute and those who do not pay contributions are covered by FONASA but are subject to special conditions.

The majority of the population is covered either by the public subsystem (FONASA) or the private subsystems (ISAPRES) Other sectors, however, are covered by other providers, as is the case of the armed forces, the University of Chile, private insurance schemes (that are distinct from ISAPRES) and direct pay per use services. A 2000 study (CASEN Survey quoted by Tajer 2006) indicates that 66.5 percent of the population was in FONASA, 19.8% in ISAPRES, 9.7% were attended privately and the remaining 4% were split between Armed Forces systems, other systems and ‘don’t knows’ (Tajer, 2006).

Coverage by FONASA is automatic for the groups not affiliated to an ISAPRE: employees who pay contributions; self-employed workers who contribute to a system of pensions (private or public); dependent relatives of a contributor (partner, children or others who are a legal responsibility); the unemployed who receive unemployment subsidies; pensioners in both contributory and social assistance regimes; pregnant women who do not have coverage; people with mental disabilities and those with no resources (the destitute). The latter receive services free of charge while low-income affiliates can receive an income-based fiscal subsidy. Higher income affiliates have to pay the full contribution but for primary care can chose between public (institutional) services or private co-payment services.

**Outcomes**

Under the impact of the reform the Chilean health sector became a mixed system, with public and private sector participation in insurance, finance and health service provision. The Health Ministry runs the public health system and is responsible for designing policies and programs, coordinating public health entities and supervising, evaluating and monitoring health policy implementation. The National Health Services System (Sistema Nacional de Servicios de Salud, SNSS) is the main structure of the public health system. Each cluster of the Health Services is responsible for the operation of several hospitals with differing levels of complexity as well as outpatient healthcare centers. They can enter into contracts with private providers to serve certain zones or for specific types of service. Primary health care is provided by Primary Care Centers (administrated by municipalities) that offer basic services through an open health care modality and engage in health promotion and disease prevention activities.

When the dictatorship ended in 1990, the new democratic government had three main challenges to address: the low level of financing for public hospitals affecting the quality of service; serious
financial difficulties faced by municipalities and health services to sustain decentralized primary care; the regulation of relationships between the public subsystem and ISAPRES and between ISAPRES and their clients. In 1990, a new law created the ISAPRES Superintendence to: monitor their operations, establish provisions relating to the functioning of the sector, and ensure the fulfillment of these regulations. But, with democracy, concerns were raised about the level of public funding to health. Between 1991 and 1992 the new government projected an increase of the health budget by 50 percent over the next four years using national funds and international loans and sent two laws to Congress, one to reorganize the primary care finance system and the other to regulate ISAPRES. In 1995, although private insurance system was reformed, not all distortions and problems were addressed. However in 2004, a new law established a basic package of services and in 2005 a compensation fund aimed at reducing age and gender discrimination was also legally approved. (See below, Box 1).

MEXICO

Characteristics of the Mexican Health System

The Mexican Public Health System is organized around three separate but related structures: the Social Security Health System (Instituto Mexicano de Seguridad Social, IMSS) which covers the population working under a formal labor contract in the private sector; the Public Sector Social Security System (Instituto Nacional de Salud de los Trabajadores del Estado, INSTE); and the National Health Secretariat (Secretaría Nacional de Salud), which provides services to what is known as the “general population”, meaning those who do not fall into either of the previously mentioned categories. A fourth source of health care is the private network mainly dominated by pre-paid insurance schemes. In the year 2000 total public health expenditure was 13.5 million US dollars, representing 2.49% of GDP, a decrease in real terms of 2.8% on 1999 levels. Total per capita public health spending was 134 US dollars, once again representing a drop of 4.3% in real terms, when compared to 1999. In contrast, per capita expenditure for the population covered by private health insurance was 188 US dollars.\(^{12}\)

The health reform was intended to revitalize the Mexican Health System by reorganizing expenditure and establishing new general criteria to ensure that health institutions and services are more efficient. The main objective of the reform was to improve access to health care for the “general population”, that is, those people not covered by either the IMSS or the INSTE. The advocates of the reform identified as one major problem the existence of parallel health systems that generated duplicities, gaps and inefficiency in the delivery of services: 10 million people living in marginalized urban areas and distant rural areas were not covered by existing services (López and Real 1995-1999). The proposed solutions to this problem were decentralization, modernization and more efficient allocation of resources.

The reform established the System of Social Protection in Health (SSPH), which introduces new financial rules for public health and community-based services, as well as for personal health care. The latter is funded through a basic package (Seguro Popular de Salud- Popular Health Insurance), a subsidized insurance that offers free access to a pre-defined and relatively narrow set of health-care interventions. Families also prepay a small premium, through a progressive means-tested sliding scale, so that the public subsidy is inversely proportional to family income. Other costs beyond basic care were to be covered by the clients themselves (user fees), and by partial investments by both federal and state governments. The poorest 20 percent of families, however, are exempt from any

\(^{12}\) Sanchez (2004)
contribution. Those eligible for enrolment include all individuals who do not benefit from social security because they are self-employed, unemployed, or out of the work force. Most of them are poor and many live in female-headed households. The main argument of the health reform advocates was and is that poverty and labor market status are no longer barriers to access to health care.

However, this focus on the poor is combined with a clear privatizing logic. The National Health Program for the years 2001-2006 is very clear in this respect, stating that, “the promotion of private prepaid schemes for sectors of the population with sufficient economic resources is another strategy intended to ensure the financial protection of families and designed to complement the Popular Health Insurance scheme and Social Security (which covers the costs of the basic package).”

The new directives also introduced new cost-effectiveness parameters (DALYs) to orient the public health interventions as well as new approaches to planning, programming, budget allocation and overall evaluation. Three new institutional structures were created to improve management and operational activities: the National Health Council, the Decentralization and Institutional Coordination Advisory Board and the Decentralization Support Units (Unidades de Apoyo a la Descentralización, UAD).

The Basic Health Care Project (Proyecto de Atención Básica a la Salud), which is the core component of the reform, was funded by a loan of US$ 310 million from the World Bank and a contribution of US$ 133.4 million from the Mexican government. The law, which finally institutionalized the new system, was passed in April 2003, and came into effect on January 1st. 2004, with the goal of achieving universal health insurance coverage by 2010. (Frenk, 2006).

Another aspect worth highlighting is that a formal integration between poverty reduction strategies (implemented through the transfer of income to poor families) and the health reform process is evident in Mexico, some aspects of which will be analyzed further on.

Outcomes

The reform maintained the general principle of health as a right and prioritized access to primary health care and the expansion of coverage and improvement in the population’s levels of health, with particular attention to the reduction of morbidity and mortality indicators. All this is positive. But as is the case in other countries, long-term distortions in the Mexican health system have fuelled arguments against public health financing and universal access to health services. The reform introduced a basic package for the “general population” lacking coverage, combined with the transfer of higher health costs of tertiary services and procedures to those clients who could pay for such services. In other words, it established a new policy logic combining simplified basic services for the poorer members of the population and a market logic to respond to health needs at higher levels of health care.

Despite the good intentions expressed in the very first reform documents, the national health budget decreased by 12 per cent between 1995 and 2001. Though this was, in part, the result of two periods of low growth of the Mexican economy, the budget cuts can also be attributed to the very logic of the reform, since the intention was a redistribution of health costs between the public sector and individual users. The privatizing model was further consolidated after the election of Vicente Fox in the year 2000.

In 2005 the country was spending only 5·6% of its gross domestic product (GDP)—about US$ 350 per head—on health care, which was well below the average level in Latin America (on average, 7 percent, with a number of countries surpassing 8 percent). In addition, out-of-pocket payment constitutes the majority of total health expenditures. As documented by Knaul et al. (2004) the
proportion of out-of-pocket spending is higher than in many other countries with similar levels of economic development and substantially higher than in more developed countries. The third major imbalance is the inequitable distribution of public funds among population groups and among states. Although the uninsured accounted for 55 percent of the population in 2002, they received just 34 percent of public funding for health. This translated into an average level of public per-head spending 2.3 times higher for the insured than for the uninsured.

**URUGUAY** 13

**Characteristics of the Uruguayan Health System**

The Uruguayan health system is a mix of public-private funds, comprising the following structures:

**Public Sector** – In 1996 it covered 40.83 per cent of the population (low income recipients) with special emphasis on primary health care. In 2003, it was estimated that this percentage had increased to 50 per cent, under the impact of the economic crisis. The Uruguayan Public Health System comprises a number of institutions, among which the most important are:

**Ministry of Public Health (Ministerio de Salud Pública, MSP)** – The MSP is the central institutional body responsible for health policies. Its’ functions include regulation, control and service delivery. It provides services through the Administration of State Health Services, (Administración de los Servicios de Salud del Estado, ASSE). The MSP-ASSE is the largest health provider in the country, responsible for 65 health establishments (polyclinics, health centers and hospitals, some specialized) and a total of 6,200 beds for acute care and 2,300 beds for chronic diseases. In each of the 18 Departments (provinces) there is a Departmental Hospital that functions as the referral unit for other health facilities controlled by ASSE.

**Social Provision Bank (Banco de Previsión Social, BPS)** – BPS coordinates national social security and social protection policies. In Uruguay, all workers with formal private sector contracts and all freelance workers have the right to Health Insurance (seguro por enfermedad), provided by the Collective Medical Care Institutions (IAMCs), which are contracted by the BPS. The main source of financing is employee and employer contributions collected by BPS (approximately 90%), to which the National Government adds 10 per cent of its five-year budget. The BPS is also a health care provider in its own right, managing a hospital and six MCH centers in Montevideo.

**Municipal Health Services** – Provide clinical and primary care to the general population and function as the “public health police”. The main source of financing for municipal health services are tax allocations in the five-year municipal budgets. The Montevideo municipal health network offers the widest coverage, through 18 municipal polyclinics, mobile polyclinics and health centers.

**Private Sector** – The private sector is comprised of IAMCs, companies providing partial health insurance, Institutes of Highly Specialized Medicine (which carry out high technology procedures paid for by the National Resources Fund), private hospices and clinics, and homes for the elderly. The IAMCs are a fundamental component of the Uruguayan health system. They are private

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nonprofit organizations that provide pre-paid full-coverage health insurance to almost 50% of the Uruguayan population (2000). Though the IAMCs enjoy a high level of autonomy, the monthly quotas have a ceiling set by the State.

**Financing** – Total health spending in 2003 was approximately 10 per cent of GDP, distributed as follows: public sector, 2.8 per cent of GDP, and private sector, 7.2 per cent of GDP. The main funding mechanisms are: (a) pre-paid quotas (42.1%); (b) user fees paid to the IAMCs (31.8%); and c) taxes (25.2%). Eighty-eight per cent of MSP funds come from the national five-year budget allocation, via direct taxes, while the remainder is collected from non-tax sources).

**Background and Contemporary Trends**

The origins of the Uruguayan health system can be traced back to the early 20th century, and owe a great deal to the IAMCs – founded by European immigrants – as well to state welfare policy frameworks that were gradually established from the 1930s onwards. In the contemporary era a first measure worth mentioning was the creation in 1987 of the State Health Services Administration in the Ministry of Public Health (ASSE), which authorized the transfer of services to municipalities as well as allowing municipal governments to sign agreements with private institutions and to manage some health units using funds from “Neighborhood Associations” (Grupos de Apoyo Vecinales). Later on, in 1995, a series of projects, funded by the World Bank, were initiated as part of a global program to modernize state machinery and strengthen social policy, which, taken together, make up an overall health reform framework. This package includes: the expansion of social security health coverage to all people in retirement; modernization of the public health information system, including the creation of a mechanism that would allow for the identification of users; revitalization of primary health initiatives; improvement of the coordination between public and private sectors; strengthening of the ministerial level policy coordination unit; decentralization of the MoH hospitals.

The logic underlying some of these proposals has provoked critiques and debate, although these did not have much resonance within public opinion at large. The main controversy centered on the role of the State. On the one hand, as also occurred in other countries, some voices supported the transfer of services to the private sector and civil society organizations, and the restriction of public health services to a basic package that would be provided to all, but would mainly be focused on low income individuals. The basic package proposal gained more visibility and some policy legitimacy during the 2000-2002 economic crises. On the other hand, there were voices advocating a stronger role for the State in terms of service provision and regulation. These groups strongly criticized the basic package model, saying that it would create a layer of health care “only for the poor” that, in the interim, would negatively affect the quality of the health system as a whole.

