

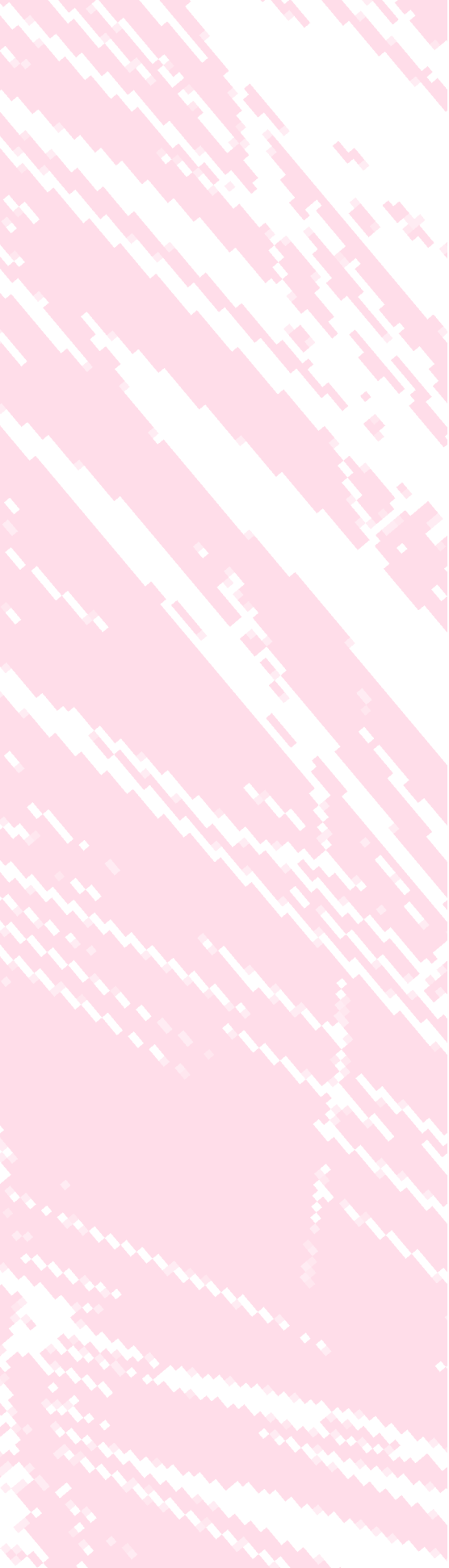
INTERLINKING POLICY, POLITICS AND WOMEN'S REPRODUCTIVE RIGHTS

A study of health
sector reform,
maternal mortality
and abortion in
selected
countries of the
South.

COORDINATED BY SONIA CORRÉA



**DAWN SEXUAL AND
REPRODUCTIVE HEALTH AND
RIGHTS PROGRAM**



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reform, maternal mortality
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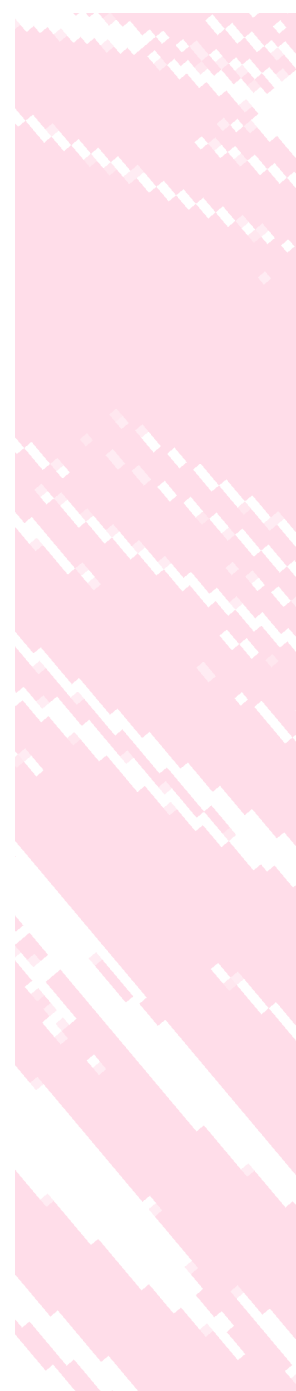
DAWN Anglophone Africa in Ghana and Nigeria

DAWN South East Asia in the Philippines

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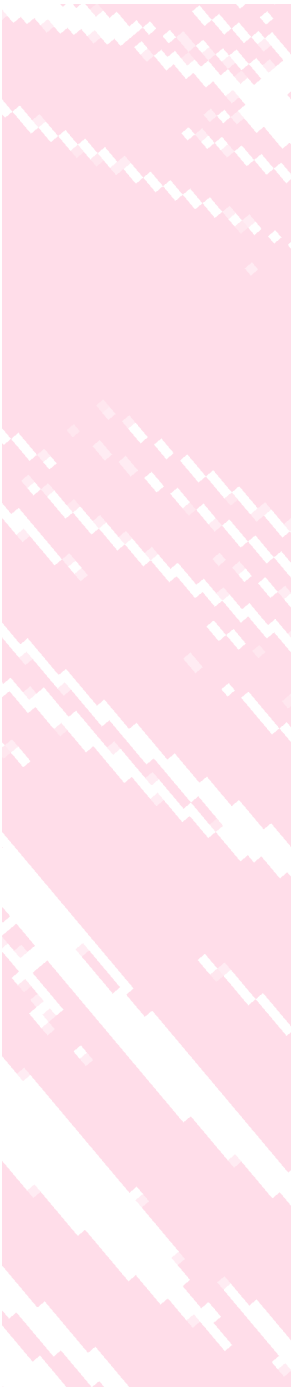


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This report of a global policy research effort on health sector reform, maternal mortality and abortion, undertaken by DAWN in 12 countries of the South under a grant from the John and Catherine D. Mac Arthur Foundation, makes a uniquely substantive and timely contribution to the literature on national level advocacy work in support of women's reproductive health and rights in the post-ICPD period.

DAWN invested heavily in both the ICPD and its 5-year and 10-year implementation reviews, producing analyses and engaging in sustained advocacy and lobbying to facilitate the consensus that was reached in Cairo, and subsequently assessing ICPD implementation across a range of selected Southern countries, highlighting the policy environments which enabled or constrained implementation.

The research represented by the present report has built on that earlier work by DAWN and was similarly led by DAWN's Research Coordinator for Sexual and Reproductive Health & Rights, veteran women's rights lobbyist, Sonia Corrêa. The 12 countries covered in the research effort span Latin America (Argentina, Bolivia, Brazil, Mexico and Uruguay), the Caribbean (Barbados, Jamaica, Surinam and Trinidad and Tobago), Africa (Ghana and Nigeria), and South East Asia (Philippines).

Interconnecting, in DAWN's signature style, macro-economic policy trends, state reform processes, sexual and reproductive health issues and women's citizenship and human rights struggles, the report combines a discussion of disquieting global trends and a pithy historical overview with a detailed study of the three areas investigated (HSR, maternal mortality, and abortion) within each of the 12 countries. The analysis unfolds a richly textured landscape, in which HSR, S&RH policies, maternal mortality, and unsafe abortion and law reform in each of the countries are thrown into relief. Commonalities and differences among the countries studied are deftly drawn out.

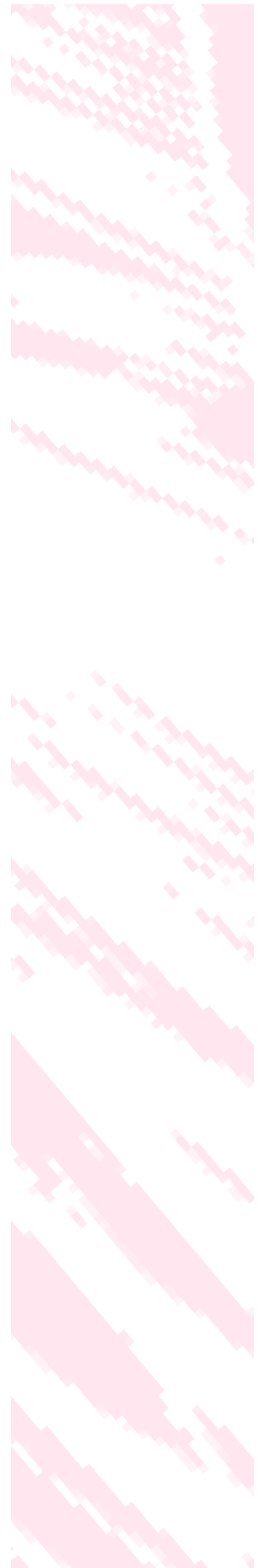
DAWN's earlier research had uncovered the disconnection between processes and actors concerned with S&R H&R on the one hand, and those concerned with state and health sector reforms on the other. The present report's overview of how, and with what effect, the World Bank model of health sector reform (which provides the framework for national public health

