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WOMEN'S NEEDS AND THE RESPONSE OF HEALTH SECTOR REFORM: EXPERIENCE IN ECUADOR

IMPLEMENTATION OF THE REFORM LAW ON FREE MATERNITY CARE IN SUPPORT OF HEALTH SECTOR REFORM[1]

The Reform Law on Free Maternity Care (LRMG) is itself a proposal for a new model of health care, whose principal purposes are to improve the access of women and children; reduce maternal mortality; guarantee comprehensive reproductive health care; diversify service providers, including nonprofit institutions and traditional midwives in addition to the Ministry of Public Health (MPH); integrate services, municipalities, and community organizations at the local level in the management of resources; and strengthen the participation of civil society in decision-making and social control of the quality of services.

A form of interinstitutional cooperation and coordination was used in the formulation and passage the LRMG. Different institutions were involved, such as the Health Commission of the National Congress, the National Health Council, the Ministry of Public Health, the Center to Promote Responsible Parenthood, the National Council of Women, and the PAHO/WHO Representative Office in Ecuador, which provided outstanding technical assistance.

The National Council of Women conveyed the expectations of the women's movement through ongoing consultations on the content of the Law. A harmonization process is currently under way between the LRMG, the new Constitution, the health policies of the current government, and the population benefiting from the "Solidarity Payment."

[1] Presented by Mrs. Lola Villaquirán, Executive Director of the National Council of Women (CONAMU), Ecuador.

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1. Background

The National Council of Women (CONAMU) was created by Executive Decree on 24 October 1997 as an entity under the National Women's Directorate (DINAMU), a division of the Ministry of Social Welfare, which was acting as the government office charged with women's issues whose principal activity was to execute productive projects pertaining to violence against women and nonsexist education, as well as other issues.

The decree creating CONAMU defines the Council as "*The steering organ for public policy that sets standards for and regulates the incorporation of the gender approach in plans, programs, and projects and its compulsory application in all public sector agencies*."

As part of its work, in 1995 DINAMU prepared the Equal Opportunity Plan (*Plan de Igualdad de Oportunidades* - PIO), which became the point of reference for government policies benefiting women up to the present.

Officially, activities in the technical health area began under CONAMU in January 1998, but the topic of health was considered in the PIO and, while still DINAMU, the agency participated in the National Plan for the Reduction of Maternal Mortality.

The first technical health activities included the preparation of the annual plan of operations (POA) with four areas of work:

- Gender and Health Sector Reform.
- Gender, Health Promotion, and the Participation of Women in the Municipios.
- Gender, Information, Statistics, and Research.
- Gender and Human Resources Training in Health.

Of all these, the topic of Gender and Health Sector Reform was chosen as a priority, with a proposal for Women's and Children's Health Insurance (SEGFEIS). This proposal was made taking into account the legal powers of CONAMU, the guidelines of the PIO, the political agenda of the women's movement, and information on the topics of greatest import most frequently debated in the health sector.

2. Context and Analysis of Circumstances Surrounding the Formulation of the Law

Studies conducted in the country revealed significant problems in connection with the population's health and services. Some data are summarized below:

- High maternal mortality, which has remained unchanged for the past decade at a rate of 1.5 deaths for every 1,000 live births, i.e., 450 women die each year due to causes linked with maternity (Report of the National Plan for the Reduction of Maternal Mortality, MPH, Quito, 1997).

- On average, 30% of births in the country are not attended by professionals, but this percentage rises to 44% in rural areas (Profile of Women, Technical Secretariat of the Social Front, Quito, 1998).

- Some 74% to 80% of Ecuadorian women have no access to health insurance (Profile of Women, Technical Secretariat of the Social Front, Quito, 1998).

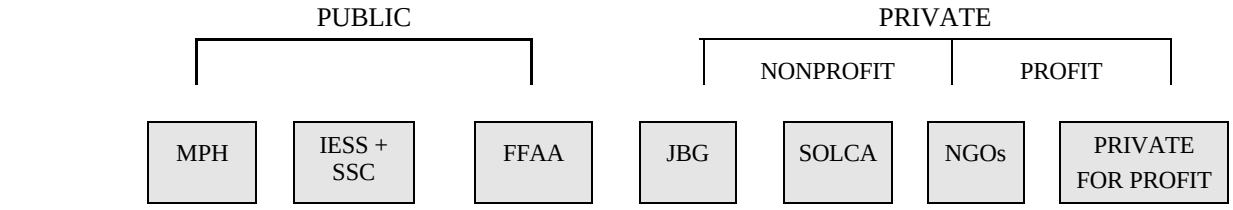
- Existence of a Law on Free Maternity Care that financed care in the Ministry of Public Health for all pregnant women and women who have recently given birth in the country. Although in effect for four years, no regulations had been issued for the Law and the sums allocated for its implementation were determined without any technical foundation or calculation of costs, coverages, etc. (Official Record No. 523 of 9 September 1994).

