

Reproductive health and health sector reform in developing countries: establishing a framework for dialogue

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Abstract It is not clear how policy-making in the field of reproductive health relates to changes associated with programmes for the reform of the health sector in developing countries. There has been little communication between these two areas, yet policy on reproductive health has to be implemented in the context of structural change. This paper examines factors that limit dialogue between the two areas and proposes the following framework for encouraging it: the identification of policy groups and the development of bases for collaborative links between them; the introduction of a common understanding around relevant policy contexts; reaching agreement on compatible aims relating to reproductive health and health sector change; developing causal links between policy content in reproductive health and health sector change as a basis for evidence-based policy-making; and strengthening policy-making structures, systems, skills, and values.

Keywords Reproductive medicine; Health care reform; Causality; Policy making; Health policy; Communication barriers; Intersectoral cooperation; Financing, Health; Models, Theoretical (*source: MeSH, NLM*).

Mots clés Médecine reproduction; Réforme domaine santé; Causalité; Choix d'une politique; Politique sanitaire; Barrière communication; Coopération intersectorielle; Financement, Santé; Modèle théorique (*source: MeSH, INSERM*).

Palabras clave Medicina reproductiva; Reforma en atención de la salud; Causalidad; Formulación de políticas; Política de salud; Barreras de comunicación; Cooperación intersectorial; Financiamiento de la salud; Modelos teóricos (*fuentes: DeCS, BIREME*).

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Introduction

Since the International Conference on Population and Development (ICPD), held in Cairo in 1994, policies on reproductive health have been increasingly influenced by questions of human rights and decreasingly by demographic considerations. To an ever greater degree, these policies are being implemented in a context of health sector reform promoted by development agencies. There have been significant changes in organization, financing, and resource management in this sector, often as part of broader restructuring and democratization of the public sector.

There has been a marked lack of dialogue on policy-making between the areas of reproductive health and reform of the health sector. Policies in each area have been developed by different actors, pursuing different objectives, through decision-making processes that have rarely coincided. Consequently, disjointed policy-making has tended to predominate. Health ministries typically lack robust and coherent systems of policy formulation and implementation. It is difficult to imagine how effective policies can be created through such a fragmentary

process. Sectoral reform has a fundamental impact on the way in which health packages, including those in the field of reproductive health, are delivered. Furthermore, important lessons can be learnt by people engaged in sectoral reform from achievements in reproductive health care when seen as an approach rather than merely as a set of service activities.

This paper explores the need for communication on policy between the areas of reproductive health and reform of the health sector. Attempts to link them have been made in research projects (1–3) and policy analyses (4, 5), but they have tended to focus on specific components of reproductive health rather than on the process of policy implementation and linkage. Here we chart the ideological developments underlying the two policy areas and identify areas of tension and factors that hinder dialogue on policy. A framework is proposed for enhancing such dialogue and collaboration between the two fields, with reference to links between policy actors, an understanding of policy contexts, the development of common or compatible aims, the use of a policy/research matrix, and the need for institutional strengthening.

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Ideology and debate

Multiple ideologies underpin the current agenda for policy on reproductive health and health sector reform, reflecting diverse actors and policy-making contexts.

Actors and ideologies

Two groups of actors have been particularly notable in defining the debate on reproductive health. Firstly, health and population economists have been concerned with improving the cost-effectiveness of reproductive health services in an increasingly constrained economic environment. They have also been promoting family planning as the spearhead of cost-effective reproductive health programmes and as a means of promoting national economic development in poor countries. This led to the development, by the mid-1980s, of a highly trained cadre of reproductive health specialists including medical clinicians, midwives, and family-planning nurses.

Secondly, women's health movements and nongovernmental organizations became more vociferous during the 1990s, emphasizing the need to move beyond the narrow goals of fertility reduction and embrace broader issues of women's empowerment. The creed of participatory development and much of the original primary health care ideology of the 1970s regained currency. In 1994 the ICPD called for an expanded framework to ensure that policy on reproductive health focused on the client and on democratization. This framework, demanding a change in programmes and policies so that a holistic agenda could be implemented, was largely promoted by a newly globalized coalition of nongovernmental organizations and empowerment groups (6–11).