After debate, however, no policy consensus was reached, nor did one position win out over the other. This impasse is what to a large extent explains the “silent profile” and gradual pace of health reform in Uruguay. Lastly, the policy proposals presented in the mid 1990s, both for the public and private sectors, are mainly treatment-oriented and based on a medical model. They have little to say about health promotion and prevention. This is problematic in terms of both financing and health outcomes. It is also important to note that the bulk of health prevention, both in the past and at present, is in the hands of the public sector, with practically no contribution from private sector providers.

Though health reform measures have not been so clear-cut as in the other countries, in our sample, changes have taken place, in particular under the impact of the financial and economic crisis of 2001-2002. A study carried out by the National Medical Union in 2003 found that every day 264
people lost their social security or IAMC coverage and had to resort to the public health system or found themselves completely excluded from any sort of health care. In relation to this trend it is important to point out that women, who experience higher levels of unemployment and labor informality, have historically relied more on public services than men. Such vulnerability has certainly increased under the impact of the crisis, and is directly reflected in reproductive health indicators, in particular maternal mortality rates.

No systematic studies are available to demonstrate that recent changes in health indicators in Uruguay have resulted in greater equity, efficiency, and quality of care and community participation deriving from health reform. The piece-meal reform that has silently evolved since the mid-1990s has in many ways made it difficult to understand more fully the changes underway and their impacts.

**Health Sector Reforms and Gender**

Among the many changes resulting from health sector reforms adopted in Latin America during the 1980’s and 1990s the three most critical were the decentralization, the separation of health service financing and provision, and the reform of the health structures linked to the social security system, which, in most countries, has meant transfer to private hands of previously public services and financing. The 1980’s and 1990’s health reform processes have therefore, on the one hand, deeply transformed the structure and functioning of health systems. On the other, in most countries, the new logic and rules they have established have made access to health care more dependent on the income of a large percentage of the population. All these transformations have clear gender equity implications, which, as noted by Pollack (2002), can be explained either by the characteristics of the health system or by social and economic determinants of the context in which it functions. For instance, when health systems are highly centralized, women who have less mobility may be negatively affected by the fact that secondary and tertiary units are distant from where they live. This implies that decentralization tends to favor gender equity. However, this may not be the case, because in many contexts the mindset of health providers and creation of regulations may adapt to dominant cultural norms that restrict the access of women and girls to health care. Or else, as briefly mentioned before, decentralization in many countries has been limited to basic health care and has not ensured adequate referrals or the rapid transfer of people in emergency situations. This type of situation is very common in obstetric care and delivery and explains a significant proportion of maternal deaths in the developing world.

When the lens is shifted to other dimensions of the reforms such as privatization, and new insurance schemes, other gender effects can be identified. For instance, historically and even today, female participation in the labor market is concentrated in the informal sector and this limits their incorporation in labor based health insurance schemes, be they public or private. The charge of users’ fees that has spread in the region, in some countries even for basic and emergency services, also tends to weigh more on women because their income levels are lower. Several studies have confirmed that such fees, together with inefficient exemption mechanisms, have resulted in the exclusion of those who are unable to pay. Although there are few studies on the impact of these payments according to sex, there is evidence that women suffer proportionally more due to their greater use of services both for themselves and their children, and the responsibility that they have to provide health care in poor households (UNRISD 2005).

However, the most striking and common feature of the experience of countries analyzed in this paper is the total absence or very limited use of a gender framework of analysis to address health
determinants, access to services, finance and employment in the health sector and social participation in health, with crucial elements or parameters guiding all health sector reform processes. Having as reference the relatively scarcer literature on the subject, this section will examine more closely the gender impact of health reforms by examining some specific components of health reforms package or processes, such publicly funded health insurance schemes, labor based insurance schemes, and basic packages.

State run public systems with fiscally funded public insurance schemes

In several countries reforms have modified State run public systems (Chile, Colombia and Argentina, amongst others) through two combined strategies: a) the decentralization of health service provision, which moved management from the national to provincial and municipal levels; b) the transformation of public hospitals into self-managed bodies in competition for public and private insurance funds with private entities. In the large majority of countries, decentralization processes made municipalities responsible for basic or primary health care while responsibility for more complex services remained in the hands of national and provincial management systems and this has inevitably affected the functioning of reference and counter-reference systems. Of the five countries analyzed, Brazil does not fully fall into this category, as the Brazilian reform followed an entirely different model of decentralization and created a system, which is universal and free of charge. However the distortions that will be subsequently analyzed also apply to the 30 percent of the population that is covered by a wide variety of private insurance schemes. Uruguay also constitutes an exception in the analysis given that until today no health sector reform has been implemented.14

Before the reforms, public health systems in Argentina, Chile and Mexico did not always offer good quality health care and had serious regional imbalances. However, they tended to be more equitable in terms of access and coverage and did not present gender related distortions deriving from gender based labor participation and income differentials. Inequities that existed in the past mostly derived from cultural income differentials linked to gender stereotypes, difficulties with the implementation of integral services and paternalistic or excessive medicalization of health practices. After the reforms, however, the combination of decentralization, fiscally financed public health insurance schemes, dissociation between financing and provision of services and the self-managing of both public and private health units has created new patterns of distortions and inequities. One main feature of post-reform models is that users can access only a certain level of services as guaranteed by their personal packages, even when the package is financed by public funds. This implies, among other things, that health care is no longer offered on the basis of health, but rather is limited by the criteria defined by the insurance scheme to which the person belongs. It is also important to observe that, in the past ten years or more, pre-reform gender biases and distortions have not been overcome.

Another important aspect for measuring gender inequity in public funded health systems is the examination of what expenditures are or not covered, which can be done, for instance, through the analysis of household expenditures (in the form of out-of-pocket expenses) on health care. However, the dominant view of the household as a homogeneous and equitable space makes it extremely hard to identify and analyze gender differentials in terms of out-of-pocket expenditures in health. (Kabeer, 1994; Gómez, 2002). For accurate analysis the supposed “unity” of the household should be broken down and gender negotiations that take place in respect to establishment of priorities and distribution of money for out-of-pocket expenses need to be identified and properly examined. Intra-

14 A comprehensive health reform process is , however, scheduled to 2008
household inequities have been examined in Argentina, in a study that followed women affected by heart disease who were treated in the public hospital (Tajer, 2006). The study concluded that when these women were in hospital it was possible to ensure that they had all the necessary medication. But when they became outpatients, very often treatment collapsed because access to medication involves out-of-pocket expenses and the women tended to lose out in family negotiations that determine household priorities and health expenditures. The researchers concluded that it is not possible to ensure gender equity in outpatient treatment when access to and use of adequate medication to treat health conditions are concerned.

As mentioned before, however, no major policy effort has been made until today to analyze the gender implications of the new regulations applying to the private sector and social security in health care. It does not seem excessive to say that, in the majority of countries, wherever efforts have been made to adopt a gender perspective in respect to public health management and service provision, this has been confined to primary health care or, as in Brazil, to specific programs addressing women’s health needs.

Insurance schemes for workers in the formal sector

Historically, in most countries of the region, the formal work force had access to health care either through solidarity funds, or through risk insurance companies. One important impact of health reform processes was the transfer or transformation of solidarity funds into risk based insurance schemes. Risk insurance companies, even where effective regulation is in place, operate on the basis of commercial risk and, consequently, the scope of coverage premiums is entirely dependent on an assessment of the potential health costs of an individual, which is made according to sex, age and number of dependents of the insured person. In Latin America, the effects of the risk insurance model on gender inequity has been well studied in Chile, which represents the first and more consolidated neoliberal inspired health reform in the region (see Box 1).

BOX 1 Gender discrimination in risk based insurance schemes: The Chilean Experience

One important element to consider is that insurance companies began as service provision intermediaries in a post Welfare State framework in which an obligatory contribution by workers (and employers) to guarantee their right to healthcare was already established. This therefore represented the entrance of market logic into a “captive” market where payroll contributions cannot be avoided but can be transferred, if the worker is accepted to another entity, as is the case in Uruguay and Chile.

The gender balance of FONANSA is 57 percent men and 43 percent women, which can be considered positive. However when the system is analyzed in regard to the status of the affiliates, in 2004, 28 per cent of those women had coverage dependent on another affiliated person in 2004, which is much greater than the proportion of men in that same situation. These two opposite tendencies compensated for each other and in the end the gender overall percentage of beneficiaries was similar. (SI 2003; FONASA 2004) This implies that the majority of women have access to health services not by themselves, but through an insured man. Such high level of dependency is explained by the fact that while just 39 percent of women are in the workforce, workingmen represent 73 percent of the population. In addition, the average female wage is 30 percent lower than men’s salary, and 45 percent of women work in the informal sector.

Similar and other distortions are identified in respect to ISAPRES’ health insurance schemes. The ISAPRE contract is individual and the insurance company itself is free to fix the cost of plans that it offers. This creates discrimination because the ISAPREs have the right to accept only those it considers will provide them with economic profits. As mentioned above, in 2000 while 66.5 percent of the population is covered by FONASA,
just 19.8 percent accessed services through ISAPRES and of this group only 35 percent were women. This indicates that the income criterion, which determines acceptance into an ISAPRE insurance scheme, discriminates against women because they have lower average salaries. Even when women are able to receive ISAPRE insurance, because their income is usually lower than men, they only have access to inferior plans. This income based gender discrimination is typical of individual based insurance health systems that are also based on risk assessments, which attract higher premiums.

The ISAPRES plans also imply gender-based discrimination in terms of costs as women have a risk assessment factor up to twice as high as men. In 2001, private insurance premiums for women aged between 20 and 40 (the most fertile period) were between 2.4 and 3.1 times higher than men’s premiums for the same age group. Even those plans that exclude medical care for delivery had higher premiums for women than for men of similar ages. Due to these inequities the great majority of women of fertile age are covered by the public system, which in this way subsidizes the private system. In the annual renewal of ISAPRES’ contracts, premiums are adjusted according to a woman’s age and the number of dependents that she has (Pollack, 2002). Maternity leave (known and maternity “subsidy”) was initially paid by ISAPRES and this caused increased premiums for women of fertile age and created obstacles for their affiliation to the private system. To eliminate this second inequity, the State took on the responsibility for paying the subsidy (out of the national budget) irrespective of the chosen insurance system and income level of the insured woman. However the maternity subsidy is highly regressive. It is also considered to be the worst example of focalization amongst all subsidized public programs because it is financed by the State but is paid in proportion to salaries. In consequence, half of the ISAPRES beneficiaries, who have higher incomes, receive 80 percent of the total state investment, which is financed by the entire population through taxes, many of them consumption taxes, and so paid even by the poor. (SPS 2002; Sojo 2003)

The private system reform law of 1995 did not address these various previous inequities. However in 2004 a new law established a basic package of services at a stipulated cost irrespective of the insured’s gender, the provision of which is required in both the public and private subsystems and at the same price in all ISAPRES. The compensation fund created by law in 2005 will reduce age and gender discrimination in the basic package financing of open ISAPRES. Additionally, increases in premiums must fall within a range established by law


Basic package insurance schemes

Policies or strategies have been implemented in the health sector in these countries for several decades in order to focalize the resources and services. The notoriety within the programs of reform in these countries arises from the publication of the report of the World Bank in 1993, where novel tools are presented to examine the burden of disease on these societies and the cost-effectiveness of the interventions available to deal with them. The great majority of countries, since then, have included directed policies to focalize the resources and services, whether through an essential or basic package of services.

The effects of the basic package in terms of gender equity can be examined in terms of horizontal fairness. If universal access to a certain package exists, then it could be said that horizontal equity has improved. However, as has been mentioned before, basic packages often implied a regression for those sectors of the population that have limited resources and greater needs, because they shifted
the overall logic of the health system from a comprehensive frame and universal access to a ‘minimum package’ that does not ensure access to other levels of services and quality of care.