- Samplings of opinion at health facilities indicated that these extrabudgetary funds went to cover the chronic shortages of equipment and supplies, remodeling, staff dining rooms, custodial services, etc. and hardly ever provided direct benefit to the women who used the services.

- Fifty-eight percent of the population feels that the quality of care in the public health services is between fair and poor (Profile of Women, Technical Secretariat of the Social Front, Quito, 1998).

- The health service providers network has been described as uncoordinated and fragmented and has been one of the principal structural problems leading to the chain of inefficiencies, duplication of efforts, and wasted resources. The figure below shows the main characteristics of the services network.

Figure 1. Composition of the Health Services Network by Institution, Coverage and Insurance. Ecuador 1998



Coverage	30%	20%	3%		7%	15%
Insurance	0%	20%	3%		0%	3%

Population without health care: 25%
Population without health insurance: 74%

Source: Ministry of Public Health
Prepared by: CONAMU Health Area

This information reflected the fact that health for women was an uncertainty due to the lack of insurance and the significant numbers of women who did not use the health services and were poorly served, often mistreated, and charged for poor quality care as well, despite the Law on Free Maternity Care.

This also meant that women had fewer opportunities to exercise their health rights during the period of maternity which, paradoxically, society recognizes as one of the most sublime functions of women.

Moreover, in early 1998 the public agenda included the Constitutional reforms that were to be made by the Constituents Assembly. Discussions on health focused on the proposals put forth by the women's movement on sexual and reproductive health and those by the Ministry of Public Health on creating the Health Chapter.

CONAMU set up roundtables on the two topics, and the conclusions and recommendations were submitted to the National Health Council (CONASA), which at the time, spearheaded the proposals for the new Constitution and Health Sector Reform (HSR), in conjunction with the Ministry of Public Health (MPH).

The main proposals submitted to the Assembly by the MPH were:

1. Separating the MPH's leadership and control functions from its financing and service delivery functions.

2. Creating a National Health System (NHS) to coordinate the providers' network and make it possible to apply the principles of universality, equity, quality, efficiency, and solidarity.

3. Publicly-based universal insurance, financed with government contributions and contributions from users based on their ability to pay.

4. Establishing a basic package of care that would be whose coverage and services would be extended until in about 15 years the entire population would enjoy coverage for all health problems. This would be accomplished with the participation of the public and private sectors.

5. Demand, rather than supply, subsidies as had been the case.

6. Ensuring that the health budget is stable and no less than 8% of GDP.

7. Declaring that public health services will be free.

8. Indicating that the financing for public agencies in the national health system would come from the Government's General Budget and from the people who use the services and have the ability to pay.

Ultimately, items 2, 6, 7, 8 were approved, and there was partial approval of item 1, which stipulates that the Ministry of Health is the steering organ for the sector.

Among the groups that had been thinking about and making proposals for HSR, the feeling was that it was important to propose universal insurance and that the best strategy for making this a reality was to propose it to progressive segments of the population.

Thus, the proposal to work on passage of the Law on Women's and Children's Health Insurance (SEGFEIS) was strengthened as a step toward universal insurance, since it was certain that no one would oppose providing this benefit to the most vulnerable populations—women and children.

The existence of the Law on Free Maternity Care, passed in 1994, the successful experience of Bolivian insurance for mothers and children, and Peru's interest in taking similar action were the arguments that also strengthened and supported the SEGFEIS proposal.

In addition, in its work agenda the Health Commission of the National Congress had proposed the amendment of the Law on Free Maternity Care in the context of the agreement between that agency and PAHO.

CONAMU began to sample opinions among the different participants such as PAHO, the National Health Council, the MPH, the World Bank's project in the MPH on modernization of the health services (MODERSA), the Project for the Analysis and Promotion of Public Policies (financed by USAID and executed by CEPAR, a private NGO), to explore the viability of the proposal, at least in technical terms, with support from all parties.

In this phase, CONAMU learned by way of PAHO that the Health Commission had the reformulation of the Law on its agenda and put the two agencies in touch with each other to open a dialogue and harmonize the two proposals, which initially differed in their recommendations.

3. Relevant Conceptual Aspects Defended in Formulating the Law

A copy of the Law is attached in the annexes. Presented below are the topics that were vital for CONAMU, around which non-negotiable ideas were developed that became the foci for the proposals on the Law that were made by our institution.

- The purpose of the Law must be to organize a system that will guarantee quality health care for women and children.