Subsequent debates concerning policy on reproductive health have ranged widely, although most attention has been concentrated on matters connected with service delivery, e.g. whom to target, whether services should be integrated, and financing mechanisms. This reflects the continuing concern with economic issues, the dominance at national level of donor ideologies (programme-specific focus on family planning, sexually transmitted infections, and safe motherhood), and the frequent sidelining of the voices of nongovernmental organizations at the national policy level (12).

There has also been a shifting of ground in debates on health sector reform. The earlier emphasis on intersectoral activity and community participation had implications for health sector structures. Ideologies were framed and fuelled by the international health organizations, such as WHO and the United Nations Children's Fund. The 1980s saw increasing concern about governance and civil society (13). The health sector responded with growing interest in the role of nongovernmental organizations and in the decentralization of decision-making through the strengthening of district health systems. These responses were spearheaded not by WHO, but by the World Bank, which laid the foundations for the concepts of health sector reform (14). Some actors in the health sector have been alarmed at the apparent usurpation of WHO's leadership and there has been concern about the appropriateness of the reform approach, particularly with regard to equity, sector fragmentation, and loss of policy leadership by health ministries (15–20).

The broad policy and financial leverage of the World Bank makes it particularly influential in shaping health sector reform. However, other groups have also been

involved in bringing reforms based on the market ethos to countries' health policies. These groups have included multilateral and bilateral agencies, national governments, policy think-tanks, consultants, consultancy firms, and academic and related research and development institutions, many of which have trained individuals who are now national players in reform processes. A vision of a limited and decentralized public sector has emerged together with the introduction of market incentives. It is within this context that policies and activities relating to reproductive health are developed and implemented.

Policy contexts and considerations

Processes of reform are also influenced by complex factors related to the environment and policy. The role of "burden of disease" analysis (21) has played a significant part in setting reform agendas, although there has been wide discussion of the limitations of this approach.

Nevertheless, assessments of the epidemiological and demographic situation have not been the principal influence on health sector reform. Contemporary processes of change in the health sector also tend to be driven by ideological, political, and economic forces, which can lead to inconsistencies in policy. For example, the broader policy objectives concerned with better health through democratic devolution and intersectoral activity can conflict with health sector reforms focusing on the financing and delivery of health care. Global economic constraints have encouraged attention to be concentrated on cost-effectiveness. This has contributed to sectoral reform being largely driven by concepts of efficiency associated with a narrow definition of health as the absence of disease. Most governments and donors have developed health policies around this definition. This failure to focus on the broad objectives of health policy has been a key criticism of health sector reform.

The field of reproductive health has, perhaps, been more dominated by epidemiological and demographic concerns about rapid population growth and major health problems associated with high-risk pregnancies and their complications. This led to the specialist clinical focus indicated above. The resource constraints of the 1980s and heavy dependence on donor funding encouraged this approach until the ICPD in 1994 marked a shift in thinking towards integrated programmes.

The predominance of donor inputs for reproductive health policy impedes moves to decentralize decision-making and resource allocation and to integrate component services in this field, particularly those traditionally outside the scope of reproductive health, namely the management of sexually transmitted infections and human immunodeficiency virus. In Ghana, Kenya, and Zambia, for example, units in health ministries found it difficult to agree where responsibilities for technical quality and supervision lay, and integration policies were consequently often piecemeal and ad hoc, with no overriding policy document or goal (1, 2).

National policy environments that remain strongly influenced by international donors who operate on a basis of narrow accountability and efficiency measures do not fit comfortably with the progressive elements of reproductive health (1). It is difficult to measure equity, client-centredness, and the democratization of power, whereas clinical goals and service packages more easily meet the strict management, transparency, and cost-effectiveness requirements of funders.

In practice, much activity in the field of reproductive health following the ICPD has focused on the integration of the management of sexually transmitted infections with family planning and antenatal services (1, 2).

The health sectors and reproductive health programmes of the 1990s thus remained characterized by top-down service implementation, despite general acknowledgement of the need for a holistic approach. The ICPD resulted in a coalition of actors demanding a change in the way reproductive health programmes and policies were implemented (6), on a basis of people's empowerment and community involvement.