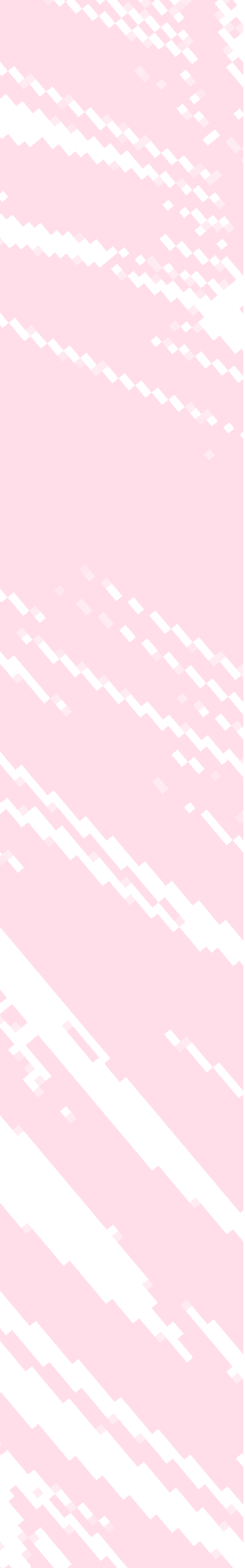
systems in all 12 countries today) is being implemented, is comprehensive, lucid and balanced. The positive dimensions of HSR and the complete absence of the Cairo framework from the HSR model are equally noted, as are the more subtle and complex dimensions of shifting from public to private health care provision, and from state-subsidised/free health service provision to user-pays and private insurance based health care.

The Cairo consensus was a milestone achievement in the struggle for women's rights promising sexual and reproductive health care, recognition of women's reproductive rights, and safe abortion where it is legal. Since then, and especially since the Bush Administration came into office, a significantly changed global political climate and the regrouping of neo-conservative political forces have several times tried to revoke the global consensus reached in Cairo with respect to women's reproductive health and rights. They have also seriously impinged on the delivery of reproductive health services, especially where such services rely on funding from USAID, as in Latin America and the Caribbean. Reproductive rights may be said to lie at the very heart of women's struggles to attain full citizenship in the sense of full autonomy. Together with sexual rights, reproductive rights provoke the fiercest opposition from moral conservatives, much of whose agitation centers on the highly-charged issue of abortion. It is in its dispassionate investigation of this controversial and divisive issue that the report really excels.

The inclusion of 'improving maternal health' as Goal 5 of the Millennium Development Goals (MDGs), with the target of attaining a 75% reduction in the maternal mortality ratio by 2015, invited a long-overdue probe into the relationship between high maternal mortality rates and unsafe abortion. Notwithstanding the importance of raising the proportion of births attended by trained health personnel, it is made patently, if unpalatably, clear in this report that any genuine commitment to effectively reducing maternal mortality rates requires recognising the facts that unsafe abortions account for a high proportion of maternal deaths, and that criminalisation of abortion does not act as a deterrent.

The last chapter's detailing of abortion law reform advocacy efforts and judicial and political processes in the 12 diverse national contexts provide a wealth of insights and useful lessons, as well as some distressing cases and uncomfortable truths about parties and political expediency. The report illustrates that a yawning gulf between law and practice often exists, and suggests that in some contexts low-key advocacy for abortion law reform, rather than public campaigning, may be more effective. Where campaigns to decriminalise abortion have been more public, women's movements have sometimes encountered political opposition where they least expected it - from Left parties or governments with which they otherwise have close political affinity. Nicaragua's legislated total ban on abortion (prohibiting termination even when a mother's life is in danger), signed into law on 17 November 2006 by President Enrique Bolaños after being passed by the





country's legislature with the backing of Sandanista members of parliament, is the most recent, and extreme, example of what can only be viewed as a viciously repressive and punitive law against women, enacted to secure the votes of conservative constituencies.

On a more positive note, the report indicates that research and statistics on abortion and maternal mortality provide crucial supporting arguments for abortion law reform. DAWN hopes that this analysis and the detailed results of research in the 12 countries that it brings together will be a useful resource for feminist and health and legislative reform advocates in other countries. We record sincere thanks to the MacArthur Foundation for the unstinting support it has provided for DAWN's ongoing sexual and reproductive health and rights work.

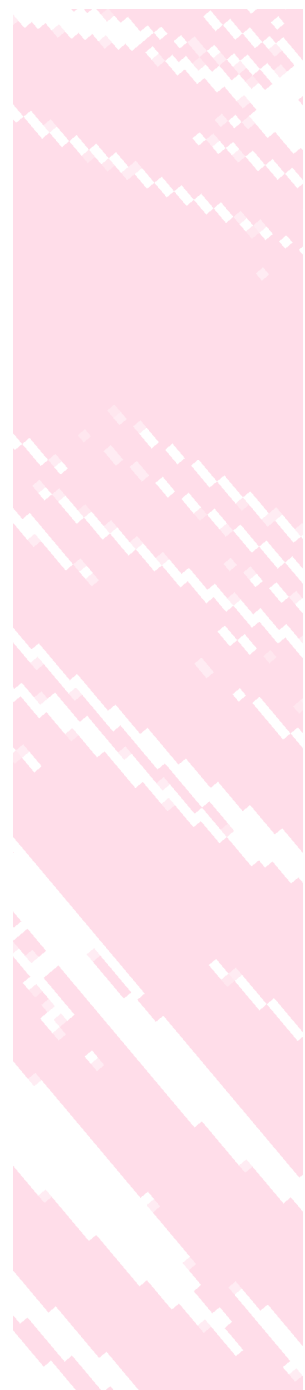
Claire Slatter
November, 2006

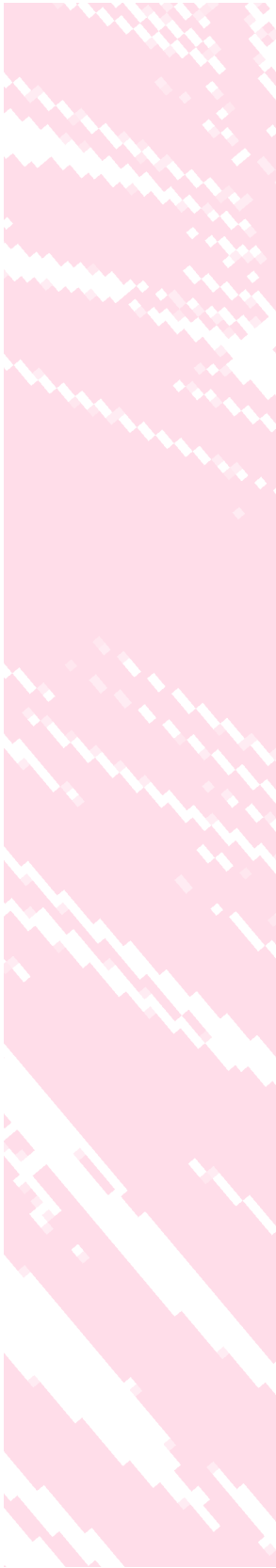
I. The Research Process: Background and Outcomes

In 2001, the DAWN Sexual and Reproductive Health and Rights (S&R H&R) Program designed a new global policy research effort to examine the ways in which health reform processes affect national responses to maternal mortality and post-abortion care, as well as context specific dynamics regarding the legalization of abortion. This initiative was motivated, among other things, by the approaching 10th anniversary in 2004 of the International Conference on Population and Development (ICPD), which presented itself as a privileged opportunity to re-visit progress in a group of countries that had been the object of a DAWN policy assessment in 1999–2000 (Corrêa 2000, *Weighing-up Cairo*).

The conclusions of the 2000 research effort had already revealed the need to address more systematically the connections between health sector reform (HSR) and S&R health policies and related advocacy efforts. By 2001, the need for a better understanding of these connections became even more relevant in the light of the new approach adopted by DAWN that sought to link the various areas of research and advocacy in which the network has historically invested. Within this broader analytical frame, HSR could be explored as a critical juncture between macroeconomic trends, processes of state transformation and S&R health issues, as components of a reconfigured citizenship and the human rights agenda.

It is clear that since 1994 maternal mortality reduction has achieved great policy visibility and legitimacy at global level, as well as receiving substantial financial investment from bilateral and multilateral donors and foundations. This trend culminated in the inclusion of a maternal mortality reduction target among the Millennium Development Goals (MDGs), in which it is strongly linked with the global poverty reduction agenda (in contrast with the exclusion of broad ICPD targets). Abortion, on the other hand, even immediately after Cairo and the Fourth World Conference on Women in Beijing (1995), did not receive adequate attention and investment on the part of major institutional players. In some cases it was openly avoided by donor agencies and state parties that considered it to be “much too controversial” to be raised high in policy agendas.