From a gender perspective it is important to note that the potential beneficiary group is predominantly made up of women. In all cases basic packages include maternal health care, even when the scope of services offered varies across countries. In addition, it should be reminded that gender inequalities in income, in many countries, imply that that in few countries in Latin America the number of women exceed the number of men in the population living under the poverty line as defined by international institutions and national governments. It is true that in some countries, such as Bolivia, basic packages adopted in the mid 1990’s have expanded access to maternal and child care and have included other dimensions of reproductive health, as it is the case of post-abortion care. But it should be noted that the “model” as defined the World Bank leaves aside a wide range of other women health needs, some of which and related to sexuality and reproduction – as in the case of cervical cancer screening and treatment and contraception – and some not as it is the case of labor related health effects, some chronic diseases and demands in regard to mental health. The abandonment of a universal and free of charge frame to guide the structure and functioning of health systems it implies has also been systematically criticized (Almeida, 2005).

**Sexual and sexual and reproductive health policies**

As mentioned before, a systematic gender based assessment of health reform processes in the countries examined in this paper is quite scarce. But another way of looking into the impact of transformation of health systems on women’s health and gender equality, in the last two decades, is to examine the evolution of sexual and reproductive health policies in relation to health reform processes. Sexual and reproductive autonomy is a key component of a gender equality agenda. Factors enabling women’s sexual and reproductive self-determination are multifaceted as they are certainly linked to individual economic empowerment, but most principally are determined by cultural, religious and institutional norms that are not restricted to legal frameworks. As has been defined in the policy recommendations adopted in the ICPD and Beijing, the role of health systems, policies and programs are crucial components of a framework aimed at guaranteeing sexual reproductive rights. Last but not least, in Latin America, in particular, feminist organizations, in the course of the last two decades, have been continuously mobilizing to transform health systems and policies to ensure access to health services, quality of care and respect for women’s human rights in the areas of reproduction and sexuality.

For instance, in Mexico, since the mid 1970’s, a broader women’s health agenda has been crafted under the influence of feminist and left-wing critiques of the population control policies that had been implemented since the previous decade. Since the 1980’s, in Uruguay and Argentina feminist activists mostly had to challenge explicit or implicit pro-natalist stances, such as the prohibition of sterilization (in both cases) and of commercialization of contraceptives (in the latter). In Brazil, in the early 1980’s, at the height of democratization struggles, a powerful feminist discourse on reproductive self-determination was constructed in opposition to both neo-Malthusian proposals and the pro-natalist ideology of the Catholic Church and other sectors. A similar situation was observed in Chile, where despite major democratic gains and significant achievements in respect to gender equality, sexual and reproductive health and rights issues remained subject to major controversies.

During most of the 1990’s these countries experienced a period of political stability and this allowed the women’s policies agendas struggled for in the 1970’s and 1980’s to gain visibility and legitimacy. Domestic processes were positively impacted by the outcomes of Cairo and Beijing. In
Brazil the UN conferences clearly re-activated the 1980s women’s health policy agenda, particularly with respect to the provision of abortion in the two cases permitted by law (rape and when the woman’s life is at risk). In Mexico, reproductive health guidelines adopted in the mid 1990’s have clearly influenced national policy debates and impacted progressive initiatives at state levels, such as the sequential initiatives to legalize abortion in the Federal District. As in other countries, these initiatives came into being due to the intersection of national dynamics and international processes.

The same applies to Uruguay, where the early 1990’s Montevideo Women’s Health Comprehensive Policy (PAIM) gained greater national visibility and legitimacy after 1994 and 1995 and most principally the movement to legalize abortion was revitalizing, leading to the Reproductive Health Law provision approved in 2002 by the lower house. In Argentina struggles and policy developments followed a different pattern as, throughout the 1990s, while the feminist movement strongly engaged with the S&R H&R agenda, Carlos Menem’s government maintained, both at home and in international arenas, an extremely conservative position with respect to S&R H&R issues, abortion in particular. Great persistence was required from women’s organizations to keep the agenda present and alive in the public arena and this is what ensured the positive policy shifts observed after 2001. In Chile, similar struggles have been also sustained but effective policy results have been meager because of the greater strength and influence of conservative forces on society and the state.

However, in spite of democratic stability and advances observed during this period in respect to reproductive health, the overall policy environment was not without obstacles. Fiscal restrictions and state reform processes created major policy constraints for the advancement of sexual and reproductive health policies. More often than not, international commitments made by governments did not always translate into consistent national policies. Electoral and administrative changeovers often gave rise to a pattern in which policy progress was erratic: two steps forward, one step back. This section examines more closely these national trajectories regarding sexual and reproductive health policies.  

ARGENTINA

A clear illustration of conservative and pro-natalist policy stances is found in the 1974 decree issued prohibiting family planning services and the supply of contraceptives, a measure later ratified by another decree passed by the military regime in 1977. But in the early 1980s, as democratization evolved, so did a public debate on women’s reproductive self-determination and from there on, for more than two decades, while feminists advocated the right to use contraceptive methods within a broader human rights framework, conservative sectors defended the notion of “responsible paternity” and systematically influenced high-level policy-making to limit (and prohibit) the provision and use of contraception. In general, therefore, the debate on public funding for and access to all contraceptive methods has until very recently been the central focus of the S&R health debate in Argentina.

15 In reference to Argentina, Brazil, Mexico and Uruguay the information and analysis offered in this section is mainly based on the DAWN research report “Interlinking Policy, Politics and Women’s Reproductive Rights: A study of health sector reform, maternal mortality and abortion in selected countries of the South”, is found at http://www.repem.org.uy/node/216. The study has mainly covered the 2002-2004 period but in some cases information on the post 2004 period. The analysis of Chilean policies is based on the Gender Equity in Health Observatory 2005 Report found at http://www.observatoriogenerosalud.cl
In 1986 a first bill on reproductive health was presented in the lower House of the National Congress and in 1988 a bill was presented in the Senate proposing the creation of a national family planning program (which, however, excluded access to sterilization). Concurrently, conservative senators presented a bill aimed at prohibiting the use of contraceptive methods considered to be abortive in nature. In 1989, despite stringent public resource constraints, the family planning program began to be implemented in public clinics, particularly in the metropolitan area of Buenos Aires. Menem came to power that same year and an expert commission was convened to discuss a new family planning legislative framework. Nevertheless, as a strong alliance between Menem and the Catholic Church developed in subsequent years this new provision was never voted in.  

In 1995, under the impact of both conferences, a new bill was presented to Congress to revise and expand the legal sexual and reproductive health framework. Given the political climate, the bill, which did not include female and male sterilization – as demanded by women’s organizations –was considered a major breakthrough. Though the House approved it, when it was sent to the Senate for ratification, no consensus was reached. Despite this defeat, it generated a live national public debate that furthered the adoption of progressive legislative initiatives at provincial and municipal levels. In 2004, 14 provincial and municipal legislative bodies had approved specific S&R health provisions: Buenos Aires (City), Cordoba, Chaco, Chabot, La Pampas, Rio Negro, Juju, Santa Fé, Tierra del Fuego and La Rioja. In 2001 the lower House adopted a newly drafted S&R health policy provision, and in October 2002 – in the midst of the political and economic crisis – Law No. 25.673, providing the legal framework for the National Program on Sexual Health and Responsible Procreation, was finally approved by Congress. In 2003, a specific provincial legal framework was finally sanctioned in the Province of Buenos Aires, home to one third of the Argentinean population.

Outcomes

After two decades of controversies and political bottlenecks, in 2002, reproductive health policies experienced a leap forward. By early 2003, 377 hospitals and clinics were already offering contraceptive assistance to 125,000 users, of which 13 percent were teenagers. By late 2004, roughly 13 million contraceptives (condoms, IUDs, pills and injectables) had been distributed by the public health system to 1.5 million users through 5,076 hospitals and clinics offering both contraceptive services and STI prevention (web magazine Pagina 12, 28 April 2005). In April 2005, the government announced it would distribute 10 million condoms, 450,000 IUDs, 1.6 million injectables and 5.8 million oral contraceptives (an increase of 36 per cent on what was distributed in 2004). The decision was accompanied by a mass media campaign to promote access to and use of these methods. The slogan used was “Get informed, ask questions, make your decision. This is the law, this is your right”, and male participation was emphasized.

It should be pointed out, however that, as noted by the DAWN study, at least until 2002-2003 the performance of the national, provincial and municipal programs remained extremely uneven. Local sexual and reproductive policies had not been properly integrated with the new social security health schemes which covered a major part of the female population. Furthermore, the effectiveness and quality of services varied widely according to specific conditions prevailing in each province or municipality. The DAWN country report also mentions limitations deriving from the wider socio-economic situation, important gaps in terms of policy integration and problems with implementation

16 In 1995 Menem supported a law creating the Day of the Unborn Child (1995), inaugurating a trend that would gradually affect the majority of countries in the region. This means that although at the time of the Cairo and Beijing conferences a national policy on contraceptive provision was in place in the MoH, all initiatives aimed at effectively implementing this policy were under sustained attack by conservative sectors.
on the ground. For instance, the increased level of economic deprivation has affected the Argentinean population, and in particular women, whose access to health services has therefore been restricted both because of the costs and time constraints involved. Although poverty alleviation programs have been created since 2002 that widely involve poor women, linkages between these initiatives and the newly created S&R programs have not been clearly established.

Discrimination, or the absence of a clear rights-based approach, is another area considered problematic, in particular in the case of adolescent pregnancy. And, though the term “sexual” appears in the title of the new law, consistent linkages with existing sexual health programs had not yet been created, neither in what concerns the HIV-AIDS national policy for prevention or treatment, nor in the case of a previously existing adolescent S&R health program (PROAME – Programa de Atención a Menores en Riesgo). The DAWN analysis underlines as well that despite the transformation of discourses at higher policy levels, what prevailed at the level of services were still conventional conceptions (deriving from old MCH programs) emphasizing women’s roles and responsibilities in the realm of reproduction.

BRAZIL

The Brazilian national S&R health policy launched in 1984 – named Comprehensive Women’s Health Program (Programa de Assistência Integral à Saúde da Mulher, PAISM) – included pre-natal, birth, and post-natal care, cervical cancer and STD prevention, adolescent and menopausal care, and contraceptive assistance. PAISM preceded Cairo by ten years and its evolution has been closely associated with the health reform struggle and implementation. The 1980’s women’s health agenda was conceived as a universal public funded policy and emphasized integration of services and levels of care (primary, secondary and tertiary) as well as prevention strategies.

Since its inception, PAISM has gone through distinctive phases. Between 1984 and 1988 the program mostly invested in the training of human resources and in efforts to supply reversible contraceptive methods through the public health system (at the time contraception was provided by UNFPA). From 1988 to 1993, though negatively affected by the financial and political crises that culminated in the impeachment of Collor in 1992, positive experiences evolved at few decentralized levels. After 1993 the reactivation of PAISM at the federal level was favored by the Cairo and Beijing agendas, which provided additional policy arguments to approve the infra constitutional legislation regulating access to contraception in the public health system (Family Planning Law, 1997), the approval of a Minister of Health protocol to guide interventions in cases of sexual violence, which encompasses guidelines in respect abortion in the cases permitted by the 1940 penal code: rape and women’s life risk.

The post Cairo and Beijing period has also witnessed the reactivation of the national women’s health policy agenda (between 1998 and 2002), which was guided by the following priorities: a) Improvement of pre-natal, childbirth and post-natal care as to achieve a reduction in maternal mortality rates; b) Measures aimed at reducing the number of cesarean sections; c) Implementation of the Family Planning Law with respect to male and female sterilization and provision of reversible methods; d) Improvement of post-abortion care; e) Prevention and treatment of cervical and breast

17 This also reflected in the Constitutional Reform (1986-1988) that, on the one hand established the basis of SUS and on the other adopted principles of reproductive self-determination in relation to family planning and – despite much pressure from the Catholic Church – did not include the defense of the right to life from the moment of conception.
cancer; f) Prevention and treatment of STIs and HIV-AIDS among women; g) Expansion of health services to respond to gender-based and sexual violence, including access to pregnancy termination in cases of rape. A series of investments have also been made to more consistently articulate PAISM guidelines and SUS structures, regulations and procedures established in the 1990’s. This implied a series of negotiations with the National Council of Health and the Tripartite Commission were state and municipal health secretaries have a seat, as well as new strategies related to decentralization.