- It must define a basic package of services, not only for women but for young children, that includes care relating to maternity, reproductive health, and violence:

a) *Maternity*: Ensures necessary and timely care for women at the different levels of the health system and includes prenatal check-ups, application of the basic treatment protocols for sexually transmitted diseases (except AIDS), care for normal and at-risk deliveries, cesarean section, post-partum care, care for obstetrical emergencies, including those resulting from domestic violence, toxemia, hemorrhage, and sepsis in pregnancy, delivery and the post-partum period, as well as the provision of blood and blood products. The sexual and reproductive health programs provide coverage for the early detection of cervical cancer and access to birth control methods, all in accordance with the applicable standards of the Ministry of Public Health.

b) *Newborns and children under 5*: Ensures necessary and timely care at the different levels of the health system for newborns and healthy babies; premature

low-birthweight babies; and/or babies with pathologies (perinatal asphyxia, jaundice, fetal distress, and sepsis); and for children under 5, care for the illnesses included in the strategy for Integrated Management of Childhood Illness (IMCI) and their complications, all in accordance with the applicable standards of the Ministry of Health.

In this sense, an attempt was made to have the basic package include care for delivery and the post-partum period, for the risks leading to maternal mortality, and for the health problems of women and children, in addition to normal pregnancy care. It was felt that it was a strategic necessity for women to consider the types of care described above and to extend coverage to children.

- That demand rather than supply be subsidized, as has been the case up to now, so that women will have the opportunity to be seen in the health services they consider most convenient and to feel that they are being treated properly and efficiently.

- That certified traditional midwives be considered service providers, since approximately 30% of births are attended by them, the Ecuadorian government does not recognize their work officially, and most of the services undervalue or oppose them.

  The Ministry of Health trains traditional midwives to apply the thinking of official medicine, its value systems, meanings, techniques and procedures, which are alien to them.

- Financing should be sufficient to cover the basic package of care for women below the poverty line (60%) and not just for indigent women (25%). This was justified because if only 30% of deliveries were being cared for the Ministry of Health and an additional 35% of women were not seen in any type of service, presumably this was being handled by traditional midwives.

- Making local governments jointly responsible for women's health promotion and disease prevention—particularly in the transport of emergency obstetrical and pediatric cases from remote areas, since most deaths are caused by delays in transferring cases—and ensuring local participation in the administration of the funds allocated to implement the Law.

- The presence of CONAMU, together with other government agencies, for support and follow-up on the implementation of the Law.

- The creation of women users' committees that, in addition to having joint responsibility for health care, could issue a certificate of satisfaction. A certificate of this nature could be one of the tools for accreditation from the citizens' standpoint and a requirement for service providers to receive funds.

  This would allow for the institutionalization of women's participation and progress beyond the utilitarian participation that the services have allowed women users' committees up to now toward the possibility of social control over the services and the fostering of civic participation by women to demand their rights without the mediation of political or other organizations.

Many of these suggestions were not initiatives of CONAMU alone, but had been shared among the different groups exploring HSR and the participating institutions.

From the description above, efforts to include specific provisions to subsidize demand in the Law were unsuccessful, and the subsidies for supply were retained. However, there has been participation not only by the operating units of the Ministry of Health but nonprofit institutions and traditional midwives as well, all contingent upon certificates of accreditation issued by the provincial health directorates.

Another important initiative that did not meet with success was for the Law to give the women users' committees the power to issue a certificate of satisfaction that would have the same weight as accreditation by the provincial agencies. However, we hope that this power will appear in the regulations.

4. Discussion of Alternatives and Evolution from Initial Suggestions to Final Proposal

The first scenario was the passage of a new Law on Women's and Children's Insurance.

The second scenario was passage of a reform Law on Free Maternity Care, which would have elements of the health sector reform proposals and would cover women's demands.

The third scenario was that nothing would be passed and we would have to wait for total reform of the health sector, which would provide some opportunities for solving women's health problems.

The second scenario was chosen, owing to political considerations, since the previous legislature had a Social-Christian majority, which had secured passage of the

1994 Law on Free Maternity Care and in the negotiating process was not well-disposed toward replacing or repealing that Law.

Another important consideration was the judgment of the economists advising the technical team, who indicated that at least 60% of the country's population would have to be subsidized due to their level of poverty, and the experience with cost recovery in the country revealed low percentages at a high political cost.

Another important criterion was the ease of implementing the Law, because if public insurance that was not linked with social security was established, it would mean creating a complex administrative apparatus responsible for collecting insurance premiums, issuing health care contracts, etc.

One of the matters most frequently discussed in the interinstitutional coordinating commission was whether the insurance should be proposed as women's and children's health insurance. The available information indicated that families below the poverty line spent about 17% of their income on health, a high percentage in comparison with international standards, and more than half of this amount was spent on drugs.