After 2001, this “rift” between the two issues would become increasingly pronounced, as an anti-abortion position became an item in the new US administration foreign policy agenda. These circumstances made it critical to examine more thoroughly the connections between abortion and maternal mortality in national settings. From DAWN’s perspective this new research effort also represented an opportunity to mobilize – or in some cases re-mobilize – local community advocacy efforts aimed at ensuring access to legal and safe abortion procedures.

Twelve countries were examined in this new research cycle: Argentina, Brazil, Bolivia, Mexico and Uruguay in Latin America; Ghana and Nigeria in Africa; the Philippines in Asia; Barbados, Jamaica, Surinam and Trinidad and Tobago in the Caribbean.¹ Since DAWN’s intersectional approach to S&R H&R was used as the over-arching framework to guide the studies, multiple dimensions of the issue were explored, though in differing degrees of depth and detail in the different studies:

- The overall socio-economic and political environment as it affects HSR, S&R health indicators and the implementation of the ICPD agenda;
- The orientation and development of HSR processes and the connections between them and S&R H&R policy and advocacy efforts;
- Whenever possible, the impacts of HSR in terms of improving or worsening national health systems’ response to maternal mortality, safe abortion services (where legal) and post-abortion care;
- Disparities observed at country level with respect to maternal mortality related policy initiatives (and their eventual connections with poverty reduction strategies) and measures regarding abortion (as one factor behind maternal mortality rates, as well as with respect to access to safe abortion and post-abortion care); and
- Political, policy, legal and advocacy processes around expanding access to safe abortion.

The wide range of countries included in the research presents a highly heterogeneous panorama as far as these various dimensions are concerned. There are significant differences with respect to which aspects each country research team considered should be given more emphasis in their contribution to public debate on these issues. Important distinctions can also be identified in terms of the historical trajectory of S&R H&R policies, as well as in terms of the main concerns being discussed at country level. While in the Caribbean and Mexico family planning programs have existed since the 1970s, in Argentina the law allowing for public distribution of contraception – under discussion since 1995 – was finally passed just shortly before the research started. While in Brazil the 1984 Women’s Health policy anticipated Cairo by ten years, in the majority of the other countries comprehensive H&R approaches mainly evolved under the impact of ICPD and Beijing. Variations

¹ Originally Cameroon was also included in the African sample. However the country coordinator was unable to complete the research due to a series of personal problems.

are also found in terms of national installed capacity to measure and address maternal mortality.

Yet more striking is the heterogeneity regarding the legal status of abortion and the struggles to make it safe and accessible. The only country studied where abortion is legal since the 1980s is Barbados. But as the research evolved, the Uruguayan parliament voted on and almost passed a bill to legalize abortion. Meanwhile in Ghana current efforts are mainly aimed at securing implementation of the relatively liberal 1980s abortion legislation, which women are not familiar with and which is not always recognized by health providers. In Nigeria and the Philippines the debate on the legalization of abortion has been politically stalled for some years.

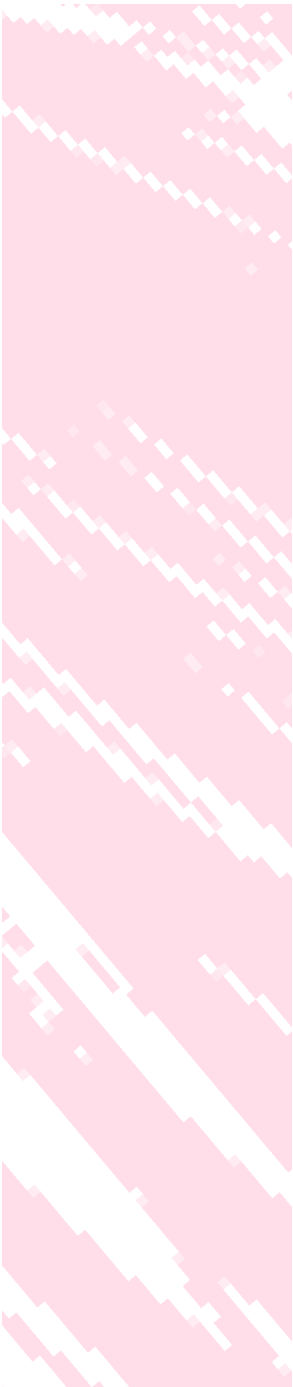
It should also be noted that the time frame covered by the case studies varies somewhat. In most cases it covers the 2002-2004 period, but in a few cases (Bolivia, Uruguay and the Philippines) information on the background economic and policy scenario is limited to 2002 and 2003. It is important to bear this in mind, since in all these cases important events have taken place subsequently which it has not been possible to analyze in depth.

Consequently, although common research guidelines were developed to orient the country case studies, the research emphasis and findings differ quite significantly from country to country. Though the global crosscutting analysis presented here aims to capture as best it can this heterogeneity, it has not been possible to avoid losing certain contextual nuances. For this reason, the publication of the separate country cases was crucial to register the wealth of the national experiences. The final outcome of the global research effort therefore combines both this global report and a series of country case study publications – Argentina, Bolivia, Ghana, Mexico, Nigeria, the Philippines and Uruguay – a Joint Report on the four Caribbean countries studied and a paper focusing specifically on the question of the legalization of abortion in Brazil (2004-2005).²



² The four Latin American country reports will be exclusively available in Spanish and the Brazilian paper will be also published in Portuguese.

II. Disquieting Global Trends



A diverse range of observers would agree that one major feature of the present global environment is the expansion of conservative forces and trends evident in a whole range of spheres: social issues, politics, economics and, last but not least, culture and religion. Gender equality and the contents of the S&R health agenda adopted at UN conferences in the 1990s, in particular those aspects dealing with abortion and sexual rights, have become prime targets of the contemporary conservative agenda.

To those who have engaged in the global negotiating arena during the last fifteen years this hardly comes as a surprise. While the first years of the 1990s were in many respects characterized by expansion and progress on these issues, by the end of the decade an array of conservative forces – such as the Vatican and Islamic countries – were already pushing regressive positions in various arenas in an attempt to curtail the gains made (Sen and Corrêa 1999, 2000, Girard 2000). In this context, the election of George Bush in 2001, and his re-election in 2004 as a champion of “moral values”, should be seen not as a peculiar accident of US politics, but as the culmination of an ongoing trend, which was not tracked and the implications of which were not fully assessed by progressive sectors, both within and outside the US (Girard, 2004).

The attack by conservative forces has been particularly virulent in the UN arena. The article by Brian Whitaker published in *The Guardian* in January 2005 provides a precise account of how the alliance between these forces coalesced immediately after the Cairo and Beijing Conferences: *“The idea of forging an international Christian-Muslim alliance to fight liberal social policies began to develop in 1996 when an event known to ‘pro-family’ activists as ‘The Istanbul Miracle’ occurred. It happened at a UN conference in Turkey called Habitat Two. Richard Wilkins – now head of the Mormons’ World Family Policy Centre – was there and, according to his own account, helped to perform the miracle. ‘The Istanbul conference,’ he wrote, ‘was convened – in large measure – by a worldwide, well-organized and well-funded coalition of governments, politicians, academicians and non-governmental organizations that were eager to redefine marriage and family life. Professors, politicians and pundits described natural marriage, based on the union of a man and a woman, as an institution that*

oppressed and demeaned women. The constant claim was that 'various forms of the family exist', and all 'various forms' were entitled to 'legal support'. The 'form' most often discussed by those in charge of the conference was a relationship between two individuals of the same gender.' Wilkins challenged all this with a four-minute speech on traditional family values, which also castigated sex education in schools. He was hissed by some of the delegates as he returned to his seat but afterwards, he recalled, 'I was approached by the ambassador from Saudi Arabia who embraced me warmly.' Wilkins gave the Saudi ambassador a list of suggested changes to the draft Habitat agenda, and The Istanbul Miracle was born. 'Thirty-six hours later, the heads of the Arab delegations in Istanbul issued a joint statement, announcing ... that its members would not sign the Habitat agenda unless (and until) certain important changes were made,' Wilkins wrote."³

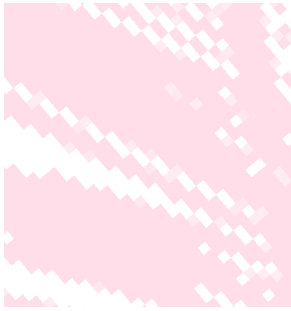
As this compelling account suggests, moral conservative forces do not simply aim at eroding UN language. They are reacting to profound transformations underway in the realms of gender, biological and social reproduction and sexuality, make visible and legitimized by the UN definitions of the 1990s. The DAWN research findings in the twelve Southern countries presented here demonstrate that, though important transformations have effectively taken place, at the ground level S&R H&R are far from being a tangible reality for the vast majority of people, most particularly women and girls. This suggests that these conservative moral forces are, in fact, engaged in a pre-emptive attack against a process of social change that is still in its early stages, but which may entirely re-shape the gender and sexuality landscape as we know it.