The 2002 elections resulted in the victory of the PT change of the Federal Administration and implied major changes in the Federal Administration. But contrasting with previous political administrative transitions, the 2002 Federal changeover did not mean a major discontinuity in terms of sexual and reproductive health policies. The general direction of the policy was not altered, but rather amplified. Publicly presented in early 2004, the new National Women’s Health Policy defined gender equality, women’s human rights, and the integrality of health care and services as its guiding principles and prioritized access to services and responses to the health needs of rural laborers, black and indigenous women, women in prison, women undergoing menopause, disabled and elderly women and lesbians.

With respect to reproductive health goals and targets, the 2004 policy framework reaffirmed and expanded the main elements of the previous strategy as to a) Reduce maternal mortality rates by 25 per cent in capital towns and by 10 percent nationally until 2008; (b) reduce the national Cesarean-section rate by 25 per cent compared to 2002 levels; (c) Expand and qualify the Humanizing Childbirth Program (PHPN) in all municipalities where PSF is being implemented; f) Expand the provision of reversible methods to 60 per cent of the target population in these same municipalities; b) increase by 30 per cent the number of hospitals providing female and male sterilization; g) Create 27 referral centers for infertility treatment; h) Reduce by 15 per cent the number of post-abortion complications; i) Increase by 30 per cent the number of services providing specialized care (including access to abortion in the case of rape) in selected municipalities; g) Expand measures aimed at reducing HIV-related female morbidity and mortality. The same year, a new Compact to Reduce Maternal Mortality was also launched that set as its target the reduction of the national maternal mortality rate by 15 per cent by the end of 2006. The compact was negotiated with state and capital city health managers and has been translated into state-level maternal mortality reduction strategies.

Outcomes

In 2002, the Minister of Health conducted a rather comprehensive evaluation of the performance of women’s health policy adopted in 1998 and identified the following gains:

Antenatal, obstetric and post-natal care: Creation of a new program (Humanizing Childbirth Program - PHPN) that included financial incentives to improve care at municipal levels and establishment of state-level hospital referrals for high-risk pregnancies. Pre-natal coverage expanded from 5.4 million women in 1997 to 10.1 million in 2001, and the average number of consultations per woman increased from 2.0 to 4.2.

Maternal mortality epidemiological surveillance: Investments were made to expand the number of maternal mortality committees and maternal death was included in the list of compulsory notification events. The number of state, municipal and hospital based maternal mortality committees increased substantially.

Contraception: In 1998, financial restrictions were adopted as a strategy to reduce the number of cesarean sections in SUS hospitals and this had immediate positive effects. In the same year MoH
recentralized the purchase and distribution of contraceptives to lower purchase costs. In 2000, soon after implementation of the plan, operational problems were detected and the distribution was suspended. A new strategy was devised to send the contraception directly to municipal health departments that fulfilled certain criteria. In 2002, contraceptive kits were delivered to more that 4.568 small municipalities and 398 cities and to establish a baseline for monitoring, research was conducted in 2002 to assess the outcomes of the new strategy.

Post-abortion care: New guidelines for the improvement of post abortion care were defined, which included Manual Intrauterine Aspiration (MIA) on the list of SUS medical procedures.

Cervical and breast cancer: In 1998 a national cervical cancer screening campaign was launched targeting women in the at-risk age group (35–60 years old) and in early 2002 efforts to prevent cervical cancer were again intensified. The 1998 campaign covered 98 per cent of municipalities and performed roughly 3 million Pap smears: 38.6 per cent of the women were screened for the first time.

Women and HIV/AIDS: Investment was made to better integrate and created more synergy between national women’s health and HIV policies.

Gender-based and sexual violence: This new strategic area was entered into after the approval, in 1998, of a new SUS Protocol on Gender-based violence (Norma Técnica de Atenção às Mulheres Vítimas de Violência) to guide access to emergency contraception and abortion procedures in cases of rape, and HIV prophylaxis. Two years later the notification of gender-based violence cases reaching the public health system became compulsory.

Though these policy measures were positive and, in many cases, had good results, the women’s health policy coordination team and other relevant actors have also identified limitations and problems in various areas. Until mid 2002 the performance of the Humanizing Birth Program (PHPN) remained very poor in most states and referral hospitals and systems for emergency obstetric care were not properly established and functioning everywhere. The number of female sterilizations and vasectomies performed as defined by the Family Law increased: tubal ligations increased from 293 to 11,480, while the number of vasectomies increased from 497 to 3,970. But these figures are far behind the thousands of female sterilizations performed each year in public hospitals. Also the reduction in the number of cesareans was already showing signs of leveling out. The 1998 cervical cancer campaign was strongly criticized, above all, because services lost track of 22.7 per cent of the women screened, which meant that those women would not receive proper follow-up and treatment. HIV/AIDS prevention and treatment among women also presented many deficiencies, among other reasons, because the HIV/AIDS and women’s health programs remain highly fragmented at the local levels. Last but not least, the new logistic aimed at ensuring the public distribution of reversible methods of contraception, remained extremely problematic as the new distribution scheme guaranteed delivery of contraceptives to municipal health departments, but they did not always actually reach the clinics or users.

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18 By September 2002 only 12 per cent of all pregnant women included in the program attended six pre-natal consultations; 5 per cent of those who attended six consultations had all the basic examinations; and just 0.1 per cent of those who attended six consultations and had all basic examinations, were vaccinated and attended a post-natal consultation.

19 To more fully understand what this means it is necessary to remember that since the late 1970’s female sterilization has been offered in the public health system, without precise regulation and often associated with unnecessary C-sections. A large percentage of these procedures imply “unofficial payment” to doctors or else “clientelist” schemes involving local politicians. One of the main objectives of the Family Law was exactly to re-organize this provision.
The performance of women’s health policies adopted since 2003 has not yet been comprehensively assessed. But information is available about specific components and it is also possible to summarize main policy debates that have taken place in the period. In May, 2006, the national women’s health program made public few indicators concerning the Maternal Mortality Compact that constitutes a main component of the new guidelines: since 2004 1,400 heads of obstetric services at 280 main maternity wards in the country had been trained as to achieve a deeper and broader transformation of dominant paradigms in obstetric care and maternal mortality rates have been reduced by 8 percent.

New and positive initiatives have also been implemented in respect lesbian health and more consistent linkages have been established between the women’s health policy and the new health policy designed to address the specific health needs of the afro-Brazilian population. On International Women’s Day 2007 a Campaign was launched to raise the visibility of women and HIV-AIDS risks and prevention, which mainly targets the Pan American games set to take place in Rio in July. The launch received great media coverage because President Lula, rather unexpectedly spoke freely about the use of condoms and criticized the hypocrisy of the Catholic Church about “sex”.

In 2006 the MOH distributed 13 million combined oral contraceptive cycles, 800,000 injectables (trimestral and monthly), 180,000 IUDs and roughly 90,000 doses of emergency contraception (EC). Even so in early 2007, the press published excerpts from second evaluation made by Minister of Health, which detected distortions and gaps similar to those identified in 2002: contraceptive methods were not reaching health services and users as expected. This failure is more evident in smaller and poorer municipalities where the levels of unmet need for contraceptives tend to be higher. This assessment has the new Minister of Health to devise and launch a new strategy, which includes a TV campaign on the right to decide and the delivery of low cost pills through a network of 3,500 popular drugstores subsidized by MoH. This new strategy has been received with caution by reproductive health activists and other observers, as the new social marketing model does not ensure access to a variety of contraceptive options nor adequate access to information and medical follow-up.

Last but not least, any assessment of the Brazilian national women’s health policy is conditioned and affected by the same structural factors that hamper the overall performance of SUS. One is the scale of the system, which implies enormous challenges in logistical terms (as the ones perennially affecting the public distributions on contraceptive methods). Another critical aspects to be looked at is decentralization. Practically all studies that have examined the evolution of PAISM conclude that in the late 1990’s and early 2000 the performance of the program is highly dependent on the technical capacity, commitment and political conditions prevailing at state and municipal levels. Even when municipalities are mainly in charge of services, the strategic planning role of the state level is crucial to ensure homogeneity across local levels The reality, however, is that very often a successful and effective municipal women’s health program is paired with a failed policy in the next municipality. This usually increases the demand for the good program, which subsequently may lessen it’s. Correa et al (1999), for instance, consider that the two key factors to ensure effective and positive implementation are systematic civil society pressure and the commitments of state and local level health managers. Unfortunately, these conditions are present in a very small proportion of the more than 5,000 Brazilian municipalities.
Abortion Legal Reform: Progress, regression and ways forward

In 2003, when the new Congress legislature began and the abortion debate heated up the feminist movement created a new platform to push for legalization (Jornadas Brasileiras pelo Direito ao Aborto Legal e Seguro). Concurrently, abortion began to be discussed at high judiciary levels. In early 2004, anti-abortion groups targeted one anencephaly case for which the woman had initially got a local level judicial authorization and called for an “habeas corpus” for the fetus. The appeal reached the Supreme Tribunal of Justice, which suspended the previous authorization. In reaction, a feminist NGO (Aniz) decided to take the case to the Supreme Court, but when the judgment was finally handed down, the baby had been born and died. ANIZ strategy shifted towards using a special juridical instrument (ADPF) to contest legal norms and judicial decision by demonstrating that they contradicted constitutional principles. The ADPF was presented on behalf of the National Confederation of Health Professionals (jointly with Anis). The initiative gained a great deal of media coverage and generated opinion polls in which the vast majority declared themselves to be in favor of expanding legal abortion to include severe fetal abnormalities. A first vote occurred in July 2004, when the Court decided that it would accept the claim and scheduled a final decision for 2005, which however has still been delayed. In parallel, the National Compact to Reduce Maternal Mortality, included a new protocol – the “Technical Norm to Guide Humanized Care for Unsafe Abortion”, which encompasses rules regarding abortion in the case of rape. The Federal Council of Medicine (CFM) publicly contested the rule which establishes that a police certificate to prove that the woman has been raped is not required for the abortion procedure to be performed. In June 2005, a new Health Ministry Protocol was suspended and it has taken some time for the controversy to be resolved, which has delayed the implementation of policy measures regarding post abortion care.

The main development in this area is a result of a successful strategy from the Jornadas targeting the 2004 National Conference on Women’s Public Policies to ensure that its outcomes included a recommendation to revise the existing punitive legislation. The recommendation was adopted in July 2004 and in December, the Ministry of Women’s Affairs announced the creation of a Tripartite Commission – involving the Executive and Legislative branches, as well civil society representatives – to propose a bill of reform. The contribution of the Jornadas was vital in the policy process, as the draft prepared by them provided the foundation for the draft provision adopted by the Commission in August 2005. The text proposes that until the 12th week of pregnancy, abortion should be decriminalized and defines that the procedures performed under these criteria must be provided freely by SUS as well as covered by private health insurance. By the time the Commission concluded its work in August, however, a political corruption crisis was at its height and it was clear that no commitment could be expected from the Executive Branch. The provision was presented to Congress by Representative Jandira Feghali, the rapporteur of all 1990’s abortion bills, with a much lower profile than expected. The conservatives immediately attacked the proposal and in November a hearing on the provision turned into a power struggle with anti-choice members of Congress and organizations. Given the extremely unfavorable climate, Feghali tried to negotiate a new shorter draft, simply proposing the decriminalization of women and providers. But even this watered-down version of the bill did not garner the necessary support and the provision was shelved. Anti-abortionists were extremely active during the 2006 general elections and, among other things, managed to defeat Feghali in her run for a Senate seat.

In early 2007, the debate was re-opened, as a few weeks before the Pope’s visit the recently appointed Health Minister, José Gomes Temporão, declared that abortion is a grave public health problem and appealed for a wide public discussion of this problem – including a referendum. The Minister’s position, though virulently attacked by conservatives, was widely supported by feminist and other civil society actors and even sanctioned by president Lula himself. A new cycle of debates and advocacy for the legalization of abortion in Brazil was, therefore, inaugurated.
The trajectory of reproductive (and sexual) health in Chile in the last four decades is a striking illustration of how conservative politics negatively affect national policies and also personal self-determination, in particular of women. Faúndes and Barzelatto (2004) describe how in the decade immediately preceding the Pinochet dictatorship, maternal and child health programs and family planning were implemented and, most principally, progressive medical professionals had been able to provide safe abortion procedures in a major Santiago hospital, despite stringent legal restrictions. It does not seem excessive to say that at that point in time Chile probably had the most progressive and effective reproductive health policy in South America. The dictatorship was then established in 1973. While under Pinochet the MCH and family planning programs were not formally dismantled, as previously mentioned, access and quality to health care was negatively affected by neoliberally inspired reforms, particularly in regards to women.