In addition, the country's experience was that the cost of medical care could be recovered at a maximum rate of 15% (recovery at about 5% was more frequent in the country). This meant that most of the financing would have to come from the government subsidy rather than contributions from the population. Therefore, the arguments for drafting an insurance Law were not sustainable from a technical standpoint.

In addition, the country did not have the administrative apparatus necessary to handle the funds, and more general agreements had not been reached in the discussions on joint efforts between Social Security and the Ministry of Health.

Furthermore, the political party that achieved passage of the 1994 Law on Free Maternity Care, which was in the majority at the time the new law was submitted, was not disposed to pass a Law that would supersede its own.

These were the main arguments that led CONAMU to relinquish its demand that the central proposition of the Law deal with insurance.

The second topic broadly discussed was the content of the basic package of care. Again, the arguments of the economists weighed heavily in the decision on the benefits that would remain in the package, excluding AIDS treatment because it is a highly costly catastrophic illness that could easily deplete the package financially. Treatment for all cases of violence was also excluded, because the country had no information to calculate

the frequency and cost of such benefits, leaving only treatment provided for emergencies caused by interfamily violence.

The third topic was the cost-free nature of medical benefits. Here the discussion focused on whether CONAMU, representing the interests of women, felt that the services stipulated in the Law should be free or not. In this area, the argument was that the new Constitution clearly indicates that public health care be provided free of charge.

The country neither had nor has a definition of what types of care fall under public health. In addition, while the ministerial agreement of the MPH of February 1998 considered maternal mortality a public health problem, another section of the new Constitution mentions that health financing could be carried out with Government funds and with contributions from those with the ability to pay. In this respect, the countries also lacked a definition of which people were able to pay and where they were.

Hence, CONAMU was in favor of the free benefits considered in the basic package, agreeing with PAHO, the Health Commission, and the CEPAR, with the MPH, CONASA, MODERSA in opposition.

The team that advised the legislative Health Commission and the representatives of the Commission held strongly to the opinion that the benefits provided under the Law be free.

The fourth topic of discussion was the demand subsidy and the participation of the private sector in the provider network. CONAMU favored support for these two proposals, agreeing with MPH, CONASA, and MODERSA.

Several studies indicated that the quality of the services was the subject of constant complaints from patients and was one of the reasons behind greater use of private services that required direct fees for services—of the most inequitable health care financing methods because it does not allow for the distribution of costs nor does it ensure reinvestment in health or technology, research, the welfare of users, the expansion of coverage, etc.

It was felt that demand subsidy would be one element that would force service providers to improve quality as a result of competition to attract users and funds.

The fifth topic was financing. While it was clear that the funds would come from the Government based on the provisions of the 1994 Law, financing would have to be broadened to cover the cost of the obligations under the new Law. Thus, a proposal was submitted on grouping the financing for health under different funds and laws directed to the same population groups of women and children.

This meant retaining the 3% tax on special consumption under the old Law, the FONIN funds for infant nutrition, the funds theoretically earmarked in the Law Creating the Solidarity Fund for Women's and Children's Health, and the INFFA funds for the same purposes. In addition, the creation of a 1% tax on foreign currency transactions was proposed.

This latter proposal was rejected by the representatives of the majority party, who held to the principle of no tax increases. In exchange, a compulsory 2 million Units of Constant Value from the Solidarity Fund was established.

The Ministry was opposed to the Law's placing conditions on the use of funds from the Fund for Infant Nutrition (FONIN) and from the Law on Free Maternity Care, which it had been managing arbitrarily for 10 years, hiring administrative staff unrelated to the purposes for which they had been created and using the funds to cover the deficit stemming from the decline in the health budget in recent years.

It was finally agreed that the initial amount of 10,000,000,000 appearing in the old Law would be multiplied by 10 and would come to 100,000,000,000 sucres.

The final topic of heated debate was the participation of women instead of men on the women users' committee, and on the Management Committee for the Local Solidarity Health Fund. On this matter, the group that prepared the draft Law did not understand the importance of promoting women's participation.

It was proposed that the committee consist of the mayor, the MPH health area chief, and three representatives from community organizations: one from the organized community; one from the women's organizations; and in rural areas, one from campesino or indigenous organizations.

As can be seen, these classifications did not explicitly include women representatives from any of the organizations of civil society.

For CONAMU, there remains the possibility that the regulations issued under the Law will stipulate that preference be given to women when choosing representatives of the organizations and women themselves and that the issuance of a certificate of satisfaction by the women users' committee will be considered as important as the certificate of accreditation when granting funds to providers.

5. Organization and Participation of Institutions in the Formulation and Passage of the Law

In early 1998, CONAMU formed the Consultative Group on Health and Gender (CONGESA) as a strategy for carrying out the four areas of work established in the POA, for which the respective commissions were also established.

