



## Initiative for sexual and reproductive rights in health sector reforms: Latin America<sup>1</sup>

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## Decentralization and Sexual and Reproductive Health in Latin America

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## **Decentralization and Sexual and Reproductive Health in Latin America**

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### **1. Introduction**

A series of reforms have taken place during the last fifteen years in the health care systems of Latin American and Caribbean nations. These reform movements, which had different goals, became one of the main tools of decentralization processes. In some nations the decentralization process meant a transfer of political power from the national government to the provincial, state or municipal ones, while in others the reform aimed at a more efficient allocation of resources. A third approach, related to the previous one, the goal of decentralization was the search for more precise monitoring and evaluation mechanisms, to increase the control and accountability of the resource allocation process. Finally, decentralization provides an alternative view for local development by promoting local capacities and the empowering specific populations or racial, linguistic, etc. minorities.

The purpose of this paper is to analyze, based on indexed and gray literature, the effects of decentralization processes in Latin America and the Caribbean and their impact on SRH.

Despite the lack of decentralization promoting reforms focused exclusively on sexual and reproductive health, this paper will attempt to establish the associations the reform processes on this specific field have had.

This chapter begins by presenting a conceptual framework of the traditional objectives of a decentralization process and the problems it faces in the Latin American context. In the second section, the different alternative types of decentralization processes carried out in the region are discussed and the probable effects of a decentralization reform on SRH are presented. In the next section, the available regional literature connecting both processes: SRH and decentralization is discussed. In the fourth section, the conclusions on the collected material are presented, and a work agenda to further study this phenomenon in the Latin American region is suggested.

Generally speaking, the decentralization process seems to have adopted different shapes in the countries of this region according to their unitary or federal political origin. Also, we conclude that though the process has promoted a greater distribution of power within the governmental structure of a nation, this has not translated into achievements in health outcomes, especially in SRH. The

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financing mechanisms of decentralization processes lacked well-defined objectives, and in many cases they became mere structures for deconcentration of functions. As regards equity and sustainability, there is not a correlation between theoretical objectives and the effects on health and SRH outcomes in the documented experiences.

## **2. Conceptual framework**

In general, the objectives of a decentralization process are related to some of the following factors:

- 1) Greater proximity between the decision-makers and the population specific needs. A central resource allocation structure is supposed to be at disadvantage to find out the local needs, therefore, a greater contact between the health system's managers, the decision-makers and the community (potentially beneficiary) is needed.
- 2) The decentralization process is related to the participation of the community when defining priorities. From this perspective, the community not only benefits from the allocation of resources, but it also takes part in the definition of objectives on which public health funds are invested. It also defines priorities according to the availability of financial resources. The so-called "participatory budgets" are an example of a decentralization process with community participation.
- 3) The ultimate goal of decentralization is to unite the two previously mentioned factors so as to promote a better social control of expenses by the community and local representatives. Even though this aspect should be considered a part of any reform, be it in the health sector or any other social investment sector, it is generally relegated to a later instance. The follow-up and assessment of defined goals process is also a part, and the lack of monitoring many times makes it impossible to document the scope of the reform, adversely affecting the alternative mechanisms it generates.

Even though these objectives –proximity, participation and social accountability- are the key factors to encourage a reform based on the decentralization of the health sector, the case analysis shows a series of difficulties found when implementing this kind of objectives. These difficulties are related to the following six aspects:

- 1) Problems in power distribution: the decentralization process, as it has been mentioned before, distributes political power from the central authority to the local governments. However, some limitations can be found in such delegation of power. In most cases the decentralization process becomes a tool for the deconcentration of those functions not necessarily associated with policy formulation, thus having an adverse effect on some of the objectives previously presented.
- 2) Problems in the operation scale: the decentralization process produces a rearrangement in the bureaucracy in charge of implementing the policies. This results in an increase, at least at the beginning, in the cost of managing the reform processes which many times is not related to a more efficient use of the decentralized resources.
- 3) Problems in the management of funds: The decentralization process requires the intensive use of resources generally scarce in developing countries: human resources trained to manage funds at the local level. In many cases, the lack of qualified human resources reduces the effectiveness of the resources allocated, generating a learning process with negative effects on the community in which the reform is applied. Therefore, in many cases, prior to the decentralization process, it is

necessary to promote training mechanisms so as to improve the skills of the personnel in charge of the implementation.