However, the global policy environment in the 2000s is problematic in many other structural respects. Some authors characterize the first years of the 21st century as an era of frustration or broken promises (Fonseca and Belli 2002). Following the fall of the Berlin wall in 1989, it was predicted that the end of the Cold War would favor multilateral cooperation, the reduction of military expenditure to fund human development and the expansion of human rights. Despite advances at the normative level, these expectations have not materialized. At present, US unilateral action undermines multilateral cooperation at many levels. The Iraq war and other unresolved conflicts occupy the center of the global stage. Once again, huge investments are being made in the arms industry and militarization, while resources for human development lag far behind what has been formally announced or promised. It is true that the human rights genie has come out of its lamp to become a compelling source of energy for political and social transformation all over the world. But, on the other hand, in addition to the fundamentalist attacks on women's human rights, measures "against terrorism" are riding roughshod over the consecrated rules of international law as well as curtailing civil and political rights in many settings, most particularly the US.

Given this general climate, it is not surprising that the global social agenda agreed upon in the 1990s is being downsized to a poverty eradication formula (or to be more precise a poverty reduction strategy). The implications of these



³ Brian Whitaker (2005). "Fundamental union", *The Guardian*, 25 January. Available on-line at: <http://www.guardian.co.uk/elsewhere/journalist/story/0,7792,1398055,00.html>.



4 There are many examples, including the headlines publicizing the launch of the 2002 UNFPA World Population Report. But Brazil best illustrates this phenomenon: since late 2002, when the recently elected administration of Luiz Inácio “Lula” da Silva announced that poverty reduction was a priority, the country has seen an unrelenting revival of neo-Malthusianism.

5 In addition to Seattle, Doha and Cancun, other relevant regional and cross-regional trade and political negotiations have also take place. These include: the Free Trade Area of the Americas (FTAA); the G3 (Brazil, South Africa and India); ongoing MERCOSUR (Mercado Común del Sur) processes; an emerging South American common economic agenda and novel trade negotiations between Latin America and the Arab countries; the EU-MERCOSUR trade agreement; the consolidation of the African Union; the further consolidation of the Association of Southeast Asian Nations (ASEAN) and of Asia-Pacific Economic Cooperation (APEC). The positive or negative impact of these complex and contradictory processes as far as gender equality and S&R H&R are concerned is far from clear.

6 A clear example from 2004 was when Brazil, under the threat of a trade boycott by Arab countries, decided not to retable a resolution on sexual orientation and human rights (E/CN.4/2003/L.92) at the UN Commission on Human Rights (CHR).

various trends for the ICPD and Beijing agendas are not trivial; suffice it to examine what have been the impacts of the Millennium Development framework as established in 2001-2002. An immediate effect was the exclusion of Cairo goals and the reduction of the comprehensive ICPD and Beijing agendas to three dimensions: maternal mortality, girl's education and HIV infection. Since 2002, this unacceptable narrowing of the agenda has been widely criticized and as a result human and financial resources have been channeled to redress this trend. Another aspect that has been given less attention was signaled by Mary Robinson: the narrow MDG frame voids the substantive connections between poverty and human rights, a linkage that is vital for women's well-being and self-determination (Robinson 2003). Finally, the narrow MDG framework in conjunction with the conservative moral agenda has somehow returned the population and development debate to pre-Cairo language. The years 2002-2004 have witnessed a revival, at both global and national levels, of the argument that fertility control is a pre-requisite for poverty alleviation.⁴ Reacting against these developments, at the 2005 World Social Forum, Latin American and global feminist networks and organizations launched a call for: “*The full Beijing agenda not just one goal*”.

As these disquieting trends evolve, the belief that market-oriented economic models would bring development remains unshaken. Still much remains to be researched and understood in relation to the synergy between economics and conservative positions regarding gender and sexuality, in particular in terms of the articulation between the interests of US corporations, trade, finances and the military and the moral agenda of the Bush administration. However, it is important to note that long before the arrival of Bush on the global scene a cultural trend favoring the growth of fundamentalism was already gaining ground. This trend was fed by uncertainty, insecurity, poverty, unemployment and the breaking of social contracts, deriving mostly from dogmatic macroeconomic rules adopted in the late 1970s, which by and large remain with us (Sen and Grown 1986; Sen and Corrêa 2000).

With respect to the economic environment, another relevant factor is the series of international trade negotiations that took place between 1999 and 2004, the best-known being the World Trade Organization's (WTO) Ministerial meetings in Seattle, Doha and Cancun.⁵ These processes have important implications both for national development and the dynamics of global diplomacy. The last Ministerial Meeting in Cancun is of particular relevance because at this meeting Southern countries, led by Brazil, China and India, raised their voices against the interests of the US and the European Union. This entirely changed the pattern that had prevailed in WTO negotiations since 1995, leading to a stalemate that has not yet been resolved. There are signs that these complex and contradictory processes somehow affect the position adopted by those countries involved in other arenas with respect to gender equality and S&R H&R. However, the full picture of the links between these different dynamics is not yet clear.⁶

These global forces and trends are meaningful in themselves because international policy arenas have become and will remain in the near future strategic sites to defend the advances achieved over the last decade as far as gender, S&R H&R, maternal mortality and abortion are concerned. But, in times of globalization they also have far-reaching and profound ramifications that either directly or indirectly affect social dynamics and the policy scenario in the most diverse national settings across the world.

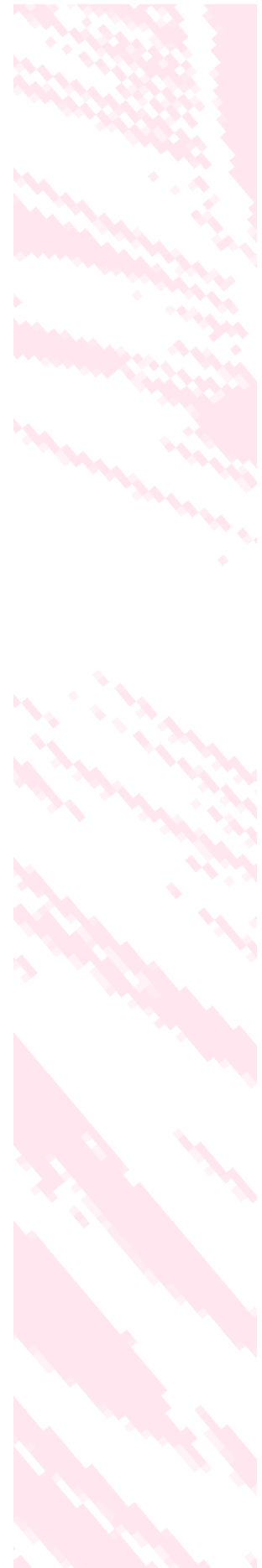
In the case of the twelve countries in which the research was performed differences do exist with respect to the timing and format of structural adjustment programs (SAPs). As will become clear from the accounts below, context-specific factors play an important part in determining the impact of market-oriented state reforms adopted since the 1980s in relation to HSR, S&R health policies, maternal mortality and abortion. But in all country cases debt problems, fiscal stringency and unemployment are cited as factors that either affect the performance of health policies or lead to political dissatisfaction and instability.

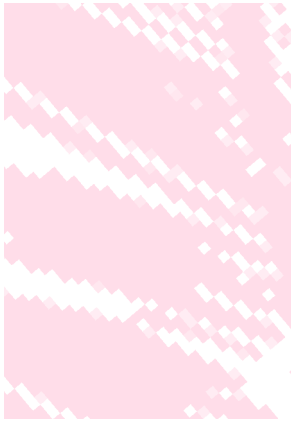
Though the impact of trade is not emphasized in the case studies, it is another important factor to be taken into account. Though the negative impact of trade rules is more clearly blatant in some cases (the Caribbean, Ghana, Bolivia), in all twelve countries WTO, bi-lateral trade agreements and EU agricultural subsidies have directly affected economic growth rates and the balance of payments, and indirectly inflation and public spending. Lastly, all the Latin American countries and the Philippines were hit by the global financial quake of 1997-1999, of which the most dramatic effect was the Argentinean debt default of 2001 and the political crisis that it unleashed.

In the same way, though the effects may vary in intensity, the negative spillover of US conservative moral policies is already visible practically everywhere. Particularly relevant is the impact of the Gag Rule and abstinence-only guidelines being pushed by the Bush administration. In fact, the case studies suggest that in most cases – at least until mid-2004 – the impact of US policies is much more tangible than the narrowing effects of the MDG agenda. As imagined, the tentacles of the Vatican can also be found across the twelve countries, even if in the case of the Caribbean its influence is not ubiquitous, nor as significant as the presence of protestant Churches. Protestant religious forces, particularly from Evangelical traditions, are also present almost in every setting under study, including in Latin America, where until recently Catholicism was clearly hegemonic. Islamic fundamentalism, which is already a political force in Nigeria and in specific regions of the Philippines, has now also started to become prominent in the Caribbean, particularly Trinidad and Tobago.