Developing a framework for policy dialogue and development

To some extent the constraints on dialogue arise from basic differences between disciplines, i.e. cost-centred efficiency and management-driven systems versus concepts of equitable health for all. They also arise from the differential involvement and acceptance of groups at the level of policy influence, differences in global and national policy-making contexts, and weak institutional frameworks that impede dialogue and linkage. Consequently, health sector reform has tended to be based on a belief in the virtues of markets, user fees and decentralization, in the absence of an assessment of reform against the logic of public health interventions. Similarly, the development of programmes for reproductive health services tends to occur in an isolated fashion, with no understanding of the broader changes in the health sector and the wider public sector.

It is clearly necessary to develop a dialogue and for these constraints to be confronted. In order to achieve this we propose a framework that while not value-free is based on a concern for reproductive health status. The complex and pragmatic nature of policy-making, which is often disjointed and non-linear, should be fully recognized throughout the process of dialogue. Dialogue on policy cannot be based on an assumption of some ideal and rational process of policy formulation and implementation (22). The framework consists of the following sequence of steps.

1. Identification of policy groups and development of collaborative links between them

The first step involves mapping the stakeholders in both policy areas, the history of links or the absence of links between them, the characteristics of the policy groups, and any possible overlap between them (22, 23).

The identification of actors' characteristics allows the recognition of both policy networks and policy communities as different configurations of policy-makers (24). Policy communities tend to be more cohesive and smaller than policy networks. They share values and exchange resources, and there is an internal balance of power between the members. The extent to which policy-making groups exhibit the characteristics of policy communities or networks can affect the potential for interaction between them. This may be particularly so when the internal integration of policy communities is reinforced by strong professional and occupational interests and ideologies, which tend to isolate the policy-makers from wider interaction. In Ghana, for example, changes in policy and management which supported increased mandates and responsibilities of midwives and senior nurses, e.g. in the management of sexually transmitted infections, were difficult to implement because of

strong opposition from doctors which the policy-makers had not taken into account (25, 26).

There is a degree of policy linkage between policy groups. For example, there are those that have sought to restructure reproductive health policies around reproductive health status and through policies of client-centredness, a multisectoral approach, and programme integration. Thus in South Africa, an integrated approach to primary health care encompasses reproductive health (1). There is common ground between this position and that in which an attempt has been made to develop health sector change around the goal of health, as distinct from health services, with a focus on community involvement, equity, and a multisectoral approach. This suggests potential for alliances and for the development of loosely formed policy networks crossing between reproductive health and health sector change. A common example of a policy linkage is provided by social marketing, e.g. of contraceptives in Ghana (1), which encompasses notions of equity, community outreach, and engagement with the private sector for the delivery of services.

There are forums for policy dialogue in many countries. In Ghana, for example, regular national meetings between the donor community operating in the health sector and health ministry officials provide an ideal opportunity to discuss linkages between the policy groups (27). During national consultative meetings for the development of the Safe Motherhood Programme, attempts to create dialogue have involved the inclusion of speakers on health sector reform from the Ministry of Health (28).

2. Introduction of a common understanding around relevant policy contexts

Policies in both areas have developed in contexts of multiple influencing factors. Dialogue between policy-making groups identifying the respective contexts can help to lay the groundwork for more developed collaboration, policy dialogue, and political action. South Africa's intersectoral AIDS policy is an example of what can be achieved when diverse actors come together to identify contexts, plan, and take collective action (1).

It should also be recognized that stakeholders have a subjective understanding of context. Social, economic, and political forces can give different meanings to the same features of the context. The way context is interpreted is not politically neutral but is influenced by power and ideology. For example, user fees comprise one of the most widely implemented and controversial components of health sector reform. There is evidence suggesting that people are willing to pay for better services, and most governments have a policy of cost recovery as part of the reform process. In Senegal and Zambia, however, where integrated packages were developed to promote a more holistic reproductive health service, user fees for a compulsory package of integrated services led to increased costs for consumers and decreased utilization (3). In Mali, on the other hand, a combination of user fees and community insurance for the provision of emergency referral services for obstetric care has proved successful (29).

These varying interpretations can lead to different explanations of policy context and to the development of different and sometimes contradictory policies on reproduc-

tive health and health sector reform. Hence the need for a common understanding.