Most important, however, was the attack on divorce, abortion and sexual autonomy. It became impossible to implement sexual education in schools, a divorce law was not approved until 2004, and at the very last moments of the dictatorship the only exception allowing for abortion in the penal code – therapeutic abortion to save mothers’ life – was eliminated by the Supreme Court. This decision made Chile one of the few countries of the world in which abortion is entirely prohibited. As in other contexts, prohibition does not mean the elimination of abortion. In the early 1990’s a study performed by the Alan Gutmacher Institute (1994) estimated that in Chile, 55 in each 100 pregnancies were terminated, despite the law.

The Socialist-Christian Democrat coalition that has governed Chile since 1990 has expressed strong commitments to gender equality and implemented effective policies to translate these commitments into reality. However these areas – abortion, sexuality, reproductive health - remain subject to major controversies, as the right wing military and the Catholic Church retain strong influence on the society and political institutions. Consequently, in the 1990’s and 2000’s, feminists and other progressive members of civil society have had a long struggle in the area of sexual and reproductive health in order to achieve the gradual expansion of the limited policy “moral boundaries” inherited from the dictatorship. Another illustration of the obstacles faced by activists is that despite the approval of divorce in 2004, two years later, the Bachelet government’s new guidelines on emergency contraception were judicially contested by conservative sectors.

In 2005 the Gender Equity in Health Observatory published and assessment of sexual and reproductive policies in Chile. The main findings are synthesized in Table 3

<table>
<thead>
<tr>
<th>Advances</th>
<th>Setbacks</th>
<th>No change</th>
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<tr>
<td>In September 2005, MINEDUC initiated a Sex and Relationship Education Plan.</td>
<td>The AIDS mortality rate for women increased from 0.76 to 0.83 per 100,000 women between 2002 and 2003.</td>
<td>No movement has been made in the approval of a sexual and reproductive rights law.</td>
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<tr>
<td>In 2004, the Adolescence and Sex Advisory Group and the Network of Adolescence Caretakers from the Health Service, formulated a document of technical guidelines for the provision of sexual health care for adolescents at a national level.</td>
<td>No information exists to show if the differences between the sexes have diminished in the incidence of obligatory STD notification.</td>
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The HIV test has been incorporated in AUGE services. In 2003, the same percentage of women were documented as contracting HIV/AIDS as in 2002 (12.5%). There has been no advancement in the design and implementation of an integral statistics system for sexual health.

The number of condoms purchased by the Health Service and CENABAST increased by 37% between 2000 and 2001. This figure is higher than the increase in the over-fourteen male population during the same period (1.8%).

The gap between the average number of children per woman in rural and urban areas reduced during the last inter-census period.

Source: Gender Equity in Health Observatory, Chile (2005)

As can be observed in the table, sexual health indicators show more advances than setbacks. Three of them particularly stand out. First was the launch in September 2005 of the Education Ministry’s (MINEDUC) Sex and Relationship Education Plan, which updated their 1993 guidelines for Sex Education Policy. The second advance was the formulation of technical guidelines for adolescent health care, with special reference to sexual health care, in the country’s primary health care centers. In consultation with doctors, the first commitments have been made for their application. A Sympathetic Modality of Attention for Adolescents in Primary Care Centers was instigated incorporating confidentiality, counseling and the provision of contraception methods. A third area where progress has been observed was the inclusion of HIV testing in AUGE (integrated health system that includes all types of illness) to facilitate the universal provision of retroviral drugs for people with AIDS. Though AUGE services are part of preventive care examinations determined by law, a new decree has established that 100 percent of pregnant women must have access to HIV testing and pre and post-test counseling.

Although some progress has been made in sexual health, one main policy gap is the lack of approval of a sexual and reproductive rights law, which has been subject of two distinct legislative initiatives. In October 2000 a group of parliamentarians from the Coalition (Concertación) and Independent parties presented the “Framework for Sexual and Reproductive Rights” bill that was discarded less than a month later. In October 2004, a Constitutional Reform bill was also presented in order to establish new articles in the bill of rights to guarantee of sexual and reproductive autonomy. This provision basically is intended to ensure that all persons, in particular women, have the right to chose the most appropriate contraception method approved by existing health legislation. It also prescribes that the State must promote and protect the free exercise of this right. This constitutional amendments would prevent conservative groups from petitioning the Judicial Power in order to control which contraceptive methods women can use, as happened with emergency contraception in 2006. The complete prohibition of abortion is also another major obstacle for the full enjoyment of sexual reproductive health and rights.

Maternal Mortality: A Distinctive Picture

In Latin America, in the last 10 to 15 years maternal mortality has been monitored in only three countries: Chile, Bolivia and Honduras. Donoso’s (2004) study on maternal mortality in Chile, from 1990 to 2000, identified a 60.3 percent reduction (19 per 100,000 live births, in the year 2000). There was a significant downward trend in maternal mortality due to hypertension, abortion and puerperal sepsis. The highest level of

maternal mortality was found in women who were 40 years of age or older (100.2/100 000 live births), and the lowest level was in adolescents 15 to 19 years old (18.7/100 000 live births).

Lago (2006) 21 who did literature review on maternal mortality policies in Latin America, notes that these impressive outcomes cannot be attributed exclusively to recent policies, since in Chile maternal mortality rates have been declining since the 1950’s. This is when the National Health System was created and midwives were engaged in pre-natal, delivery and post partum care. However the reduction observed between 1990 and 2000 from 40 to 19/100.000 live births suggest that a sustained policy as well as important financial investments have characterized maternal health policies in Chile since democratization.

Though extremely positive, these policy investments and outcomes contrast with the limitations: lack of a comprehensive sexual and reproductive rights policy framework, as well as the negative impacts of health reform on women’s access to services and quality of care.

**MEXICO**

Mexico is the only country in Latin America where in the 1970’s a solid family planning program was established based on fertility and contraceptive prevalence targets. Since the First World Conference on Women in 1975 (which took place in Mexico City), the coerciveness of this policy has been systematically criticized by the feminist movement and other progressive sectors. In the 1980’s and 1990’s these critiques also emphasized that family planning was a vertical intervention that remained dissociated from MCH programs and that this model was unable to respond to women’s health needs.

Due to the mobilization of women’s organizations for both Cairo and Beijing, Mexico became a major player in pushing through the new 1994 and 1995 consensus on population and development. Immediately after 1994, an ICPD follow-up Commission was established involving governmental agencies, the academic sector and feminist NGOs, and a variety of advocacy and policy initiatives were designed to implement the two Programs of Action. The language and goals of the two programs of action were widely disseminated through feminist networks and a great deal of academic investment has been made in relation to gender, sexuality and reproductive health. 22 At the policy level, investments were made in gender and reproductive health by training health professionals working for the Federal Health Department (Secretaria de Salud) whose service network covered the “general population”. The family planning program guidelines were also carefully reviewed in order to overcome existing problems, such as post-partum and post-abortion sterilization and IUD insertion, which were often denounced as coercive. The National Council on Population (CONAPO), established in the 1970’s to undertake demographic research and to monitor

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22 Among the top academic institutions involved in these efforts are the Mexican College (Colegio de México), the Gender Program (Programa Universitario de Estudios de Género - PUEG) of the National Autonomous University of Mexico (Universidad Nacional Autónoma de México – UNAM) and the Metropolitan Autonomous University (Universidad Autónoma Metropolitana) at Xochimilco.
population policy, also reframed its agenda portfolio and started looking at gender empowerment, gender-based violence and the quality of family planning services, with particular emphasis on informed consent, and agenda that went far beyond the traditional focus on demographic structure and trends and contraceptive prevalence. The policy framework adopted immediately following the ICPD prioritized the following elements:

- Expansion and improvement of pre-natal, obstetric and post-natal care to overcome gaps in coverage. Between 1994 and 1997, 88 per cent of women had access to pre-natal consultations; Cesarean sections represented 25 per cent of deliveries; just 6 per cent of women received proper post-natal care; in four states roughly 40 per cent of deliveries occurred at home.
- Strengthening and greater visibility of a high level commission on maternal mortality.
- Correction of distortions observed in the family planning program through the implementation of informed consent and the expansion of services to rural areas, poorer urban sectors and among the indigenous population (in municipalities where more than 40 per cent of the population is indigenous the contraceptive prevalence rate is roughly 10 per cent).
- Improvement of post-abortion care: Since the 1970’s, abortion has been recognized as a major public health problem. As mentioned above, the problems with post-abortion provision of contraceptives (including sterilization) have received a great deal of attention post-ICPD. Since then, correction measures have been undertaken along with expansion of training programs (mainly provided by IPAS) to improve the quality of care.
- Expansion of cervical cancer screening programs and more attention to HIV/AIDS transmission among young people.
- Development of normative measures to enable the public health system to respond to gender-based violence, including the adoption of a specific protocol on the health implications of intra-household violence.
- Training of health managers and professionals at all levels. Programs sponsored by the Health Secretariat started to include a gender and rights-based approach to S&R health and a number of feminist organizations and progressive academics were directly involved. This gradually evolved toward the Women and Health Program (Programa Mujer y Salud, PROMSA) which is currently responsible for gender and health training across the health system.
- In relation to safe and legal abortion, no immediate policy measures have been adopted. But since the mid-1990s there has been more widespread and visible public debate on the issue, leading to legal reform in Mexico City and several major controversies, as will be discussed below.

Outcomes

Reproductive health policy trends in Mexico today are paradoxical. On the one hand, the ICPD and Beijing remain references in public debate, research and policy directions regarding contraceptive provision, gender training and, most principally, abortion. On the other hand, the health reform agenda somehow weakened the rights dimension in Mexican social policies in general and reduced the 1990s goals to cost-effective basic health care interventions. At the same time, the political climate in relation to abortion related issues became increasingly unfavorable. In the year 2000, the Federal Health Department adopted a specific protocol governing the provision of Emergency Contraception (EC). This policy decision was considered very relevant because in Mexico, as in other Latin American countries, after the ICPD, EC became a main target of the Catholic Church’s campaign against the legalization of abortion. On the other hand, the Fox government’s initiative in reproductive health – the “Fair Start in Life” Program – was a clear step backwards in relation to
previous policy agendas. Even though even the overall reproductive health policy framework remained formally in place, the main goal of the new program is the reduction of maternal and infant mortality. The guidelines signaled the revival of a conventional mother and child policy approach that is radically distinct from the previous Mexican commitments to the ICPD agenda. The election of Calderon in 2006 appears to have further distanced federal policies from a comprehensive sexual and reproductive policy agenda. This tendency is not, however, homogeneous across states and, most principally does not reflect societal opinion itself, as is demonstrated by the trajectory of abortion debates in recent years.

Abortion debates

1. After the ICPD and Beijing there was a great deal of public visibility in broadening of existing norms and ensuring that abortion is accessible in the cases allowed under existing legislation. In the 2000’s a national feminist campaign for reproductive rights was launched and systematic advocacy for reforms of abortion laws began in the Federal District. During the 2000 electoral campaign, presidential candidate Vicente Fox sent a letter to the Catholic hierarchy stating that if elected he would promote the “right to life from the moment of conception until the moment of natural death” (Ubaldi 2003). In contrast, Rosario Robles, who was Governor of the Federal District at the time, sent the State Assembly a bill to expand access to abortion in cases where the woman’s health is at risk or a grave fetal abnormality has been detected. Though the law passed and services began to be made available, this implementation was suspended because anti-abortionists appealed to the Supreme Court, arguing that it would infringe premise of the Constitutional right to life. The Court, however, upheld the state law in October 2002.