- 4) Equity Problems: decentralization processes need inter-jurisdictional mechanisms of resource allocation so as to avoid perpetuating existing inequity gaps. The lack of clear allocation criteria may attempt on the ultimate purpose of decentralization, crystallizing inequities at the time of the reform.
- 5) Problems related to health systems segmentation: the segmentation of the Latin American health services financing systems become an additional problem for the decentralization process. The lack of unified or coordinated funds for resource allocation on a national level provokes the existence of various funding portfolios, triggering the creation of unwanted crossed subsidies between sub-sectors. The decentralizing program should take into consideration the existence of these mechanisms in order to minimize them, while taking advantage of the installed capacities and resources in each of them.
- 6) Coordination problems among the different levels: a decentralization process also requires coordination between superior and inferior levels of implementation. The existence of a decentralization process does not necessarily determine the lack of functions in fund allocation or provision carried out by the central Ministry of Health. Therefore, it is necessary to coordinate the policies designed and implemented at a local level, and the implementation of vertical programmes, so as to avoid duplicating efforts.

### **Forms of Decentralization**

Decentralization mechanisms in the Latin American region vary according to two aspects: the political characteristics of the country in which the reform is implemented, and the way in which decentralization was applied.

The first one has to do with the existence of two typical State organization structures in the region. One of these structures, shared by most of the Latin American nations, is the unitary system, in which the central government is elected by vote and in turn establishes mechanisms to delegate functions to inferior levels. The region's three larger nations have a federal system: Brazil, Mexico and Argentina. In these countries, each jurisdiction (provinces or states) has its own sovereign power and establishes decision-making mechanisms not related to a delegation from the central power. The existence of these two alternative mechanisms makes the decentralization process have different profiles as to the political point of view. In the presence of a decentralization process, a unitary country requires a normative and institutional background for decision-making already in existence in a federal country. Also, each nation has idiosyncratic characteristics which have taken the decentralization process in the health sector through different paths.

Within the structure of constitutionally unitary nations, as in Bolivia, the Dominican Republic and Chile, the decentralization process for the financing and provision of health services has adopted different roles. In Chile, this process has tried to deconcentrate functions towards regional and municipal structures. The objectives and the implementation strategies are coordinated at the national level. This coordination allows for a delegation of functions, and in some cases the

management of budgets by authorities in lower governmental levels. A similar structure, although with less autonomy as regards decision-making, can be seen in the Dominican Republic provincial health units. In contrast, Colombia's decentralization combines a redefinition of the social health insurance system structure with geographical decentralization. The Colombian model reorganizes resource allocation and decision-making mechanisms. Nowadays, the Colombian departments have greater responsibility and autonomy than Chile or the Dominican Republic in the definition and implementation of the local health strategy.

Bolivia is a special case of decentralization into social sectors within a unitary nation. In 1994, the institutional framework was redefined, allowing the direct election of municipal mayors. From then on, a political decentralization process was promoted, related, although in a limited way, to budget distribution to the prefectures and municipalities. However, and parallel to the implementation of this decentralization/ deconcentration process, a novel social insurance structure was created -the Maternal and Child Insurance - with great financial support from the national government. Its implementation required the coordinated participation of the new decentralized authorities as well as the concurrence of the social security system.

In contrast, the decentralization health reforms implemented in federal countries such as Brazil or Argentina, originally had power distribution mechanisms at the state and provincial level. However, the reforms took place in different contexts, with alternative mechanisms for the definition of policies and resource allocation.

In the Brazilian case, decentralization is part of a wider process which includes the creation of the *Seguro Unico de Salud* (Unique Health System) (SUS), a universal insurance mechanism. The funds allocated by the nation to the state and municipal governments are assigned by per capita payments on the basis of a basic care package (BAP). Thus, the decentralization process leads to the definition of a basic objective for a mandatory health package in which the implementation strategies at the local level are established.