3. Agreement on a common purpose

Some of the achievements of the South African health sector can be cited in this connection (1). Another example is provided by coordination between staffing reforms and support for the expansion of nurses' roles in reproductive health, for example in Chile, Morocco, Tunisia, and Turkey, where legal frameworks have been developed to allow midwives to deliver services previously carried out by doctors only (29).

Fig. 1 illustrates the key determinants of reproductive health status and indicates where they are affected by components of health sector reform. The following points should be noted. First, reproductive health should lie at the heart of all health-related activities. It is therefore at the centre of the model. However, in many countries there is a tendency to focus on reproductive health services as the goal rather than on reproductive health status and its importance as an approach.

Second, the outer determinants of reproductive health status are viewed at the macro and micro levels. The macro level refers to the complex interrelationship between economic, epidemiological, demographic, social, and political factors. The micro level refers to the more immediate determinants of reproductive health status, in particular: gender-sensitive community empowerment of individuals and families; partnerships between sectors, organizations, and communities; health policies on reproductive health; and service delivery and access through a range of public and

private sector organizations providing a continuum of specialized and integrated services.

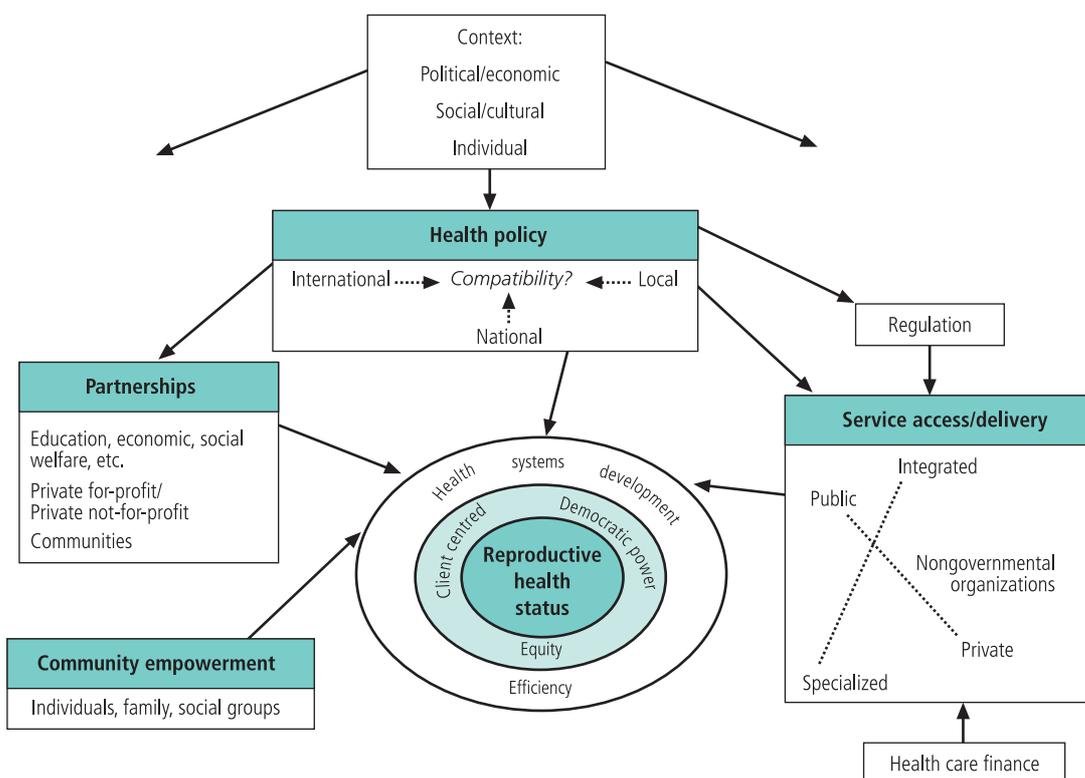
Third, this range of contextual factors influences reproductive health status. The influence is mediated through the process of change in the health system. In Fig.1 this is shown by the outer ring around reproductive health status. The key issue is the compatibility (or common purpose) between the contextual factors affecting reproductive health status and the form of change in the health system.