SITES OF RESISTANCE AND VIRTUOUS GLOBAL-LOCAL LINKAGES

Though the global policy environment has become adverse and prospects are somber, sites and signs of resistance can be identified, which must be more





7 HIV-AIDS UNGASS (New York, July 2001); Rio+10 (Johannesburg, August 2002); 35th Session of the UN Commission on Population and Development (CPD, New York, April 2002); Ten-Year Review of the World Summit for Children (New York, May 2002); 5th Asian and Pacific Regional Conference on Population and Development (Bangkok, December 2002); 59th CHR Session (Geneva, March-April 2003); ICPD+10 Regional Review in Latin America and the Caribbean, first meeting (Port of Spain, November 2003); Adoption of the WHO Reproductive Health Strategy (January, 2004); ICPD +10 Regional Review in Latin America and the Caribbean, second meeting (Santiago, March, 2004); 37th Session of the CPD (New York, March 2004); ICPD+10 Regional Review in Latin America and the Caribbean, third meeting (San Juan, June-July 2004); ICPD+10 Regional Review in Africa (Dakar, June 2004); Ninth Regional Conference on Women in Latin American and the Caribbean (Beijing+10 Regional Review, Mexico City, June 2004); UN Economic and Social Commission for Asia and the Pacific (ESCAP) High-Level Intergovernmental Meeting on Beijing+10 (September 2004); 7th African Regional Conference on Women (Beijing+10 Regional Review, October 2004); 38th UN CPD Session (April 2005).

closely examined and valued. As the DAWN policy research effort progressed (2002- 2004), a series of ICPD and Beijing related global and regional negotiations occurred in which the negative forces and trends described above were at play. Nevertheless, on at least fourteen occasions Southern countries – including those studied in this sample – re-affirmed the consensus reached at Cairo and Beijing a decade earlier.⁷

In all cases countries supportive of these agendas had to confront old adversaries – the Vatican and regressive Islamic voices – as well as the US. The US in particular used both political and economic threats, such as the suspension of funds for HIV and family planning, to pressure poor countries to support their regressive positions. Further analysis is still required with respect to the main factors and actors behind these victories. In particular, as mentioned above, much remains to be learned about the convergences and inconsistencies between the positions adopted by Southern countries in these negotiations and the struggles evolving on the global trade front. But more is known about the dynamics observed at the various ICPD and Beijing related negotiations mentioned here. A first important aspect to underline is that Southern countries' support for the ICPD and Beijing agendas in the recent Plus Ten Review processes should not be seen as a novelty. It has, in fact, been gradually building, despite the fact that a number of developing countries expressed reservations in 1994 and 1995.

Already during the Cairo process itself, a few countries – such as Brazil, Mexico, Uruguay, Bolivia, the Caribbean, South Africa, India, Egypt – took distance from the Vatican and other conservative moral positions. The number of progressive Southern voices clearly expanded at Beijing. In 1999 during the ICPD+5 Review, SLACC (Some Latin American and Caribbean Countries) emerged as a new “negotiating progressive bloc” that did not align with the regressive positions dominating the Group of 77 and as the negotiations progressed, other voices as South Africa, Namibia, Ghana and Cameroon would also join SLACC even if they did not belong to the Latin American and Caribbean regions. But at that stage it was already clear that Islamic countries, especially Egypt, and other African countries had abandoned their early commitments to ICPD. One year later in the Beijing +Five Review, though India remained committed to the 1995 agenda, South Africa and the Caribbean countries also lowered their profile in the negotiations and not few difficult negotiations would remain silent. Despite these defections, it is not excessive to say Southern countries' support for Cairo and Beijing has been, by and large, maintained up until the ICPD and Beijing Plus Ten Reviews.

One concrete example was at the Asia and Pacific Population Conference in Bangkok (2002) – and later in the Beijing+10 Regional Review – when the whole of Asia and the Pacific openly confronted the US. This meant a strong consensus involving a number of Islamic delegations, including Pakistan and Iran as well as the Philippines, which is historically prone to Vatican pressure. Similarly, at the Latin American and Caribbean ICPD and Beijing Plus Ten

negotiations that took place between November 2003 and June 2004, countries maintained or adopted even more progressive positions, with the exception of the Central American countries.⁸ In Africa at the Dakar meeting in June 2004, the ICPD agenda was reaffirmed despite the presence of some strongholds of moral conservatism, such as Egypt, Algeria and Sudan.

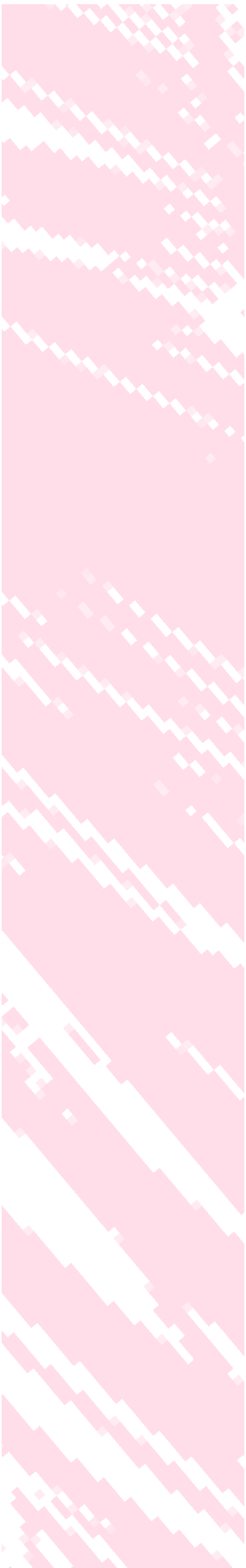
When all these negotiations are examined in connection to global processes a patchwork emerges of shifting and contradictory positions between global and regional levels. For instance, Pakistan would never be so progressive in New York or Geneva as it was in Bangkok. Some Latin American countries, like Chile, would not be so vocal in the Commission on Population and Development as they were in Santiago and San Juan. It is not at all clear that the African Dakar Consensus will transfer intact into the General Assembly negotiations. This is one aspect constantly emphasized in the DAWN research discussions: there are multiple inconsistencies between positions taken by countries in regional and global arenas, just as there is also a big gap between the nice-sounding speeches made at international negotiations and the realities of the policies being implemented on the ground. Often it is the task of women's advocates to call attention to these contradictions.

However, even bearing in mind these contradictions, the systematic defeat of regressive forces on these different occasions should not be minimized, if only because the pressure and the threats that were brought to bear were considerable. Instead, the factors explaining these positive outcomes must be highlighted, among other reasons because they may be signaling a new political and diplomatic dynamic that may prevail in the future with regard to the ICPD and Beijing agendas. One clearly visible factor behind these positive regional outcomes seems to be the US's arrogance in all the negotiations. The gradual strengthening of regional economic alliances may be another unmapped factor. Another viable hypothesis is that in some cases donors' support for ICPD and Beijing provided an important impetus for countries to express progressive positions that they would otherwise have avoided. This means that the role played by European Union delegations and UN agencies, particularly UNFPA, was extremely valuable. But it is difficult to imagine that these global and regional outcomes would have been achieved if the ICPD and Beijing agendas had not somehow been incorporated over the last ten years into domestic policies as a result of sustained pressure by women's organizations.

The DAWN research findings strongly suggest that there is a great deal of coherence between the diplomatic positions taken by the twelve sample countries in global arenas and what is occurring on the domestic policy front. In the case of the Latin American and Caribbean ICPD+10 process, Brazil, Argentina, Uruguay (operating as Mercosur) and Mexico have played a key positive role. A major turn-around was Argentina's change of position with respect to reproductive health and rights in general and abortion in particular, which since ICPD had been extremely regressive. This shift is related both to



⁸ The Vatican has historically had a strong influence in Central American countries. Most of them expressed reservations in Cairo and are currently under very strong aid and trade-related pressure from the US.



the recent political changes that have taken place in the country and the growing strength of feminist voices. The Caribbean has also somehow regained its international voice in relation to the ICPD and Beijing agendas, even if the country cases suggest that policy implementation is far from perfect. In Asia, the Philippines, despite many internal contradictions – and regardless of the historical Vatican and recent US pressures – took a flexible position at the Bangkok ESCAP Conference and a positive leading role in the Beijing+10 Conference. In Africa, the outcomes of the ICPD+10 Dakar conference would also have been different if it were not for the presence of feminist NGOs and the positive role played by a handful of countries, including Ghana and Nigeria.

This means that – while we should not lose sight of the extremely negative trends mentioned above – sustained advocacy by women’s organizations, both at national and international levels, and the effective implementation of policies are crucial elements explaining why Southern countries have not retreated back from the commitments made in 1994 and 1995. The analysis that follows below will describe in more detail how these trends are evolving at country level, in terms of progress made but also with respect to obstacles, fault lines and gaps.