Initially, the commission on gender and reform called meetings to work on SEGFEIS and later set itself up as a working and interinstitutional coordinating commission with the participation of the Ministry of Public Health, the National Health Council, the MODERSA Project (with the three organizations represented by a single person), PAHO, CEPAR, CONAMU, and the Health Commission of the National Congress.

The working commission met regularly once a week, and CONAMU was designated as the coordinator charged with handling the meeting notices and the minutes of each session.

In compliance with one of the commission's resolutions, CONAMU developed a project profile for developing SEGFEIS that became the instrument for coordinating the participating institutions as well as the point of reference for the commitments undertaken and the direction the proposal should take.

An addendum on the structure of the commission prepared by PAHO and CONASA was later included in the profile. It established three levels:

- Political level, which would include senior representatives of the participating institutions;

- Interinstitutional coordinating level, which would include the experts from each institution who have responsibility for the technical direction of the process and who work at the technical level;

- Technical level, comprised of consultants hired for specific studies and the technical advisors of the Health Commission of the National Congress, charged with compiling information and structuring the technical content of the draft law.

This is how the participating institutions divided up the responsibilities for carrying out and financing the different project activities, the most important being the hiring of consultants for studies to support the formulation of the Law.

Thus, PAHO would hire international consultants for the comprehensive structuring of the Law, based on the experience of Brazil with women's and children's insurance, and national consultants to explore the sources of financing. For its part, CONAMU would hire consultants on health care costs and protocols. In addition to its existing adviser, the congressional Health Commission would hire an expert to compile epidemiological information and develop the basic package of services.

The MPH, CONASA, MODERSA contributed primarily with knowledge and guidance on the content of HSR and harmonization with the content being developed for the Law.

CEPAR had also accumulated knowledge on HSR, a technical team that recently worked on the Reform for more than two years, and an important database.

The Congressional Health Commission was responsible for submitting the draft law and securing its passage in the full hearings.

CONAMU, in the context of the interinstitutional commission, devoted itself to maintaining the appropriate level of interest and the work pace to achieve the goal that had been set, monitoring compliance with agreements and the commitments that were being established and ensuring that the suggestions and perceived needs of women were not diverted toward a proposal lacking a gender approach. In addition, it established a bridge of ongoing consultation with the women's movement.

For four months, the interinstitutional coordinating level held sessions each week in which in-depth discussions took place on the direction and content of the proposal. Here, the position of each institution was identified.

It also assisted in clearly defining the terms of reference for consultants and in the search for information in drafting the Law.

During this time, the interinstitutional coordinating level performed appropriately, which was recognized by the members and participating institutions, but also led to a desire on their part to lead the commission. In the fourth month, the coordinating entity was changed, with the argument that the topic was of general interest to the health sector and should be carried forward by CONASA, which was the ranking institution in the sector.

From then on, the good working habits, such as meeting notices and the taking of minutes at each session, ceased, and initiatives for meetings and discussion topics became improvised.

In the next three months, the technical level, led by the congressional Health Commission and PAHO, did the most work because of political pressures, since the legislative term would come to an end the next month, July 1998.

During this period there were some meetings in which the technical level consulted the interinstitutional coordination level. The final document for the draft law was prepared by the consultant hired by PAHO and the advisers to the congressional Health Commission.

Thus, it is important to remember that for two years divergent positions on certain aspects of HSR had been developing among some of the international cooperation agencies—for example, the emphasis of HSR, its direction, charging for services, financial management by private organizations, maintenance of the supply subsidy, etc.

As for the final document, the participating organizations were vaguely in agreement on the content of the Law. In some cases, there was agreement on certain aspects among CONAMU, the Health Commission, and PAHO, and in other cases, among CONAMU, MPH, CONASA, and MODERSA.

This may be what led the Ministry of Health, CONASA, and MODERSA to isolate themselves and to send in their comments and objections at the end of the process.

While the interinstitutional coordinating level was operating in a disorderly manner, CONAMU consistently sent in documents arguing that the participation of women and the demand subsidy should be considered in the content of the Law.

Finally, the Ministry of Health-CONASA-MODERSA were dissatisfied with some areas of the Law's content, arguing primarily that the areas of consensus that had been built around the discussion of the Reform had not been honored--areas such as the demand subsidy, private sector participation in service delivery and/or financial management, and charging for services.

One more argument was added later on that contradicted the conclusions of the earlier discussions and postulated that it would be more advisable for the country to develop a basic package of services for the entire population, rather than a partial one for women and children.

CONAMU was also dissatisfied with the content, especially continuation of the supply subsidy and the fact that the law did not specify that it should be campesino women, women from popular organizations, who would serve on the local fund management committees.