4. Identification of causal links between policy content in reproductive health and health sector change as a basis for evidence-based policy-making

It is necessary to follow the broad modelling of the de facto linkage between reproductive health and health sector reform (Fig. 1) with the development of a policy and research matrix. The vertical axis of the matrix we have developed shows typical policies on health sector reform and the horizontal axis indicates key elements of policies designed to improve reproductive health: equitable access and delivery, a multi-sectoral approach, community empowerment and programme integration. Each element can be exploded into its key components. The matrix may be used as a basis for developing dialogue between policy networks or as a means of determining research needs. It has been used for the latter purpose in the United Republic of Tanzania by one of the authors (SHM).

Drawing on available case studies, analysts may ask whether there is a relationship between each part of the reproductive health determinants and each of the reform components and whether this has been analysed through research. Research studies providing knowledge on the nature

Fig. 1. Determinants of reproductive health status



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of reform components or their impact on reproductive health can be recorded in the appropriate box. In this way a visual representation can be constructed of the current state of knowledge. There are clear clusters where much is known and others where there appears to be little knowledge.

To illustrate our analysis we consider programme integration (Box 1). The integration of management services for sexually transmitted infections with family planning and maternal and child health services became an issue during the 1990s. However, there is increasing evidence that, for practical reasons, integration may not be as efficacious as was anticipated, either for reducing the incidence of sexually transmitted infections or for enhancing the coverage of reproductive health services (32, 33). An analysis of programme integration by means of the matrix helps to clarify critical issues for consideration and to reveal which have been covered and which have been neglected in the literature.

Box 1 is not intended to be a comprehensive representation, nor are all the examples specifically related to reproductive health. It illustrates research and linkage relating to specific components of health sector reform and specific components of programme integration. Among the research questions and issues generated by the matrix in Box 1 are the following.

What is the impact of increasing the presence of the private sector on programme integration? Mongolia, Nicaragua, Trinidad and Tobago, and an increasing number of other countries are encouraging competition for government contracts for service provision. A public-private mix of service delivery already exists in Brazil, Egypt, and the Philippines (3). The contracting out of discrete activities of service provision (e.g. antenatal care) and support activity (e.g. transport services) to the private sector may lead to an increase in the number of separate organizational units in the field of reproductive health. This fragmentation may result in the separation rather than the integration of programmes. On the other hand, the contractual terms may require programme integration. In Malawi, the Government encourages non-governmental organizations to provide family planning and reproductive health services by offering to subsidize about 15% of the recurrent costs of facilities if the terms of service provision are complied with (29).

Does the separation of funding and service provision promote or impede service integration? The separation between financing and service provision in health care may promote a wider definition of health through a shift away from a provider-led service (34). In Ghana, a nongovernmental organization is contracted to market condoms and other contraceptives through the social marketing initiative (27). Programme integration may well be demanded as a condition for funding by the separate funding body. Conversely, the separate contracting out of programme structures could increase the fragmentation of funding and services.

What is the impact of decentralization on programme integration? The move to a decentralized system of health care may be seen as facilitating the shift away from vertical structures to a more horizontally organized and integrated system of health care. Vertical and top-down programmes are essentially centralized, leading to the proliferation of so-called tall and top-heavy programmes. To the extent that decentralization augments the authority of district level organizations it presents the possibility of programme integration at the field level. Without proper management and capacity

however, decentralization can result in the confusion of responsibilities and the deterioration of services, as was reported in connection with the integration of reproductive health programmes in Ghana, Kenya, and Zambia (2). In Bolivia and the Philippines, decentralization to rural municipalities occurred before they had acquired adequate experience and capacity (3). In both the Philippines and Zambia, the transfer of funds from central to local government was associated with a loss of benefits and changes in salary for health workers, inadequate funding of services, and a deterioration in the quality of care (3). The main reason for this in Zambia was that the technical support system had been dismantled when decentralization occurred (3). Furthermore, there is a general lack of capacity at the local level to manage reproductive health care and there is often a reluctance at the central level to transfer power to the localities (35).

What is the impact of user fees on integrating reproductive health services? The introduction of user fees for some reproductive health services might lead to more discrete and fragmented forms of financial management and possibly to programme separation or to priority being given to activities yielding comparatively high monetary returns. In Brazil, for example, fees for services led to an increase in unnecessary caesarean sections and a depletion of reproductive health resources that would have been used elsewhere (3).