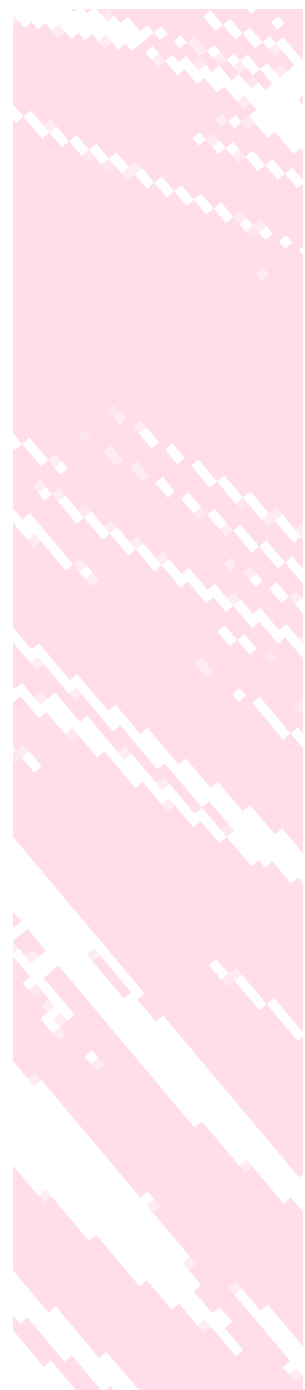
III - Country Profiles: Heterogeneities and Commonalities


The group of countries studied in the DAWN research effort is extremely heterogeneous in terms of size and scale, main economic and social conditions, health and gender indicators. However, as mentioned above, common features are also found with respect to macroeconomic policies and their negative impacts, and the presence or influence of conservative forces. While detailed data on individual countries is provided in the Annex, this section explores heterogeneities and commonalities in a concise cross country analysis covering four dimensions: 1) Size, scale, internal heterogeneity; 2) Historical and current political trends, including the role of women's organizations; 3) General economic and social aspects; 4) Basic gender and health indicators.

SIZE, SCALE AND HETEROGENEITY WITHIN

Among the cases studied in this research we find both Brazil – one of the largest countries in the world – and Barbados – a tiny island of 430 square kilometers. There are also huge differences with respect to population size, which is not automatically related to the size of territory. While Brazil also has the largest population (172 million), the number of people living in Nigeria, Mexico and the Philippines ranges from 130 to 82 million although their territories are much smaller, in particular the Philippines (just 300.000 square kilometers). Argentina is second in size but has a population of just 30 million. The Uruguayan territory is practically the same size as Ghana, which has roughly triple the number of inhabitants. Even among the Caribbean countries, all of which cover about a thousand square kilometers, variations are observed in terms of population density. A related aspect is the variation in the distribution of the population between urban and rural areas. In the Latin American countries, Surinam and Trinidad and Tobago over 60 per cent of people live in cities. In the other two Caribbean Island States over 50 per cent of the population is urban-based. In contrast, Ghana, Nigeria and the Philippines have larger rural than urban populations, even though they also have large cities with millions of inhabitants.

Within countries differences and disparities are also observable in terms of geographical, environmental and regional aspects, as well as race and ethnicity,





and urban-rural divides. The country cases indicate that these heterogeneities impact on economic, social and health outcomes as well on political stability. Nigeria and Bolivia are extreme examples of this as, during the period under study, internal heterogeneity has concretely affected the stability of the state system and even gender-related norms and policies. But internal differentials and disparities in Mexico, the Philippines, Trinidad and Tobago, Surinam and Ghana, should not be minimized either. In the Caribbean, Trinidad and Surinam also present great ethnic diversity. In Brazil, race and regional inequalities are extremely important factors behind policy deficits in a variety of areas. Even in Barbados, Uruguay and Argentina – which are clearly more homogenous societies – class, race, urban-rural differentials are mentioned in regard to access to services, poverty levels and gender indicators.

Cross-country heterogeneity presents many challenges in terms of comparability of data and findings. Internal diversity and disparity requires caution when national average social and health indicators are examined. The policy implications of these differences and disparities are not trivial either. Even if we leave aside the differences in national income and government spending that actually exist between the twelve countries, it must be recognized that the political will as well as the human and financial resources required to design a health reform program for Mexico, Nigeria and the Philippines are not equivalent to what is needed in Barbados, Surinam, Uruguay and Jamaica. The same is true of the challenges faced in implementing programs aimed at reducing maternal mortality in Brazil, the Philippines and Ghana, on the one hand, or in the Caribbean Islands, on the other.

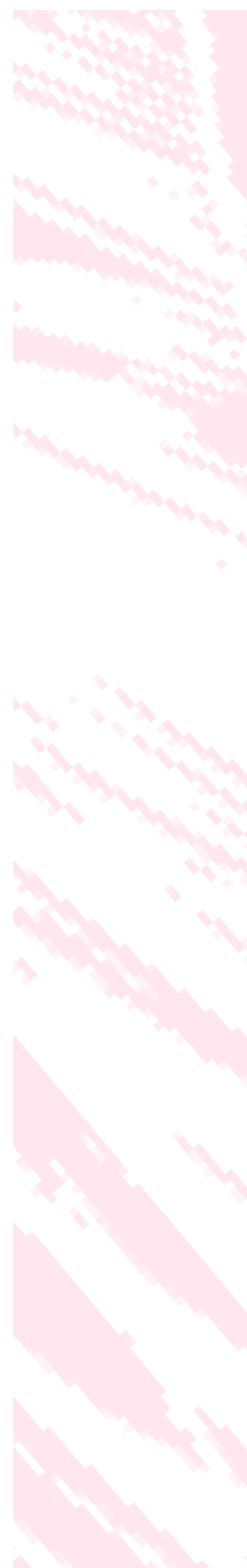
The findings tell us that the ability of women's groups to develop a public discourse on legal abortion and to promote public debates on the subject is strongly determined by culture, religion and politics. But the size of countries and their internal heterogeneities cannot be minimized when assessing the impacts of these efforts. It is much more difficult to influence public opinion in large countries – like Brazil, Mexico and Nigeria – than in smaller ones, because access to the media and other means of communication is not as easy. It is much easier to create a successful public debate on abortion in a more homogenous society such as Uruguay, than in a country as diverse as Trinidad and Tobago. Challenges to openly discussing legal abortion are evidently greater in countries where the large majority of the population still lives in rural areas.

The DAWN team fully recognizes the limitations that these factors imply for cross-country comparability and the use of national average indicators (that are widely used in the country reports). The policy challenges deriving from internal differences and disparities were also stressed in our collective research discussions. For precisely these reasons, these aspects are being raised up-front in this analysis as a call for caution. When reading both the country-specific and cross-country analyses that follow, the heterogeneities

signaled here must be borne permanently in mind in order to avoid easy or erroneous comparisons and conclusions.

TABLE 1: HETEROGENEITY AMONG AND WITHIN COUNTRIES

Country	Size (Km2)	Population	Urban/Rural	Internal Heterogeneities
Argentina	2,780,000	32,200,000	90/10 per cent	Urban and rural disparities. Regional disparities northern provinces less developed and poorer. Remaining indigenous population much more vulnerable.
Bolivia	1,000,000	8,200,000	63/27 per cent	Great geographic ecological diversity (mountains, plains, forest). Great ethnic diversity: 62% indigenous, distributed between two main groups (Aymaras and Quechuas) and at least 38 other smaller ones. 38% mixed and white populations. From 2001-2004 combined economic and ethnic tensions led to great political instability.
Brazil	8,000,000	172,000,000	82/18 per cent	Great geographic and ecological diversity. Important regional gaps (north and northeast). Great racial inequality: 50% Afro-Brazilians (comprising mixed and black), 50% Caucasian and Asian, roughly 400,000 indigenous.
Mexico	1,100,000	101,000,000	75/25 per cent	Great geographic and ecological diversity. Great regional gaps (south and southwest). 10% indigenous population (10 million), concentrated in 11 states (north and south), who are much poorer and more vulnerable. Persistent ethnic-based conflicts, particularly in Chiapas.
Uruguay	174,000	3,400,000	92/8 per cent	Urban-rural disparities. 10% Afro-Uruguayans.
Barbados	431	264,000	51/49 per cent	Majority of the population is Afro-Caribbean but has the largest percentage of white population in the region. Urban-rural disparities.
Jamaica	10,891	2,515,500	52/48 per cent	Afro-Caribbean majority, relevant Chinese and Lebanese communities and a smaller percentage of East Indians. Urban-rural divide.