Alternatively, in the case of Argentina, the allocation of resources is carried out by means of federal co-participation mechanisms not related to specific health sector objectives. Once the funds per province are established by using mechanisms of tax co-participation, each jurisdiction defines its budget priorities per area and in the health sector. Provincial activities are coordinated by a Federal Health Council.

When considering not only the initial political differences between unitary and federal nations, but also the resource allocation strategies and the definition of public health programs, it is clear that there is a great diversity in the application of decentralization policies within the Latin American region. This will obviously influence the impact of the reform on the sector's outcomes and the effectiveness of the health care strategies in sexual and reproductive health.

### **Effects on sexual and reproductive health**

Decentralization reforms have two kinds of impact on sexual and reproductive health. The first is the direct effect on the how service is provided and how this is facilitated by local decision making mechanisms. The second is an indirect effect: how decentralization, seen as an alternative

dynamic of resource allocation, impacts on health services in general, and influences sexual and reproductive health interventions.

From the first point of view, decentralization allows for better orientation of expenditures, having a greater impact on sexual and reproductive services at the local level. Also, the decentralization process may become a useful tool for identifying specific vulnerable groups for whom standardized SRH policies do not work. Racial, cultural and even linguistic limitations may hinder the access of relegated groups. Finally, decentralization by means of political participation and power distribution mechanisms would result in a greater debate, making the community and its leaders sensible about particular aspects of sexual and reproductive health. This could create opportunities for the participation of interest groups, and even install certain issues in the local debate that would otherwise have no impact on the national level. Also, decentralization seen from this point of view may become a school for local networks to develop negotiation and action skills.

As regards the indirect effects or spillover of decentralization on sexual and reproductive health, two aspects can be identified: the first one is the need to establish coordinating structures between crossed vertical programs and local initiatives. As stated in the literature reviewed (Glassman, Levine and Schneidman), coordinating vertical sexual and reproductive health strategies with local initiatives is one of the main challenges for decentralization processes.

The second effect related to the decentralization spillover comes from the financing mechanism of the health model in general. The impact of this kind of reform is strongly associated with the local management capacity and the different distribution of functions at the various governmental spheres. For instance, a basic service package including SRH care and the simultaneous implementation of a decentralization process can have different impacts depending on the follow-up and monitoring of social and health indicator mechanisms used. Obviously, the local management capacity accounts for the great impact of decentralization processes, producing program performance variations from one municipality to another.

### **3. Case analysis of Latin American region**

There is very little Latin American literature on financing and provision of health services decentralization processes, as well as on their impact on sexual and reproductive health. Studies on decentralization usually focus on the advantages and disadvantages of these processes, without presenting the specific characteristics of the countries in which this kind of reforms have been implemented. Moreover, the effects of decentralization on sexual and reproductive health services have rarely been documented. This is basically due to the fact that these reforms were not associated to changes in patterns of health care provision in this particular type of services, but with the incorporation of alternative mechanisms for management decentralization and distribution of the political power between the nation and the jurisdictions.

According to the literature available, decentralization makes management more flexible, it allows adjusting services to the needs of local communities, and it favors community participation promoting democracy in countries historically governed by authoritarian regimes or dictatorships.

Janovsky (1995 - World Health Organization), stated that usually, public participation and greater decentralization are essential parts of the democratization process in the region. The political objectives of decentralization include democracy, popular participation, rendering of accounts, communication between the downtown and the periphery, and support to the electoral system, etc.

According to many studies, decentralization has not increased community participation since the national and local elites do not find it appealing enough to share their power. Scarpaci (1992), based on the experience of the Chilean decentralization process, points out that an authentic decentralization is hardly possible, since it threatens the interests of the dominant classes at the local level. However, Maceira (2001) finds that after the decentralization process carried out in Bolivia there was greater social participation in decision-making and in public function control.

According to Hardee and Smith (2000), there are two reasons for the little evidence on the impact decentralization has on sexual and reproductive health: (a) there are no local level studies, and (b) a substantive period of time is needed before health indicators show the concrete results of decentralization. However, in some cases, such as Argentina, Brazil, Colombia and Bolivia the reform processes were implemented over ten years ago.

Also, there are no systematic mechanisms to evaluate reforms at micro-economical levels that could allow for the identification of decentralization effects, and to isolate them from the macroeconomic and social factors that influence the changes in patterns of use and financing of SRH services. Neither are there systematic mechanisms to evaluate the effects of other reform instruments simultaneously implemented.