2. An earlier case is representative of the struggle between pro-choice activists and conservatives. In 1999, Paulina Ramírez Hyacinth was a thirteen year old who became pregnant when raped by a drug addict, in Mexicali, Baja California. Since the state code allows for the possibility of abortion in such cases, her mother requested judicial authorization. The judge authorized the abortion but the director of Mexicali General Hospital refused to perform the procedure. A second effort was made by Paulina’s lawyer to obtain authorization without success. As delays continued the pregnancy was taken to term. Feminist organizations publicized the case widely and started a lawsuit against the hospital director for having violated medical confidentiality, as well as Paulina’s privacy and liberty. As the decision from the Mexican court was not favorable, Mexican feminist organizations in partnership with the Center for Reproductive Rights took the case to the Inter-American Commission on Human Rights. In 2006, in a landmark settlement, the Mexican government agreed to pay a financial compensation to Paulina and issue a decree regulating guidelines for access to abortion for rape victims.

3. In 2006, PAN won once again the presidential elections. But the electoral process revealed a country sharply divided between conservative and progressive groups (clustered around the PRD and other smaller parties). Since then progressive groups have taken pro-active initiatives in respect to sexuality and abortion as key issues demarcating this ideological divide. One striking result of these complex and novel political dynamics was the approval of provision legalizing abortion by the Federal District Assembly on April 27th, 2007. Right before the vote the Pope sent an open letter to the Mexican bishops appealing to them to impede, at whatever costs, the legal reform. Parliamentarians from various parties interpreted this letter as an infringement of Article 113 of the Mexican Constitution which defines the separation between State and Church and the Minister of Interior (Secretaria de Gobernación) requested the Church hierarchy to refrain from interference. In relation to this episode the Mexican LGBT activist Gloria Careaga affirms that: “The Pope’s open intervention has given strength to those who called for the laicité of the State to be respected when abortion is discussed as public policy issue”. (Castilhos, 2007)
The history of S&R policies in Uruguay can be traced back to the 1940s and the beginning of the demographic transition in the country, which led to relatively low fertility rates in the 1970s, when population growth was becoming an issue in the region. Also, until the late 1990s the relatively good performance of the health system ensured that the majority of the population had access to MCH services. Lastly, Uruguay has a remarkably liberal and secular political tradition, which includes an episode when abortion was legalized in the late 1930s, for a brief four-year period. These characteristics do not completely prevent the Catholic Church from having an influence on policy, which at some times is greater than at others.

In relation to the reproductive health agenda, a key precedent was the adoption in the 1950s of a coherent MCH policy that expanded pre-natal care services and ensured hospital-based deliveries across the country. Though mainly focusing on child survival, it had positive impacts in relation to maternal mortality. From the 1960s onwards, contraceptive prevalence also increased, both through market outlets and a national family planning NGO (Asociación Uruguaya de Planificación Familiar y Investigación en Reproducción Humana, AUPFIRH), which established a formal cooperation agreement with the MoH.

Therefore with respect to maternal health care, maternal mortality and contraceptive prevalence, by the late 1980s the country indicators were fairly good by Latin American standards. But a comprehensive women’s health policy was not yet in place, female sterilization was not permitted, linkages among programs was poor and there was still great moral resistance with respect to abortion. In the early 1990s discussion began regarding a comprehensive women’s health program to be implemented by the recently elected left-wing administration in the Municipal Government of Montevideo (Intendencia Municipal de Montevideo, IMM). This was then followed by Cairo and Beijing, which gave a further boost to the drive towards a broader S&R rights perspective. From then on, feminist advocacy systematically emphasized the commitment to the ICPD comprehensive policy perspective, which in addition to maternal care and contraception identified abortion as a major public health problem, and placed emphasis on adolescent health and sex education within a human rights framework.

Under the impact of ICPD, and with UNFPA support, two reproductive health programs which included access to contraceptive methods were launched: in 1996 the Women’s Comprehensive Health Program (Programa de Atención Integral a la Mujer, PAIM), implemented as part of the primary health program of the IMM; and the Chosen Maternity and Paternity Program (Programa Maternidad-Paternidad Elegida), which in 1999 was defined as a policy priority by the MoH. Subsequently, a new law (Nº158/97) was passed in 1997 on the testing of pregnant women and free treatment for those identified as being HIV-positive.

The ICPD paradigm change regarding the correlation between population and development would also gradually lead government agencies to reconceptualize population-related policies in terms of investments in human development. This was an important shift, since until then the early demographic transition and the small size of the population had perpetuated a belief and a popular discourse that Uruguay did not have a “population problem”.

Recent policy developments

In the early 21st century these new reproductive health policy frameworks evolved substantially, but with differing degrees of consistency at the two managerial levels. In Montevideo, in addition to funds provided by UNFPA, PAIM had its own budget and provided prenatal and post-natal care,
cervical and breast cancer screening and referral, as well as condoms, pills and IUDs through 18 municipal polyclinics. In 2003 emergency contraception would be added to this basic package.

As for the national program, the main focus was also contraceptive delivery, which in Montevideo would be ensured through MoH-managed health centers and the main public maternity hospital (Pereira Rossell), and in other departments through family doctors. At the same time measures were adopted to ensure that national S&R health norms were drafted in dialogue with civil society actors. In parallel PAHO supported a series of consultations to inform the National Health Plan for Children, Adolescents and Reproductive Health (Plan Nacional de Salud, Ninez, Adolescencia y Salud Reproductiva). However, the performance of the national program was poor as it lacked leadership and was negatively affected by a constant turnover in management. In the year 2000, a new Women’s Comprehensive Health Program (Programa de Salud Integral de la Mujer, SIM) would be launched for the country as a whole through ASSE, the main MoH implementing agency. On 8 March 2001 the MoH launched SIM in Montevideo, where it would be implemented by the External Health Care Services (Servicio de Salud de Asistencia Externa, SSAE), the agency responsible for MoH primary health care. Finally, in 2003 the MoH began drafting S&R health norms and protocols and in 2004 a National Commission on Sexual and Reproductive Health was created, which, among other functions, liaises with the Mercosur Commission on Sexual and Reproductive Health.

In addition, in 2003 a Program for Children, Adolescents and the Family, which includes an Adolescent Sexual and Reproductive Health component, was negotiated directly between the Uruguayan Presidency and the IDB, as part of a wider poverty reduction strategy. In fact, one interesting insight provided by the country report is that in practically all reproductive health policy documents debated or adopted after 1999, a connection is made with poverty reduction strategies. In 2005, after election of a leftist national government, the possibility for substantial transformations in the health system which could create better conditions to deal with S&R Health have been observed.

OUTCOMES

The country report highlights as a positive outcome the fact that a more comprehensive program framework was in place which included access to contraceptive methods through the public health system. By 2003, these services were available in all Montevideo polyclinics. In late 2002 a survey conducted by Women and Health in Uruguay (Mujer y Salud en Uruguay, MYSU) identified fifty health units across the country that were following the new comprehensive guidelines, even if the scope of services provided varied somewhat.

On the other hand, the report also lists certain limitations, including the following:

- One main policy gap relates to the fact that the private sector and the IAMCs do not always include contraceptive provision in their packages. Given that these networks cover an important percentage of the population, the national policy framework should include measures to ensure that these specific services are offered through these schemes.
- Policy design often lacks analysis of inequalities and discrimination based on gender, race and ethnicity, and sexual orientation. Public health interventions usually homogenize users in “broad categories”, an approach that often fails to respond to specific needs. Since programs on the whole also lack clarity with respect to gender and health, very frequently gender is translated as a focus on women, or simply as sex-based differentials.
- Lastly, the report observes that while the links made between S&R health and poverty in recent official documents has opened up a window of opportunity for a more consistent articulation between these two agendas, a rights perspective is entirely absent from these frameworks. The
main arguments behind them easily fall into using women and young people as a means to other ends, instead of emphasizing their entitlements as citizens.

The last monitoring effort performed by women’s organizations engaged in sexual and reproductive health and rights advocacy (CNS, 2006) shows a slow but progressive advance in terms of sexual and reproductive health policies, which reflects, for instance, in the creation of a National Program on Women’s Health and Gender in the Ministry of Public Health, and the implementation of the National Sexual and Reproductive Health Program. Another sign of progress is that the national sexual and reproductive health program now incorporates non-traditional program components, such as gender-based violence and masculinity. However, as it has been previously mentioned the program only covers the population of the Montevideo metropolitan area and the various protocols elaborated by MoH have not been effectively disseminated across the public health system and other relevant public and private health care institutions.

Abortion Legal Reform: An illustration of persistency

In Latin America, Uruguay provides a key illustration of how abortion reform campaigns can be sustained in time. Though between 1934 and 1938, under the dictatorship of Gabriel Terra, abortion was legal in the country, the penal law No. 9763, which is still in place today, condemns women who undergo abortions and the person who performs the procedure, even when there are extenuating circumstances. A first bill aimed at decriminalizing abortion was presented to Congress in 1985, which was the same year that the country completed its return to full democracy. In the 1990s, other bills would reach the House of Representatives, which, however, never went beyond being studied by the parliamentary committees.

In 2001, however, data on the increase rates of abortion-related deaths triggered a new wave of public debates on unsafe abortion. A new round of parliamentary debates started and this led to the drafting of the Bill for the Protection of Reproductive Health, which addressed sexuality education, access to family planning and new measures aimed at reducing unsafe abortion-related maternal mortality, among them the principle that all women have the right to decide about termination in the course of the first twelve weeks of pregnancy. The criteria allowing for abortion require that women state to the physician that the circumstances deriving from the conditions under which they got pregnant, or economic, social, family, age or other constraints limit their possibilities of taking the pregnancy to term.

The House of Representatives approved the bill without on 10 December 2002. During 2003, the Senate Committee on Health examined the bill but could not reach a consensus that would allow the text to be sanctioned without going to a vote and the provision was sent to the plenary early in 2004. At that point the growing social mobilization in support of the bill had created an extremely favorable environment for its approval: a public opinion poll performed in March that year concluded that 63 per cent of Uruguayans approved of the new proposed law. Despite the evident support within society, in the Senate the bill was defeated by four votes (17 votes against and 13 in favor of the law). Public debate and policy initiatives would, however, continue. In 2004, health professionals that had been directly engaged in the legal reform started pressuring the Minister of Public Health Protocol to adopt a protocol aimed at reducing the harm of unsafe abortion, which requires doctors to properly counsel women who resort to clandestine abortion in respect to risks, prophylactic measures and adequate follow-up. Between 2006 and June 2007, roughly 3,500 women have been counseled and abortion-related mortality has been reduced.

In October, 2004 the leftwing Frente Amplio candidate Tabaré Vásquez, a respected cancer specialist, was elected in the first round of the presidential elections and many expectations existed that the bill would be soon re-tabled. But in early 2005, even before the presidential inauguration, he publicly declared that if the bill were re-presented and passed, he would veto the law. Even when this was a watershed, the political debate did not vanish and since then systematic pressure has been exerted over progressive Parliamentarians and the president himself. As the executive response to this pressure has been far from positive, feminists and their allies have continuously re-defined their public campaign strategies. In early 2007, a women was condemned for having resorted to a clandestine abortion and this enhanced a new campaign of solidarity in which other women who have aborted publicly declare they have done so as to make evident the hypocrisy and class biases of the existing punitive legislation.
Sexual and Reproductive Health Policies and Health Sector Reform: More Disjunction than Connections

As seen in the previous sections the evolution of health sector reform and sexual and reproductive policies in the five countries examined in this paper took place during the same time frame. However, as shown in Box 2, in Argentina, Chile and Mexico, development of health reform processes and the sexual reproductive health agendas were completely dissociated, when not openly in conflict. This dissociation can be attributed to the fact that in both institutional and societal terms, health reform and sexual and reproductive health and rights constitute distinct fields, which are informed by different disciplinary parameters and involve different set of actors. The policy trajectory in the five countries examined here suggests that this dissociation reflects deeper distinctions in what concerns policy formation and guiding paradigms.