Can sector-wide approaches aid the integration of services? The successful operation of sector-wide approaches could also be seen as overcoming the separate donor funding of vertical programmes and the possibility of shifting to a more decentralized, horizontal, and more integrated provision of services. However, the needs of reproductive health have to be upheld against other health sector priorities, otherwise supplies for reproductive health could be reduced (30, 31). In Uganda, for example, decentralization resulted in insufficient resources and support for reproductive health care. This eventually led to intervention by the central government (29). A particular concern is that ministries of health often lack full control over all public sector health care delivery. For example, health care functions are also exercised by ministries of labour in countries with compulsory health insurance, by ministries of defence and by ministries of local government (36). Governments have been reported to hold negative perceptions about health ministries (37). Poor management and organization have been described in the health ministry of El Salvador (38). Doubts have been raised about the capacity of the Colombian health ministry in respect of information systems, consensus-building, and staff retention (17). A strong institutional framework in health ministries is vital for maintaining funding levels under sector-wide approaches.

Clearly, particular measures of health sector reform can unleash forces that may facilitate or obstruct the development of reproductive health and health services. The impact of health sector reform is also mediated by different contextual factors. Furthermore, the fact that a particular measure, e.g. contracting out, may affect reproductive health does not necessarily imply that actions cannot be taken to avoid or accentuate this. There may be scope for policy-makers and managers to ensure effectiveness and a measure of compatibility between particular policies of health sector reform and reproductive health. The extent to which this occurs depends on the development of the type of policy dialogue advocated in this paper.

Box 1. Matrix of programme integration and health sector reform			
Health sector reform	Programme integration		
	Planning and priority-setting	Service delivery	Service support
Increasing private sector presence <ul style="list-style-type: none"> Privatization of public property Tax concessions Contracting out Subsidies to private sector 	Mongolia, Nicaragua, and Trinidad and Tobago encourage competition for government contracts (3)	Public–private mix of service delivery in Brazil, Egypt, the Philippines (3)	
Separation of financing and provision <ul style="list-style-type: none"> Managed markets Commissioning 	<p>Potential fragmentation of funding through contracted programme structures</p> <p>Egypt, Jordan: government controls on contraceptive prices to make products affordable; this has discouraged commercial sector interest and may inhibit commercial markets (3)</p>	Ghana: United States Agency for International Development-funded nongovernmental organization contracted to market condoms and other contraceptives through social marketing initiative (27)	
Decentralization <ul style="list-style-type: none"> Deconcentration Devolution Delegated autonomy 	<p>Ghana, Kenya, Zambia: lack of policy coordination can lead to unclear integration responsibilities (2)</p> <p>Bolivia, the Philippines, Zambia: decentralization to rural municipalities with little or no management experience (3)</p> <p>Uganda: government had to intervene when district decision-making resulted in insufficient resources and support for reproductive health (29)</p>	<p>South Africa: reproductive health elements could be coordinated as a single entity with the common goal of integrated primary health care (1)</p> <p>The Philippines, Zambia: transfer of funds from central to local government was associated with loss of benefits and changes in salary for health workers, inadequate funding of services and deterioration in quality of care (3)</p>	<p>Bolivia and the Philippines: decentralization led to drug shortages because of inadequate and delayed funds for procurement (4)</p> <p>Zambia: technical support system dismantled under decentralization, leading to confusion and lack of responsibility (3)</p>
Financing health care <ul style="list-style-type: none"> User fees Private health insurance Community financing 		<p>User fees: compulsory integrated packages could increase consumer cost and decrease utilization, e.g. in Senegal and Zambia (4)</p> <p>Brazil: fee-for-services led to increase in unnecessary caesarean sections and depletion of reproductive health resources which could have been used elsewhere (3)</p>	Mali: emergency referral and evacuation scheme for obstetric care funded through community financing and user fees (29)
Improving regulatory capacity	Malawi: nongovernmental organizations required to contribute to public goals — health ministry subsidizes ca 15% of recurrent costs of facilities in return for compliance for provision of family planning and reproductive health services (29)	Regulation of integrated services in private sector problematic	Provision of legal frameworks for midwives to deliver services previously carried out by doctors only, e.g. Chile, Morocco, Tunisia, Turkey (29)
Human resources management <ul style="list-style-type: none"> Performance incentives Non-permanent employment 	Ghana: management changes upset some professional interest groups who felt disadvantaged in relation to others (26)	Indonesia: incentives to village midwives for care of “high quality” led to oversupply and non-use; replaced with performance-based contracts (29)	South Africa: middle management is multipurpose rather than programme-oriented (1)
Sectoral planning <ul style="list-style-type: none"> Sector-wide approaches Sector investment programmes 	<p>Reproductive health neglected in sector-wide decision-making (30)</p> <p>Sector investment programmes monitoring criteria largely quantitative — will not benefit reproductive health (30)</p>	Improved health sector coordination could facilitate integrated services but could weaken accountability and service support — little experience of implementation (31)	Sectoral supply of drugs and commodities could reduce availability for reproductive health — little experience of implementation (31)