In the case of Colombia, González Vélez and Betancourt Zúñiga (2002) identify obstacles to the provision of sexual and reproductive health care and barriers that hinder the access of “related” population (*población vinculada*) to the social health security system. For that purpose they interviewed women between the ages of 15 and 55 at three hospitals with services of first, second and third degree of complexity. All the women belonged to low educated, poor sectors.

The authors found economic, socio-cultural and institutional obstacles in the access to health services. Economic obstacles for the access to health services have to do with this population’s low participation in paid jobs within the formal labor market. Therefore, health becomes an out-of-pocket expenditure that affects the family budget, and it is not considered a priority since other basic needs are not usually covered. This situation makes it difficult to invest in prevention, and money is spent only in those situations considered to be urgent or critical, limiting the chances of receiving comprehensive care.

As to the socio-cultural obstacles, the authors point out that women from this socioeconomic group are not aware of their condition of citizens entitled to the right to receive health care. This is the result of non-equitable social practices that start at home and have prevented women from “perceiving themselves as individuals with rights”. The third obstacle mentioned in the study has to do with reducing sexual and reproductive health to a mere reproductive function. Care and prevention given to other components of reproductive health (such as family planning), as well as promotion and prevention actions, are usually limited. The lack of specific regulations in the provision of services for the *población vinculada* in Colombia has led hospitals to use their own criteria to fulfill the reproductive health agenda. Therefore, the contribution of decentralization to the improvement of



integral SRH programs is not clear. Nor can it be stated that the condition of the población vinculada fosters accessibility to health services.

According to Glassman, Levine and Schneidman (2001), decentralization can be considered an adequate tool to achieve the active participation of women's representative groups, as in the case of Brazil. According to Oliveira Araújo (1998), the participation of local governments in introducing the gender perspective in women's health governmental policies has been successful. Based on the experience of the Women's Total Health Care Program (*Programa de Cuidado Total de la Salud de la Mujer*) implemented in Sao Paulo between 1989 and 1992, the study emphasizes on the importance of the participation of professionals aware of gender equity and feminist organizations in the definition of sexual and reproductive health strategies.

According to this study, in 1998, and thanks to the pressure exerted by women's groups, the government of Sao Paulo created the Office for Women's Health, a division of the Municipal Health Secretariat. This office coordinates offices or Women's Health Councils formed by women who foster gender perspective. It also created districts of health authorities to implement pioneering programs on issues such as legal abortion (in cases where the woman's life is at risk), assistance to adolescent women victims of abuse and violence, access to information regarding contraception, prevention of childbirth related deaths, and new delivery practices. This resulted in a redistribution of resources, taking gender needs as a priority. However, the study does not show results as to the impact these political and community participation initiatives had on sexual and reproductive health.

Glassman, Levine and Schneidman's (2001) also analyze the case of Chile, where decentralization allowed to better adapt programs to local conditions and to promote the inclusion of innovative intervention forms. Since the municipalization of primary health care in 1980, the maternal program received an impulse through the provision of resources and the expansion of coverage.

In a series of IADB Working Technical Notes (n/d) regional innovative sexual and reproductive health alternatives are analyzed from the initiative of some non governmental groups that help the public sector of decentralized systems. One of the initiatives analyzed is the Warmi program in Bolivia, carried out in Inquisivi, whose main goal to develop and test a community approach aimed at improving maternal-child health in a remote location with very little access to formal and appropriate health services. For that purpose, personnel who spoke the language and knew the cultural rules of the community was hired in the area, and women's groups were organized to discuss their problems. The rest of the community was not excluded from the meetings. In 1993, the project led to a 50% reduction in the detected cases of perinatal and neonatal mortality and to an increase in the number of women seeking prenatal attention. The use of contraceptives among women of reproductive age also increased from 1% to 27%, and the percentage of deliveries attended by health care professionals grew from 13% to 57% in the last year of the project. This initiative shows that decentralization, acting as a problem-focusing and community participation mechanism, can achieve successful results.