It was also dissatisfied about the outcome of the issue of committees with exclusively female participants, which would be responsible for issuing a certificate of satisfaction with the quality of services as a prerequisite for the granting of funds, since the Law was devoted to women and their children and they did not require any intermediaries to participate. (the draft law finally included the term “women,” but the Congressional secretary did not honor this, and the document sent for the President's signature considered it more advisable for the term be "users," male and female).

During the negotiations to secure passage of the Law, CONAMU played an important role, approaching several representatives who were very active in obtaining votes in the hearings and in passing the Law. The congressional Health Commission also sought agreements with representatives for passage of the Law.

At the first hearing, the full session of Congress received CONAMU in a special committee, and there, a speech was made that had a positive impact on the representatives, resulting in unanimous passage of the Law.

At the second hearing, which occurred 15 days before the government changeover and the end of the congressional term, the current government's party made its vote contingent on approval by the future Minister of Health, something that was achieved after a long distance call. It should be stressed that CONAMU had contacted the representatives and had had the votes necessary for passage hours earlier.

Anecdotally, it should be noted that at the opening of the full session, the Chairman asked for a moment of silence for the death of a former deputy. The representatives allied with CONAMU took this opportunity to call for three minutes of silence because on that day in some part of the country at least one woman and three children would die.

At that phase of political negotiation, CONAMU played a dominant role, even beyond that of the congressional Health Commission. This was also true in the President's promulgation of the Law, which constitutes the final approval of any law prior to its publication in the Official Record and its taking effect.

6. The Women's Movement and the Law

During different stages in the formulation of the Law, workshops were held to discuss its content with the women's movement. The movement’s demands focused on the following:

- CONAMU should not lower expectations for women's and children's insurance, since the percentage of women without insurance in the country is high.

- The Law should provide treatment for all violence occurring at any point in the life of women.

- The basic package of care should include treatment for AIDS.

- The basic package and the financing should cover all health problems for all women in Ecuador.

The proposals were presented within the interinstitutional working commission, and it determined whether these demands would be acceded to after undertaking an economic analysis of the costs and actual possibilities for achieving political consensus in the Congress for passage of a law with such content.

Now that the Law has passed, virtually every sector of the women's movement has expressed satisfaction with its content.

CONAMU felt that once the Law had passed, it would be appropriate for the women's movement to jointly monitor its implementation as one more victory in securing rights for the country's women. For this reason, in the post-passage phase, coordinating activities have started up once again to disseminate the Law and organize women.

7. Outlook for Future Implementation of the Law

Some determinants of the future implementation of the Law are indicated below:

A historical view of HSR in Ecuador indicates that treatment of the topic under the concept defined by PAHO has been under discussion for about three years. During this period progress has been made in designing proposals and creating pilot experiments that could provide valuable information on the shortcomings or virtues of the models to permit their countrywide dissemination.

The HSR process in Ecuador is unlike that of other countries in the Region, whose beginning was marked by a law, a public declaration by the authorities, or regulations.

If there is a definitive moment or starting point that marks the beginning of health sector reform, it has not yet occurred in our country. However, the MPH has worked ceaselessly toward this goal, with the backing of the Interagency Committee to Support the Reform, led by the PAHO/WHO Representative Office and the Project for Modernization of the Health Services (MODERSA), financed by the World Bank.

The main achievements of this process are the health reforms in the new Constitution and the broad discussions on the direction and content of the reforms, which took the experiences of other countries into account.

Health sector reform has been limited to reform of the Ministry of Health and should be considered in many ways as being in the formative stage. The Ministry has issued health policies during the current administration.

In September the new government took significant economic steps but simultaneously created the "solidarity payment" as a compensatory measure for women with children under 18 years of age with incomes of less than 1,000.00 sucres per month (US$130) who are not affiliated with Social Security, and half that amount for the elderly.

To date, 800,000 people have registered, approximately 500,000 of them women. Most of these women reside in marginal urban areas. This number is expected to increase with the addition of women from rural areas.

The MPH has suggested that the Law be changed to make it consistent with the interpretation of the Constitution, which it believes requires charging a fee for services for the types of care indicated in the Law.

The Solidarity Payment has opened up the possibility of an agreement whereby the people covered by it will be the female beneficiaries of the Reform Law on Free Maternity Care. This has begun to open up channels of negotiation for implementing the Law.

Meanwhile, news reports have noted that, under the aegis of the health authorities and the National Government, implementation of the new Law has begun in the Province of Guayas.

In the rest of the country, the operative units of the MPH continue to receive funds from the old Law, and there have been no changes in the way they are administered. Exceptions include some provinces such as Loja, where there is a PAHO project on healthy spaces and the gender approach and where total implementation of the new law is beginning. Many other provinces have also advised CONAMU of their interest in launching this process.