The best illustration is the trajectory through which policies have emerged and been legitimized in each situation. Sexual and reproductive health policy agendas evolved out of civil society mobilization that in most cases was fueled by democratization. In contrast, the paradigm informing the health reform process in Chile, Argentina and Mexico, was top-down and technocratically driven. The same applies to Uruguay, even when the effects are not so visible because the reform has not really taken off. In addition, sexual and reproductive health policy agendas are and remain strongly rights-based, and work on expanding the policy agenda beyond maternal health and family planning (abortion, cervical cancer, adolescent health, etc). In contrast, health sector reform guidelines and processes tend to systematically draw back the policy agenda towards conventional MCH approaches that are more easily measured in epidemiological terms, such as the DALY indicators. Consequently, although in theory HSR processes appear to offer a window of opportunity to enhance the S&R H&R agenda, the construction of positive linkages between these two agendas depended on a wide variety of factors and required much more than semantic convergence between policy documents and the promotion of cross-sector dialogue. Existing literature on the subject provides some insights into other relevant factors.

Brazil is one exception, as both the health reform process and the women’s health agenda originally evolved during civil society struggles. In addition the SUS has a built-in structure for popular participation (health councils at all levels), which has, somehow, sustained this vitality throughout the years. Even so, some elements of the 1990’s reform model have been incorporated into SUS planning and management, in particular the emphasis on primary health care provided by the Family Health Program (PSD) and focalization on the poorer sectors. What tends to prevail in regards to these strategies is the conventional MCH approach and not the renewed sexual and reproductive health agenda.
### Box 2 Health Sector reforms and Sexual and Reproductive Health Policies

<table>
<thead>
<tr>
<th>Country</th>
<th><strong>Main Features</strong></th>
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<tbody>
<tr>
<td><strong>Argentina</strong></td>
<td>Though developing at the same time, the S&amp;R H&amp;R agenda and the HSR process have been independent until very recently. While the first was mainly “political” – centered on the struggle for support for reproductive health legislation in Parliament and within society – the second has been silent, technocratic and top-down. The privatizing nature of the reform had clearly detrimental effects on women’s reproductive health. However, following the 2001-2003 crisis new possibilities began to open up for greater dialogue and connections between the two policy agendas.</td>
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<tr>
<td><strong>Brazil</strong></td>
<td>The health reform and the women’s health agenda were part of the same broad agenda of social transformation in the 1980s. The 1984 Women’s Health Program was an early experiment with integration of services, prevention and care. The development of the Brazilian HIV-AIDS Program is closely linked to the nature of the SUS as a publicly funded universal health system. From 1998 onwards women’s health policy items have been increasingly incorporated into the SUS’ global strategic guidelines. However, this does not automatically resolve the problems deriving from decentralization or the integration of S&amp;R health issues in primary health programs that have recently expanded.</td>
</tr>
<tr>
<td><strong>Chile</strong></td>
<td>The Chilean 1980’s health reform is the icon of neoliberal model of reforms in the region. When, in the late 1980 and early 1990’s, sexual and reproductive health and rights issues gained visibility, the reform was fully mature and democratization created the possibility of a gender critique of the impacts of reform. The analyses that ensued became main references in the regional debates. However, as it has been seen, conservatism remained major obstacle in the advancement of S&amp;R H&amp;R policies and as a result the gender critique of the Chilean reform concentrates on other aspects of the policy framework.</td>
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<tr>
<td><strong>Uruguay</strong></td>
<td>Given the nature of the HSR process – silent and gradual – the advocacy work performed by the S&amp;R H&amp;R community was critical in increasing visibility of S&amp;R health policies, not as a technocratic agenda, but as a citizenship rights issue. In 2002-2004, the impact of the economic crisis in terms of higher fertility rates among adolescents and abortion-related maternal mortality became increasingly visible. In other words, reproductive health issues appeared to be linked to poverty and economic issues. This opened new windows of opportunity to link the two agendas more consistently.</td>
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<tr>
<td><strong>Mexico</strong></td>
<td>The ICPD and Beijing coincided with the beginning of the second phase of HSR. This allowed some dialogue across the two processes and allowed for community involvement although the directions of each policy domain were not exactly convergent. The reform retained the constitutional definition of health as a right, which is consistent with the ICPD rights-based approach. Other common conceptual links between the two agendas are equity principles, the need for a better integration of services and the emphasis on primary care. However, there are limitations in respect to the basic package model, as it abandons the universal comprehensive rights-based approach to health. Moreover, the positive synergy between the two agendas diminished from 2000 on under the Fox administration, when a narrower maternal mortality reduction strategy was adopted, based on a more traditional MCH approach.</td>
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The Brazilian experience in regard to participation is worth looking at more closely because, as mentioned before, another important element of the 1990’s reformed health reform is the emphasis on participatory approaches advanced by the 1993 World Bank Report. At present all reform
packages include “participatory structures”, though their format varies from situation to situation. Although it has not been possible to examine in depth the implications of this trend, in practically all the countries studied, mention has been made of regional or local-level health councils and, in Africa of “revolving fund schemes”. However, in very few cases are these new participatory structures highlighted as a key platform from which to advance further the S&R H&R agendas. One positive example comes once again from Brazil, (which, however, constitutes an anomalous HSR model). Overall, however, it appears fair to say that the existence, per se, of participatory structures does not automatically ensure that a progressive vision of S&R health issues is incorporated in health sector planning and priorities. The DAWN (2000) study of Brazil suggested that for that to happen many other elements must be in place, such as: sufficient density of women’s organizations, sensitization of other actors participating in health councils about gender and SRHR issues and also health managers that are committed to these agendas.

Another key element to be addressed in relation to this policy intersection concerns the new financial logic of the “reformed” reform packages. Second, with the increasing feminization of poverty, greater reliance of the health care system on out-of-pocket payments, which are regressive in nature and reduce access of the poor to health services, disproportionately punishes women. Third, the national health insurance benefits package discriminates against the reproductive health needs of women since it does not cover basic reproductive health care, such as normal deliveries. Furthermore, many women work in the informal sector and do not have access even to this limited form of insurance. All this indicates that devolution was not accompanied by supportive policies, such as legislated cost-sharing schemes between central and local government, development of regulatory and financing policies for moderating reliance on out-of-pocket payments, and development of health benefit schemes protecting the vulnerable through risk-pooling mechanisms.

In Latin America, an extremely valuable contribution to this specific area of debate is provided by Almeida (2004), who closely examined the “mother and child basic insurances packages.” She is also rather skeptical about their potential as a strong basis for expanding comprehensive S&R health policies: “The mother and child basic health insurance schemes do not fulfill minimal requirements to be considered a form of social insurance. They are more precisely subsidies that support a basic health package aimed at mitigating the effects of poverty and the lack of coverage by wider social policies. A basic package of medical interventions can be an efficient programmatic tool in countries experiencing great deficits in terms of health care coverage (such as Bolivia and some Argentinean provinces). However the lack of connections between the basic package funded services and the health system at large, in particular the units providing more complex level of care….make them valid for short term policy intervention but not as an effective form of long term social insurance. Moreover the sources of financing of basic packages are not sustainable in the long run. To summarize, basic packages must necessarily be combined with structural mechanisms that would require additional efforts in terms of both health and macroeconomic policies.”

V. PLANS AND PROGRAMS TO COMBAT POVERTY IN LATIN AMERICA

The study of poverty from a gender perspective has gained importance since the 1990s. Studies within this framework “examine gender differences in the poverty-generating results and processes, particularly focusing on the experiences of women and asking whether they form a disproportionate
and growing contingent among the poor. This emphasis implies a perspective that highlights two forms of asymmetries that become intersected: gender and class.  

The studies that confirm gender inequalities, particularly in access to and fulfillment of basic needs, support the claim that “female poverty cannot be comprised under the same conceptual approach as male poverty.”

Since the end of the 1990s social protection programs aimed at the poorest members of the population were initiated in several countries of Latin America. In this study we will focus on income transfer programs and the relationship between these programs and health.

The objective of these programs is the provision of support for families so that they can improve their living conditions and exit the cycle of poverty and/or overcome a severe short-term income crisis situation. In addition to these social protection objectives, such programs promote investment in human capital by making support conditional. Beneficiaries must take responsibility for children’s attendance at school and/or access to health services for specific interventions. In some cases where the programs emerged in the context of deep economic crisis, the transfer is linked to some labor commitment on the part of the beneficiaries. These programs benefit large numbers of the population, particularly in the case of Opportunities (Oportunidades - previously Progresa) of Mexico, Family Bag (Bolsa Familia) of Brazil and Female and Male Heads of Households (Jefas y Jefes de Hogar), in Argentina.

Several countries in Latin America have developed these types of program.

- Brazil: Family Grant and Zero Hunger (Fome Zero), initiated in 2003 and preceded by School Grant (Bolsa Escola) in 2001 and Food Bag (Bolsa Alimentação) in 2000, as well as PETI in 1998.
- Ecuador: Human Development Bond (Bono de Desarrollo Humano), initiated in 2003;
- Argentina: Female and Male Heads of Households (Jefes y Jefas de Hogar), initiated in 2001;
- Colombia: Families in Action (Familias en Acción), initiated in 2001;
- Mexico: Opportunities (Oportunidades), initiated in 1997;
- Chile: Solidarity Chile (Chile Solidario) initiated in 2002;
- Bolivia: Emergency Employment Plan (Plan de Empleo de Emergencia), initiated in 2001;
- Nicaragua: Social Protection Network (Red de Protección Social) initiated in 2000;
- Uruguay: the last country to initiate such a program with the National Plan of Social Emergency Assistance (Plan Nacional de Atención a la Emergencia Social) in 2005.

These programs have the following characteristics in common:

- They are subsidy programs that operate through direct monetary transfer for families to improve their levels of consumption.
- They define as their goals: poverty alleviation and investment in human capital.
- Most programs are of a conditional nature and incorporate an educational component as well as a health and nutrition component.
- Input from national economies is moderate, not exceeding 0.35% of GDP.
- They specifically focus on poor or extremely poor sectors.

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24 Ibid.
Women are usually the recipients of transfers either because this is stipulated in the program’s rules of operation or simply because this is what happens in practice.

They claim to be different from previous transfer programs in that the beneficiaries of these current programs have to take responsibility for fulfilling an agreement or contract with the program.

Several of these programs declare that they operate within logic of rights: the right to social insertion.

These programs are financed, or supported and encouraged, by multilateral financial institutions, which play a strong supporting role in their design, operation and evaluation.

Gender impact of antipoverty programs

Transfer recipients are usually women, either because the programs so specify in their rules or because this is simply what happens in practice. This implies that women are the ones in the household who request, manage and receive benefits. Although some authors and actors emphasize that these programs empower women by making them the main administrators of the income transfer, from another angle it can also be said that these resources are not aimed at women themselves but rather to them as mothers and caregivers of the household. This means that women continue to be intermediaries between the State and households to ensure social well being, or to say differently, they are the main actresses in the “social organization of care”. As it is well known, this has repercussions for their use of time, and may generate an overload of work, stress and responsibility and negatively impact on their health.

In some countries, such as in Argentina, a greater proportion of women beneficiaries are required to work as compensation than men. At the same time potential work for women is associated with reproductive tasks. There can also be unexpected negative effects. In some cases men stop contributing to the household when they perceive that additional resources are available. (Serrano, 2005).

Evaluations that have been undertaken indicate positive effects on access to education and support to families for their daily needs, but it is not very clear what have been their impacts in respect to the reduction of women’s poverty, per se, and opportunities created for these women to evade the cycle of economic exclusion and discrimination. These programs fail to combine protection and well-being, and remain limited to assistance for the poorest members of society without addressing key issues of development such as citizenship, empowerment and capacity building. They do not take into account the social division of responsibilities for the construction of a society with higher levels of equity; on the contrary, they propose focalized protection dynamics, which do not involve solidarity criteria at a social level. They trust in their investment in human capital, which has demonstrated its limitations when applied on the basis of linear assumptions. They also fail to intervene in, or mobilize for, policy-making aspects of poverty.

Conceptually such programs are criticized for associating rights, which are a matter of citizenship, with access to social services. They are also said to have design and management defects that inhibit the possibility for linkage with socio-community dynamics in the locality where beneficiaries live. In addition, the programs do not intervene in the supply of education and health services but only in the demand for them, which raises the question of the quality of social services and could create a vicious cycle of poor services for the poor.