It is important to recognize that the quality of policy may be affected by the characteristics of the decision-making structures and systems within which it is made. In particular they can affect the way in which the information derived in the earlier stages of the framework is used. The process of institutional strengthening is therefore critical.

Conclusion

There is a growing body of research indicating that components of health sector reform may be both beneficial and detrimental to reproductive health. Moreover, the approach to reproductive health which gained strength during the last decade could enrich the debate on health sector reform by refocusing health systems on fundamental tenets of equity, empowerment, and reproductive rights. The critical challenge is to engage the two policy networks in constructive debate. The present paper analyses the difficulties facing the establish-

ment of a constructive dialogue and develops a framework to facilitate progress towards this.

The paper illustrates the principal matters requiring consideration if current development strategies for health care systems are to be refocused in a way that can be expected to benefit not only reproductive health but also health status more broadly. The current approach to the development of health systems will undoubtedly continue to provide the dominant framework within which reproductive health care is organized and delivered. We believe that the development of constructive dialogue and mutual understanding through a framework of the kind presented here is a critical step towards the enhancement of reproductive health status and the integration of the reproductive health approach into health systems. ■

Conflicts of interest: none declared.

Résumé

Santé génésique et réforme du secteur de la santé dans les pays en développement : instauration d'un cadre favorisant le dialogue

Il n'y a pas de lien clairement établi entre l'élaboration des politiques en matière de santé génésique et les modifications inhérentes à la réforme du secteur de la santé dans les pays en développement. Il n'y a guère eu de communication entre ces deux domaines : or, c'est dans le cadre des changements structurels que doit s'inscrire la politique en matière de santé génésique. Dans cet article, les auteurs examinent les obstacles au dialogue entre ces deux domaines et proposent le cadre suivant pour l'encourager : identification des groupes d'élaboration des

politiques et établissement de bases de collaboration entre eux ; vision commune des grandes orientations à suivre ; accord sur des cibles compatibles concernant à la fois la santé génésique et la réforme du secteur de la santé ; identification des liens de causalité entre la teneur de la politique de santé génésique et la réforme du secteur de la santé en vue de la formulation de politiques reposant sur des bases factuelles ; enfin, renforcement des structures, systèmes, compétences et valeurs en matière d'élaboration des politiques.

Resumen

Salud reproductiva y reforma del sector sanitario en los países en desarrollo: establecimiento de un marco para el diálogo

No está clara la relación entre la formulación de políticas en el campo de la salud reproductiva y los cambios asociados a los programas de reforma del sector de la salud en los países en desarrollo. Ha habido poca comunicación entre esas dos áreas, pese a que la política de salud reproductiva tiene que ejecutarse en el marco de los cambios estructurales. En este artículo se examinan los factores que limitan el diálogo entre las dos áreas y se propone el siguiente marco para fomentar ese diálogo: identificación de grupos de políticas y desarrollo de las bases necesarias para

asegurar los vínculos de colaboración entre ellos; introducción de una perspectiva común en torno a contextos normativos de interés; logro de un acuerdo respecto a objetivos compatibles de salud reproductiva y de transformación del sector sanitario; desarrollo de vínculos causales entre el contenido de las políticas en salud reproductiva y los cambios del sector de la salud como base para formular políticas basadas en la evidencia; y fortalecimiento de las estructuras, los sistemas, las aptitudes y los valores en materia de formulación de políticas.

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