8. Conclusions

The content of this Law is in itself a proposal for a new model of health care, whose principal purposes are to improve the access of women and children; reduce

maternal mortality; guarantee comprehensive reproductive health care; diversify service providers to include nonprofit institutions and the providers of traditional medicine, among them midwives, in addition to the MPH. The Law integrates services, municipios, and local community organizations in the management of resources, and it strengthens society's participation in decision-making and social control over the quality of services.

In addition, the following should be pointed out:

- Interinstitutional cooperation is difficult but possible, if clear objectives, continuous motivation, appropriate leadership, and transparency are retained in the process.

- The process is manageable, provided a good level of information and clear concepts are maintained.

- In an interinstitutional relationship, it is necessary to keep the channels for dialogue and negotiation open at all times, anticipating the need for concessions.

- The Law has been passed, but difficulties in implementing it remain. It would thus have been advisable to provide for greater participation by the Ministry of Health, which in the second phase was to be the principal agent for implementing the Law.

- Greater involvement of the women's movement should have been sought in all processes related to the drafting and passage of the Law, instead of just the consultative workshops.

While for the other institutions, the passage of the Law may have represented just another task or activity, for all of us in CONAMU it is a vital issue, because it represents a launching pad in the struggle to improve women's health conditions.

Annexes

Monday, 10 August 1998

No. 129

National Congress

The Plenary Session of the Legislative Commissions

Whereas:

High rates of maternal and infant mortality are recorded in the Republic of Ecuador, and it is the function of the State to care for and monitor the health of the population throughout the nation;

The Political Constitution recognizes the creation of the National Health System, comprised of all health care providers and governed by the principles of equity, universality, efficiency, quality, and solidarity in health policies;

The Ecuadorian Government has subscribed to the goals of the World Summit for Children and is also a signatory of the resolutions of the Summit of the Americas in Miami, the International Convention on the Elimination of All Forms of Discrimination against Women, the Vienna World Conference on Human Rights, the International Conference on Population and Development in Cairo, the Fourth World Conference on Women: "Action for Equality, Development, and Peace," held in Beijing, and other agreements;

There are laws in effect that are intended to ensure timely and adequate funding to care for pregnant women and children, such as the Law on Free Maternity Care, the Law Creating the National Fund for Nutrition and Protection of the Infant Population, the Law Creating the National Institute on Children and the Family, and others;

The Ministry of Health has issued Ministerial Agreement 1804 of February 1998 declaring execution of the Plan for Reduction of Maternal Mortality to be of the highest priority;

It is necessary to update the legal instrument in effect to ensure coordination of the scattered financial resources of the public sector with a view to providing appropriate and timely care for pregnant women and children; and

Exercising its constitutional and legal powers, issues the following:

LAW REFORMING THE LAW ON FREE MATERNITY CARE

Art. 1. In the title of the Law on Free Maternity Care, published in Official Record No. 523 on 9 September1994, after the word "Free" add "and Infant Care."

Art. 2. Replace Article 1 with the following:

Every Ecuadorian woman has the right to free quality health care during pregnancy, childbirth, and the post-partum period, as

well as access to sexual and reproductive health programs. Similarly, health care will be provided without cost to newborns and children under the age of 5 as a public health action, a responsibility of the State.

Art. 3. Replace Article 2 with the following:

One of the goals of this Law is financing to cover expenses for medicines, inputs, micronutrients, supplies, basic laboratory tests, and supplemental check-ups for pregnant women, newborns, and children under the age of 5 through the following benefits:

a) **Maternity**: Women are assured necessary and timely care at the different levels of complexity for prenatal check-ups and application of the basic treatment protocols for sexually transmitted diseases (except for AIDS), care for normal and at-risk delivery, cesarean section, the post-partum period, obstetrical emergencies including those arising from domestic violence, hemorrhage, and sepsis during pregnancy, delivery and the post-partum period, as well as the provision of blood and blood by-products.

b) **Newborns and children under 5**: Necessary and timely care at the different levels of complexity is assured for newborns and healthy babies, premature low-birthweight babies, and/or babies with pathologies (perinatal asphyxia, jaundice, fetal distress, and sepsis), for children under 5 for illnesses included in the strategy for integrated management of childhood illness (IMCI) and their complications, all in accordance with applicable Ministry of Public Health standards.

Art. 4. After Article 2, add the following, which states:

"Art.... The provisions of this Law shall forcibly apply at all health facilities that are agencies of the Ministry of Public Health.

The other organizations in the public health sector shall implement this Law according to their internal systems, using their own resources.

With prior accreditation from the Ministry of Public Health and the signing of management agreements, nonprofit health service providers, including those providing traditional medicine, may also participate."

Art. 5. Replace Article 3 with the following:

"Increase by three percent (3%) the tax rate on special consumption indicated in Article 78 of the Domestic Tax Regulations, published in Official Record No. 341 of 22 December 1989."