Surinam	163,820	418,912	75/25 per cent	16 ethno-linguistic groups: Creole 35%; East Indian 34%; Javanese 16%; Maroons 10%; native Amerindians 2%; Chinese 2%; Lebanese, Europeans and others 1%. Great geographic and ecological differences between coastal areas and the tropical forest hinterland.
Trinidad	5,128	1,270,000	75/25 per cent	Great ethnic diversity: African origin 39%; East Indian 40.3%; mixed race 18.4%; white/Caucasian 0.6%; Chinese, Syrian, Lebanese 0.5%; other 0.6%.
Ghana	238,540	19,000,000	45/55 per cent	Five major ethnic groups. English and 75 African languages. 50% Christian (mostly protestant); 15% Muslim; other African traditional and syncretic religions.
Nigeria	923,768	130,000,000	46/55 per cent 10 million in Lagos	300 ethnic groups; three main groups: Yoruba, Ibo, Hausa-Fulani. 50% Muslim; 34% Christian; other African traditional and syncretic religions. English; main ethnic languages: Edo, Efik; other local languages. Tensions between states and between states and the center.
Philippines	300,000	82,000,000	30/70 per cent Urban population concentrated in 4 major cities	7,107 islands (3 main ones). Tagalog (main mother language), English and another 102 languages and dialects. Indigenous population: 6 million. Catholics 81%, local Churches 7%, Protestants 6% (20 denominations) and Muslims 5.1%. Harsh conflict in the Muslim region.

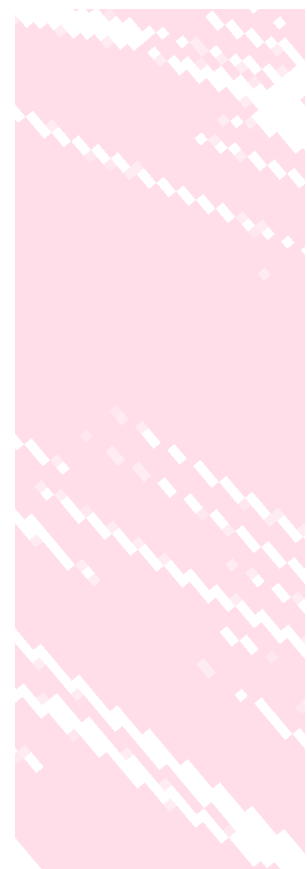
Source: Country reports and UNDP database

IV - The Political and Economic Landscape: Past and Present

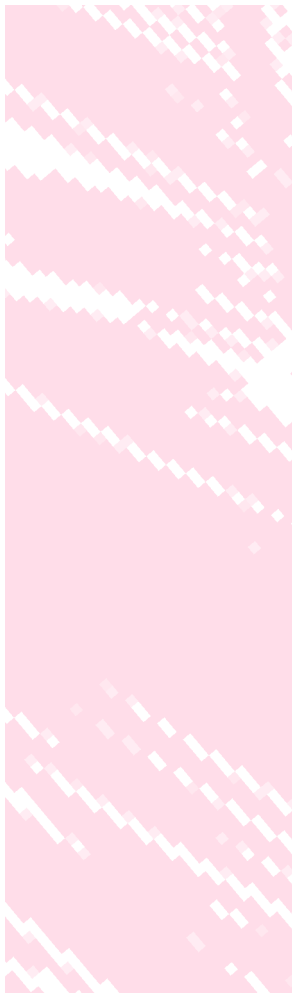
Profound historical trends shape the environments in which the policies examined by the DAWN research are evolving. Religious and cultural traditions, as well as legal contexts, are of particular relevance. The slave trade – a tragedy from which Africa, especially West Africa, has not fully recovered –⁹ determined economic and stratification patterns that still explain many of the present social structures in most of Latin America and the whole of the Caribbean (even if the detrimental effects of slavery are not being widely debated everywhere). In Bolivia, Brazil, Mexico and the Philippines the exclusion and vulnerability of the indigenous population is one clear-cut feature of the current social environment. In Surinam, Trinidad and Tobago, and to a lesser extent Jamaica, the colonial legacy of indentured labor has defined the ethnic composition and related conflicts that still mark these societies today.

In Africa and the Caribbean colonial missionary work established the presence of both Protestantism and Catholicism, while in Latin America and the Philippines the Catholic Church was a key player in the colonial enterprise and it remains a dominant influence today. But nowhere is Christianizing an omnipresent social phenomenon in the same way that in three countries – Ghana, Trinidad and Tobago, and most particularly Nigeria – Islamism has been highly influential in both historical and contemporary politics. In fact, the 1990s have witnessed the expansion of Islamism, particularly in Africa. In the Caribbean, Hinduism must also be taken into account in any analysis of the region's culture and religion. Practically everywhere local religious practices, either traditional or modern, co-exist with Christian Churches, often in the form of syncretism.

The countries' juridical and legal systems also share many common features. In all cases, anti-colonial struggles – even where socialism had a dominant influence within them – led to the emergence of nation states modeled on the liberal social contract of the European and North American traditions. The ongoing implications of this legacy are both profound and far-reaching, for example, in terms of property rights, the delimitation of the boundary between the public and private spheres, the unequal position of women, and labor relations. But certain aspects merit closer attention as they impact more specifically on the various areas examined by the DAWN research.



⁹ It is estimated that 40 million West Africans were enslaved to work on plantations in the Americas between the 15th and the mid-19th centuries. Beyond the human cost it implied, the slave trade had dramatic political, economic and social effects on the African countries, including the neglect of agriculture and the destruction of local and regional trade.



While in Africa and the Caribbean current juridical systems and legal frameworks mostly derive from Anglo-Saxon common law, in Latin America and the Philippines the juridical system has its origins in the Roman tradition of statutory law. This is not a minor distinction since in the first case legal reforms are not always necessary and positive changes may be achieved through jurisprudence, while in the second they usually require long and complex legislative processes. Setting aside this fundamental difference, colonial norms coming from both traditions that curtail S&R self-determination, have in all the countries remained in place until recently or are still being enacted. For example, following the two thousand year old Roman tradition, the 1916 Brazilian Civil Code defined the man as the head of the household, giving him absolute rights in that sphere, including the right to return his wife following the wedding, if it was proved that she was not a virgin; only in 2002 was the Code fully reformed. The wording of the 1987 Philippines' Constitution and the Revised Penal Code that still criminalizes abortion today is not very different from what was enshrined in the Spanish Colonial Penal Code of 1870 (Viado 2004).

In Nigeria, Jamaica and Trinidad and Tobago sodomy is considered a criminal act and this imposes great limitations in terms of providing sex education for those people who are most at risk. In the Caribbean existing regulations also create obstacles for the dissemination of S&R H&R information for people under sixteen.^x Similarly, in these three countries abortion is a crime, in the case of Trinidad and Tobago under a Colonial Ordinance of 1924 (Ahmed 2006; Madunagu and Olaniran 2005). In a number of countries – Bolivia, Ghana, Mexico, Nigeria and the Philippines – these “modern” juridical and legal norms co-exist and conflict with customary laws and systems of justice. The most widely known and striking example is the application of Sharia Law in Nigeria by local Muslim authorities, despite the fact that the Constitution defines the State as secular.

In fact, secularity is another crucial aspect to be examined in this brief historical overview. While the motivations may have differed from region to region, in all twelve countries the principle of the separation between Church and State was adopted, if not immediately, at least shortly after independence.^{xi} Nevertheless, in most cases, secularity remained more formal than real. The exceptions are Uruguay and Mexico where the commitment to a secular political system was strongly ingrained in the political culture of the late 19th and early 20th centuries. In all the other cases, striking ambivalences and contradictions have always been at play.

Everywhere the Catholic Church and protestant missions have for centuries been the main providers of education and health services. In Latin America monks and priests have engaged in high-level politics since colonial times.^{xii} The past and present political history of the Philippines was also heavily determined by the influence of the Catholic Church. Church-State connections are not so evident in the Caribbean countries, except in Trinidad

10 *The same limitation also applies to Barbados even though in the 1980s the Penal Code was reformed to allow for abortion in certain circumstances.*

11 *This holds true even in the case in Brazil that became independent as an Empire, which governed by a Regent who was clerical in the first half of the 19th century. But as the century evolved principles of secularity gained legitimacy and at its end the rule of separation between State and Church was a constant matter of public debates.*

12 *In our sample the best example of this is Argentina, where a formal agreement between the State and the Church, known as the Concordata, was in place until the mid 1980s and even today a Ministry of Cults exists.*

and Tobago, where a Catholic majority opened the way for the Catholic Church to exert greater influence. But even so Christian religious influence was and still is pervasive in State machineries. In Nigeria, Ghana and Trinidad and Tobago both Christian and Islamic forces always played a role in the dynamics of national politics. These historical ambivalences have undermined the principle of secularity, allowing, in recent years, fundamentalist tendencies to start creeping in.

Within this longer-term historical perspective it should be remembered that a time lag exists between independence movements in Latin America in the first half of the 19th century, and the second cycle of de-colonization in Barbados, Jamaica, Ghana, Nigeria, Surinam and Trinidad and Tobago, which occurred after the Second World War. In the Philippines independence was also won during this later cycle, but it had been preceded by a successful nationalist revolution in the late 19th century, followed by a period of United States' occupation, under which the country was considered a Special Territory (Viado 2004).^{xiii} This time lag is relevant when considering issues relating to the political and functional realities of states, the construction of national identities and the nature of state-civil society relations.