From a gender perspective, these programs should work to create greater equity in the division of labor and access to power, by promoting social responsibility for reproduction and a social
organization of health care which does not overburden women. Greater weight must be placed on the integration of gender equity policies, antipoverty policies and employment policies, with the aim of introducing measures that strengthen the productive role of women without neglecting the necessary supports which make these activities compatible with the reproductive sphere. Daeren (2004) highlights the need to investigate opportunities available to women who are not targeted by such programs, are not mothers, are not of reproductive age or are part of a non traditional family.

The legitimacy and ground gained by income transfer programs in the regional social policy agenda raises few concerns of which the more critical are listed below.

- First foremost these programs fail to combine protection and well-being. They remain on a threshold in terms of assisting the poorest and do not incorporate other key dimensions of social and human development such as citizenship, empowerment and capacity building.
- Secondly, they do not pay enough attention to the necessary share of responsibilities in the society at large to ensure higher levels of social and economic equity, but instead they propose a limited and focalized state financed protection, which does not involve solidarity criteria at a broader societal level.
- Thirdly, they are informed by a conceptual framework that attributes great benefits to increased investment in social capital. This frameworks is fundamentally based on the assumption that disenfranchised social position deriving from birth can be easily broken by education or training, a hypothesis that has been contested, by a variety of authors.
- Fourthly, because they associate rights, which is an issue of citizenship, with access to social services, which is an issue of population coverage.
- Last but not least they present design and management caveats. On the one hand, they may inhibit connections between assisted households and the surrounding communitarian and social dynamics. On the other, they do not always consistently link with other social policies and the social protection system as they has promised.

**The health, gender poverty nexus**

The links between poverty and health when examined through the lens of gender is most clearly seen in terms of overwork, hazardous work and poor nutrition as well as mental illness, vulnerability to violence and stigmatization due to health problems. Nutrition is a key area where the combined effects of gender inequality and poverty produce ill-health for women and girls, including transmission of that ill health by undernourishment or overwork of pregnant or lactating women. Additionally, certain health conditions can lead to the social exclusion of women, and their subsequent decent into poverty. Therefore, it is important to recognize that women’s health problems and access to health care are affected not only by poverty, but also by gender inequality.

Studies suggest that the constraints of poverty and gender mean that it is poor women (and girls) who are least likely to have access to appropriate care and to seek adequate treatment. The range of factors which limit access for poor women include time constraints, intra-household resource allocation and decision-making relating to health care, as well as legal and socio-cultural constraints. Issues of health policy, financing and service delivery also have important gender aspects, particularly in relation to budgetary allocation, the impact of user fees on poor women, and the quality of care.

A gender analysis of health and poverty suggests the need for policies which consider the broad range of women’s health needs, not just reproductive health. Efforts must also be made to ensure that health sector reform strategies do not put extra-heavy burdens on poor women through increased demands on their time or income. Improvements in quality of care, which take into account women’s perceptions and experiences, are necessary in order to increase effectiveness of services.

A range of implications for policy and programmes arise from a gendered perspective on health and poverty:

**Attention to women’s non-reproductive health needs:** poverty lays women vulnerable to a range of health problems, not all associated with reproductive health. Working conditions and poor nutrition increase vulnerability to a range of health problems.

**Non-health sector strategies:** Non-health sector strategies are needed to address socio-economic and legal issues (e.g. legality of abortion, rights of the girl child) which affect gender inequality.

**Primary health care interventions** should assess the costs and benefits of interventions to women, as well as children, with particular attention to women’s time constraints

**Community participation initiatives** must ensure that the perspectives of poor women are included.

**VI. CONCLUSIONS**

The recent health sector policy reforms throughout the region have given rise to intense debate in governments, civil society, and multilateral agencies about the actual and potential effects of these policies on health equity and human development. However, this concern has focused almost exclusively on geographical and income considerations without taking into account the differential impact of these policies on women and men. The absence of this concern in the public debate has translated into a lack of policies to correct the gender inequities associated with these reforms. These inequities cannot be combated with the same measures employed to reduce the gaps between geographic locations and socioeconomic strata.

Certain trends have become evident within much of Latin America. Some have been favorable: vaccination and other interventions have lowered infant mortality; polio has been eradicated from Latin America. Some countries, such as Chile and Cuba, have health indices similar to those registered in the north. But in most of Latin America increased privatization has led to a widening gap in access to quality health care

When health and poverty reduction policies in these five countries are examined through the lens of gender the results are rather paradoxical. On the one hand, positive trends must be acknowledged: the adoption of poverty reduction policies and within that of income transfer programs which directly benefit women as well as the legitimatization of sexual and reproductive health frameworks, despite strong conservative resistance. Additionally, research and policy debates on both health and gender and gender and poverty have expanded and consolidated.

On the other side, however, a series of disjunctions are easily identifiable, such as sheer disconnections between health and poverty reduction policies and most principally a lack of
conceptual clarity and inconsistencies in respect to the gender dimensions and implications of existing policy frameworks.

**The health - poverty disjunction**

Despite the longstanding recognition of a poverty-health link in conceptualization, research and policy debates, the case studies suggest that in reality disconnection and fragmentation prevail in implementation of policies. One clear illustration is Brazil where the historical direction of health reform and recent development of health systems in terms of expansion of primary health care programs is strongly convergent with the overall principles of income transfer programs.

Until today no strong connection has been built across these two macro social policies on which 50 billion Reais (25 billion US$) are spent every year. The Bolsa Escola program of the mid 1990’s was constructed in close connection with educational policy as the transfer was connected to schooling of children under 14. In 2001, another transfer program was created in connection with the health system, but basically aimed at improving the nutritional condition of pregnant women and children (Bolsa Alimentação). This program was never systematically accessed. In 2003, these programs were integrated under the Bolsa Família, which now provides income transfers to roughly 10 million households, contingent on schooling.

The Bolsa Família policy includes a link with health care that encompasses a nutritional component for pregnant and nursing women and children as well as conventional maternal and child care. In addition in many cases the identification of the target population is made by Family Health Program teams. The Ministry of Social development informs that health conditionalities are being fulfilled in 90 percent of cases. However, no consistent study has yet been published that analyzes how exactly Bolsa Família and health care are connected at the ground level. Most importantly a clear disconnection exists between the conventional health components of the income transfer program and the comprehensive sexual and reproductive health frame that characterizes Brazilian policy initiatives since the 1980’s. This disjunction is surprising in many ways as the Brazilian policy scenario theoretically provided a privileged opportunity to devise consistent policy strategies that would connect poverty reduction and sexual reproductive health policies, in a manner consistent with the rights-based approach adopted in ICPD and Beijing. However efforts in that direction have been practically non-existent. If nothing else it is rather ironic to observe that, since late 2002 -- when the recently elected Lula administration announced poverty reduction as its priority-- neo-Malthusian positions have been strongly re-activated in the Brazilian public debate, which systematically call for programs to control the fertility of poor women, in particular teenagers.

Examination of Argentina and Uruguay provide a different perspective to the same issue. In both cases the 2000-2001 crisis created a window of opportunity for sexual and reproductive health agendas. Even so, poverty reduction strategies are being developed on similar principles to health policies, but neither consider gender, not even in sexual and reproductive health policies. Different patterns emerge in Chile and Mexico. In Chile a sustained anti-poverty program that began in the early 1990’s was converted into an income transfer program in 2000. As well, a consistent strategy for maternal mortality reduction has been adopted. It is not clear, however, if these two policies were or not organically connected and more importantly, as relevant as maternal mortality may be, a gender sensitive policy is more than that. In Chile is also critical to recall that while the models to address poverty and maternal mortality evolved positively, the gender biases of the health reform model intensified.
In Mexico, a similar contradiction is found. Broader gender and sexual and reproductive health agendas emerging from Cairo and Beijing contrast with the structural limitations of the more narrow health reform framework and basic packages. In the mid 1990’s efforts were made to link the Cairo and Beijing agendas and the reformed health system. The poverty reduction programs (Progressa and what comes next), had stronger connections with health departments at federal, state and local levels and the national database on fertility expanded to include aspects relating to poverty and gender as well as gender based violence. These positive steps, however, lost ground under the Fox administration when sexual and reproductive policy was reduced to a mother and child approach.

At least two hypotheses may be raised to explain these disjunctions. The first is that the health and poverty policy arenas are very different in terms of the actors involved, conceptual frameworks and disciplinary traditions. It is challenging to correlate such distinct policy domains. Additionally, the competition for resources in different policy areas is intensified under conditions of fiscal stringency. The second hypothesis is that the difficulty of conceptualizing and implementing comprehensive policy frameworks encompassing health – including gender aspects and sexual and reproductive health – is also related to “focalization” and selectivity policies adopted in recent years.

**Gender Equity**

Gender equity demands that health resources and services are allocated and received according to the needs of each sex and are paid for according to each individual’s economic ability without reference to differing gender related risk assessments. In most countries of the region the percentage of women affiliated to the social security system is much lower than that of men; Costa Rica and Uruguay are exceptions where the situation is reversed, but even so there are more subtle inequities.

Gender inequity has causes both external and internal to the health system. Women suffer the following discriminations:

- more than 50 percent of women are not part of the paid labor force;
- they have a higher unemployment rate than men;
- a majority of them work in low paid jobs or receive less pay for the same work and consequently have less ability to pay private health insurance premiums or out-of-pocket expenses and so have access to lower quality health plans than men;
- as heads of households they suffer greater incidences of poverty,
- complications during pregnancy, birth and the postnatal period are more frequent in groups that live in conditions of poverty;
- they are over-represented in jobs that do not provide social protection, such as informal or domestic work.

Amongst causes internal to the health system are:

- direct access to health social security for women is affected by the discontinuity caused by pregnancy and child rearing, which often forces women to leave the work force and thus lose their sickness insurance coverage.
- women frequently have indirect coverage as dependents of men who have insurance; however they can lose this in the event of widowhood, abandonment or separation.
- in many countries, social security only provides maternity coverage to insured women, or, in the case of the partner of insured man coverage is limited to maternity care, without provision of healthcare for illness.
• private insurance and service companies usually discriminate against women of fertile age because of their higher costs of medical care that they need (due to maternity and certain typical pathologies) by excluding coverage of those services or charging higher premiums to compensate for such costs
• user fees in the public subsystem affect poor or low income women more because they use these services more for themselves and their children.

Policies for gender inequity reduction must relate to the causes, whatever the nature of the health system.

In regard to the external causes it is necessary:
• to promote productive and stable jobs for women;
• to invest more in their training both at national level and in the corporate sphere;
• to rigorously apply the principle of equal pay for equal work;
• to require that companies of a certain size provide day-nurseries
• to establish a fiscally subsidized low fee public program of day-nurseries.

In regard to inequity causes internal to the health system, the following measures are recommended:
• that social security requirements are extended to cover those types of employment principally engaged in by women, such as domestic service, informal self-employed work, etc.;
• guarantee that maternity coverage continues during periods of unemployment;
• allow the reduction of pre-natal maternity leave and the extension of post-natal leave to give mothers more time to take care of their newborn babies;
• in countries where the wife or partner of an insured man only receives maternity coverage and not sickness coverage, the latter should be made available to her in exactly the same form as it is available to the man (and equally, a husband or partner dependent on an insured woman should have the same sickness coverage);
• provide optional coverage for homemakers (“housewives”) as is already done in some countries by providing a fiscal subsidy incentive to low income groups;
• allocate more health resources to women than to men
• invest more in prevention and make the provision of a basic package obligatory in the entire health system (public, social security and private) taking into account the needs of women;
• prohibit the gender discrimination by private insurance companies;
• make a collective determination of premiums, compensating for higher risk women through transfers from men and from women who have passed the fertile age. For this purpose a compensation fund could be created.

Many of the previously mentioned measures would have a strong positive impact on inequity reduction.

In terms of gender equity policies it is clear that the greatest differences by sex in the use of services occurs during the reproductive years, which is exactly when non solidarity insurance plans discriminate most against women. The immediate consequence of this actuarial logic is that costs for the social function of reproduction fall principally on women, an increasing proportion of whom do not have a partner to share them with. The higher expenditure on health that accompanies a greater use of services during the reproductive years is an inequality that infringes on the principles of equity in the division of financial expenditure. This is made even worse when the lower purchasing power of women as a group is taken into account.
The evidence presented in this article clearly shows that in order to achieve the objective of service access equity a greater understanding of gender needs in the provision of health services is required.
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