"Initially assign the value corresponding to 2,321.062 Units of Constant Value from the yields from the Solidarity Fund for Human Development of the Ecuadorian population, created by Law published in Official Record No. 661 of March 1995.

The resources allocated to the Ministry of Public Health under the Law Creating the National Fund for Nutrition and Protection of the Ecuadorian infant population, published in Official Record No. 132 of February 1989, and the funds that the INNHA allocates to programs for reducing maternal and infant mortality and/or for reproductive health shall preferably be used to finance the provisions of this Law.

The financial resources from international cooperation and those contracted through foreign loans to the health sector shall give priority to investment in areas directly or indirectly related to the implementation of this Law.

The sums derived from application of the provisions in the preceding articles shall be transferred monthly by the Ministry of Finance to a special account of the Ministry of Public Health, designated the Solidarity Health Fund, which shall allocate them in their entirety to financing solely and exclusively the provisions of this Law."

Art. 6. After Article 3, add the following unnumbered articles:

"Art.... In coordination with the Ministry of Public Health, the municipios may develop programs for education, promotion, information, and communication fostering the implementation of this Law and may create and implement mechanisms in remote rural areas to ensure the timely transfer of obstetrical, neonatal, and pediatric emergencies to facilities that provide more complex care, all in accordance with standards established by the Ministry of Health."

Art.... For fulfilling and implementing the provisions of this Law, it is established that:

a) The Ministry of Public Health, at its different management levels, is responsible for enforcing this Law in the context of the provisions of the National Plan for the Reduction of Maternal Mortality and other plans and programs related to the purpose of the Law.

   The Ministry of Public Health shall define the national standards that guarantee the implementation of this Law and the criteria for accrediting the health services, in keeping with the provisions of the Law on Government Decentralization and Social Participation and the creation of the National Health System.

   Created hereby are the Committee for Support and Monitoring of the Implementation of the Law, comprised of the Ministry of Public Health, the National Institute for Children and the Family (INNFA), the National Council of Women (CONAMU), and the National Health Council (CONASA).

   The National Council of Women shall participate as the body charged with guaranteeing equity and the gender approach and promoting the

participation of women's organizations.

The National Institute for Children and the Family shall guarantee the comprehensiveness of the activities directed to pregnant women and to children.

The National Health Council shall be responsible for interinstitutional coordination in the Health Sector for proper implementation of this Law.

b) The Provincial Health Directorate is the body responsible for enforcing, within its jurisdiction, the regulatory instruments designed by the Ministry of Public Health; and

c) Created hereby in each Municipality are the Local Solidarity Health Funds, which shall receive financial resources from the Solidarity Health Fund in order to guarantee implementation of the Law.

Established hereby is the Committee for Management of the Local Solidarity Health Funds, which shall be made up of the Mayor or his legal representative, the respective health area chief or chiefs representing the Provincial Health Director; one representative from the organized community; one representative from the women's organizations; and, in the rural area, one representative from organizations of campesinos or indigenous peoples. Two registered signatures shall be required for use of the funds: the signature of the Mayor and that of the Health Area Chief.

Established hereby are Users' Committees charged with promoting joint citizen responsibility in the promotion of maternal and child health, for follow-up and monitoring the implementation of the Law."

GENERAL PROVISIONS

Art. 7. All provisions contrary to this Law are repealed.

Art. 8. In the implementation of this Law, priority shall be given to the geographic areas with the highest rates of maternal and infant mortality and the most economically depressed areas.

Art. 9. The local solidarity health funds are free to add health benefits required by the epidemiological analysis of the Provincial Health Directorate and the local socioeconomic analysis, within the framework determined by the National Health System, identifying additional sources of financing that do not include those allocated under this Law.

Art. 10. In municipalities whose operating capacity makes implementation of the provisions of this Law difficult or impossible, the Law may be implemented through municipal consortia or associations.

Done in the city of San Francisco de Quito, Metropolitan District, in the Hall for Plenary Sessions of the Legislative Commissions of the National Congress of Ecuador, on the twenty-third day of July, nineteen hundred ninety-eight.

signed: Estuardo Gavilánez Ramos, Eng., Chairman of the National Congress (E.).

signed: Jaime Dávila de la Rosa, General Secretary of the National Congress (E.).

National Palace in Quito, on the seventh of August, nineteen hundred ninety-eight.

THIS LAW IS HEREBY PROMULGATED

signed: Fabián Alarcón Rivera, Interim Constitutional President of the Republic

This is a faithful copy of the original. I DO SO CERTIFY

signed: Dr. Wilson Merino M., General Secretary for Public Administration.

ANNEX B

HEALTH CHAPTER OF THE NEW CONSTITUTION, 1998

Only available in Spanish from:

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