Within the health system deconcentration strategies in Jamaica, the Jamaican Women's Center Foundation organized sexual education workshops which offered educational activities on nutrition, prevention of sexually transmitted diseases, individual counseling and family planning together with a program to help adolescent mothers return to school. The success of this program is

shown by the participants' higher rates of school attendance compared to those seen before the implementation of this program.

In Argentina, the impact the decentralization process had on SRH can be analyzed considering: (a) the resource allocation mechanisms, (b) the capacity to coordinate actions with focalized programs, and (c) the participation of the national public sector in a given decentralized health system.

As regards resource allocation mechanisms, Bisang and Cetrángolo (1997) believe that the decentralization processes that took place in Argentina from the end of the '70s to the beginning of the '90s were not motivated by the search for greater equity and efficacy levels; instead, they were greatly influenced by the pressure the national government exerted to modify to its favor the financial relationship with the sub-national states. This determined the absence of coordination mechanisms, the searching for greater efficacy and for policies favoring equity from the national government. Thus, each province had the autonomy to define their own policies, to execute their own programs and to manage their own institutions. As a consequence, each jurisdiction had different degrees of development in their sexual and reproductive health strategies, with dissimilar results in terms of effectiveness and coordination with the social security system. In their analysis of two Argentine jurisdictions, Díaz Muñoz, Maceira and Mercer's (2001) show the results of this. The Maternal-Child Nutrition Program for poor urban population with high poverty rates co-managed by the National Health Ministry and the provincial executing units is a good example of coordination between focalized health care vertical mechanisms on the national level and provincial decentralization,.

Finally, Maceira's study (2002) on decentralization in federal countries shows how, despite the fact that Argentina is a decentralized country, the incidence of the national government on the financing of the health system is very high, with over 40% of the total health expenditure. However, the study shows that the national government does not have strong mechanisms for transferring subsidies to those provinces with high percentages of population with unsatisfied basic needs, nor does it focus its resources towards sexual and reproductive health care. In the national ministry's budget for the year 2000 no more than 2% was allocated to SRH.

#### **4. Conclusions and identification of a research agenda**

The decentralization attempts carried out in Latin America and the Caribbean had different impacts in the countries which implemented them. Most countries found it difficult to transfer financial and political responsibilities from the national level to the local jurisdictions. Decentralization processes also faced logistic problems: functions from the central level were delegated to units that did not have enough trained personal to fulfill them. This resulted in a partial transfer and, in some cases, in the structure recentralization at the intermediate levels located between the central level and municipalities.

Decentralization poses special challenges to the sexual and reproductive health programs traditionally organized in a vertical way, such as maternal-child and family planning programs. In fact, it is common for responsibilities to be transferred to the local level while the organizational structure keeps on working in a vertical way. This makes it difficult to establish priorities at the local level, to

estimate the costs of the program, to secure their financial sustainability, or to adequately operate in terms of quality and technical efficiency.

Despite the very little literature available, there is enough information to assert that decentralization of health services as designed and implemented in Latin America is not an adequate solution to the serious management and administration problems faced by this region.

The analysis of the existing literature suggests the need to further study the region's decentralization processes together with their effect, or at least their coordination with those initiatives that have strategic objectives associated with sexual and reproductive health. Therefore, it is necessary to set a research agenda to fill in the information gaps. The first line of research suggested has to do with the analysis of the information provided by home surveys on the use and financing of health services and the effects of decentralization. Second, we suggest the analysis of specific assessments with reliable methodological criteria showing the impact of decentralization on sexual and reproductive health, given the concomitance between this reform and other health interventions. Also, studies connecting the political conditionality of reproductive health strategic planning and the decentralization reforms should be considered. Finally the problems found by decentralization processes when transferring capabilities and the effects on the management of programs at the local level should be studied.

Last, research promoting international comparisons on the basis of shared basic aspects should be carried out. These basic aspects should be defined by the objectives of the reform, of the implementation strategies and of the different mechanisms used by each one of the reforms. The actors involved and the timing of the reforms also have to be considered for they generate bottlenecks and conflicts of interests associated with the implementation of any public policy. All this information should come together in a matrix of indicators not only describing SRH results, but also making correlations with the implementation of decentralization mechanisms at the regional level.

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