THE IMMEDIATE PAST AND CONTEMPORARY POLITICAL LANDSCAPES

The main factors determining the trends and actors that are relevant for analyzing and understanding HSR as well as policies and debates in the areas of maternal mortality and abortion are to be found in the political and economic developments of the last four decades. By the mid 1960s de-colonization in Africa and the Caribbean was reaching completion while in Latin America and the Philippines there was great social and political unrest, triggered by the unequal distribution of power and resources in these countries. In several countries in Africa, Asia and the Caribbean (Cuba) national economies based on the socialist economic model were established following revolutionary wars inspired by socialist ideas. In many other cases too, governments in power experimented with variants of leftist social and economic reforms that included nationalisation and other protectionist policies, and had established links with the socialist world, making them targets for external intervention. At that time in history, dominated as it was by Cold War politics, developing countries did not have much margin for positioning themselves outside the rigid bipolar division of the world between the capitalist “West” and the so-called Socialist bloc. As a result, in four of the Latin American countries (the only exception being Mexico) and the Philippines the confluence of internal conflicts and external forces would lead to the establishment of harsh dictatorships, supported by the US, which would remain in power until the mid-1980s. The post-independence experience of Ghana and Nigeria was also marked by political upheavals and military coups, in which the “West” also played a significant role. This is particularly evident in the case of Nigeria – where oil has always been a source of external interest



13 One implication of this time lag is that in the latter group of countries the UN itself and UN agreements are better known and more widely valued than was the case in Latin America until very recently. This is entirely understandable, given the role played by the UN in the post-World War II de-colonization processes.

and internal instability – which was ravaged by a bloody civil war in the late 1960s.

The Caribbean also experienced similar trends, centered on Jamaica where a democratic socialist party (led by Manley) was elected in the early 1970s. As happened with the governments that were overthrown by military dictatorships in the other countries in the DAWN sample, Manley established diplomatic links with the socialist world and promoted state interventions in the economic sphere. The effects of the Jamaican experience spread to other islands, but it also prompted a reaction by both national and international private interests and ended in a climate of State violence, the ramifications of which still permeate politics and society today.

The region as whole was affected by the Cold War political climate, manifest in the constant US threats against Cuba, the perennial Haiti crisis, the 1965 intervention in the Dominican Republic and, most of all, the traumatic invasion of Grenada in 1981. Even so, the political trajectory observed in the Caribbean countries studied in this sample was much more stable than that of the Latin American countries and the Philippines, as no longstanding dictatorship was ever established. The study findings, however, mention corruption, clientelism and a lack of accountability as persistent problems in the political sphere.

The Caribbean political process over this period also differs from the other regions in that it was also very positive as far as gender equality and even reproductive health issues were concerned. A series of laws relating to women's equality were passed – the Maternity Bill, the Minimum Wage Bill, equal inheritance rights and access to education regardless of the marital status of the parents – in parallel with the development of a family planning public education campaign.

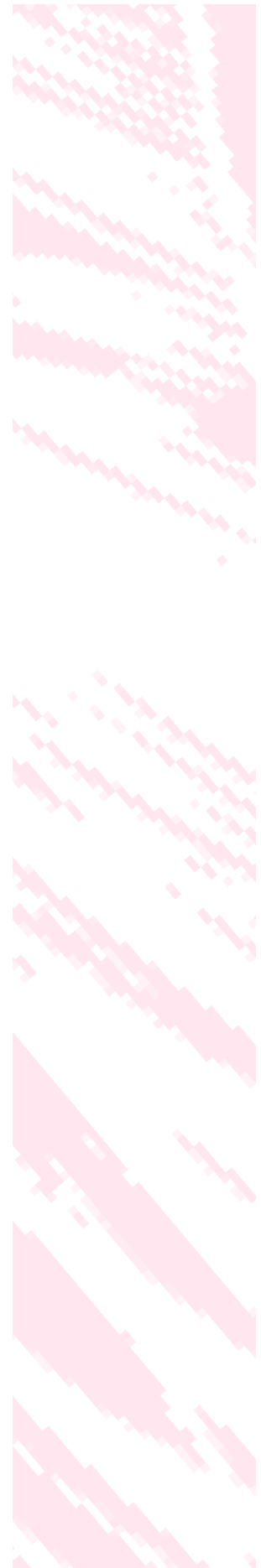
Returning to Latin America, the Philippines and Africa, it is important to bear in mind that the democratic transition processes that followed the two decades of dictatorships were lengthy and not exactly smooth. In Brazil in 1992, the first directly elected president (Fernando Collor) was impeached under charges of corruption. The same would happen in the Philippines in 2001 (President Joseph Estrada). In Nigeria the early 1990s heralded the possibility of re-democratization, while the later years of the decade saw the country striving to get rid of the dictatorship that had toppled the president elected in 1993. In Mexico the late 1980s and 1990s witnessed the culmination of the long drawn out political transition from the one party system established in the 1920s, under the hegemony of the Revolutionary Institutional Party (Partido Revolucionario Institucional, PRI), to a multiparty regime. This process was not free from difficulties and instability, as illustrated by the assassination in 1994 of the PRI presidential candidate.


While before 1989 domestic politics were mostly determined by Cold War dynamics, in the 1990s other global trends would prevail. The period from 1991-2001 favored political stability at both global and national levels. It is

true that the promises of the beginning of the 1990's of greater investments in human development were not fulfilled and also that dominant neo-liberal economic frames, though highly contested, have remained on place. But it is not excessive to say that the political stability have benefited, though to varying degrees, the majority of countries included in the DAWN sample. This holds true for the Latin American countries, Ghana and the Philippines where, despite some setbacks, a cumulative process of consolidation of democratic institutions occurred, at least until the early 21st century. More specifically, in all the national policy environments examined by the research positive global political synergies around gender equality were also enhanced, primarily under the influence of the major UN conferences of the 1990s and the growing connectivity of S&R H&R advocacy, which broadened and deepened the previous impact of the 1975 (Mexico City) and 1985 (Nairobi) UN Conferences on Women and Development.

Before 1989, international economic trends also affected domestic politics. Suffice it to recall the oil and debt crises of the 1970s and 1980s and the first generation of SAPs imposed on African and Caribbean countries. The effects of decades of Soviet-inspired economic protectionism (in the developing world) and semi-autarky (in the socialist bloc), combined with growing recession in industrialised countries, the formation of the Organisation of Petroleum Exporting Countries (OPEC) and subsequent oil price hikes in 1973-1974, and the demand by Third World states for a New International Economic Order (NIEO), had together triggered an economic crisis' in the 1970s which paved the way to the strategy of global adjustment through SAPs, subsequently instrumentalised by the IMF and the World Bank. But in the 1990s the negative effects of economic globalization – in terms of technological change (particularly information and communication technologies (ICTs)), fragmentation and re-location of production chains, capital and financial flows, trade liberalization and privatization – would be much more far-reaching and deeply felt. As several authors signal (Sen XXXX; Stiglitz 2003) these global trends did not generate growth everywhere as predicted. Moreover, where growth happened it was often accompanied by unemployment, greater inequality, increased informality and even higher poverty levels in some cases. Fiscal stringency kept restricting resources for social policies, even though in the 1990s, in response to the critiques raised in the previous decade concerning the destruction of health and education systems, a new generation of adjustment programs allowed for investments in basic education and primary health.

The intensification of capital and financial flows created a new cycle of internal and external debts and related weaknesses that would be particularly acute in the case of middle-income countries, like Argentina, Brazil, Mexico and the Philippines, as illustrated by the financial quake of 1997-1998 and its ongoing effects. Intensification of migration is another important contextual phenomenon, which in the Caribbean, African countries and the Philippines





has resulted in the loss of human resources needed both for the effective functioning of health systems and to sustain the vitality of progressive politics.

Consequently, in the early 21st century a “mixed picture” is the most accurate way to describe the political landscapes observed in the twelve countries. It is undeniable that political stability has improved in Brazil, Uruguay, Ghana and to a lesser extent in the Philippines and Mexico. In all settings, progress has also been observed in terms of the consolidation of electoral processes and other institutional democratic rules. But after 2001 Argentina and Bolivia were shaken by profound crises deriving from the interaction between internal political factors and the effects of globalization. As late as 2004 in Nigeria democratization remained problematic in many respects. Nowhere has democracy resolved inequality and poverty and practically everywhere it co-exists with clientelism, nepotism, state violence and corruption. During the 1990s in all countries – although to differing degrees of intensity – religious fundamentalism spread in the social fabric and also in political systems through electoral politics.

LOCATING HSR AND S&R H&R ISSUES WITHIN THE POLITICAL LANDSCAPE

It is against this complex and shifting historical, political and economic background that the issues and policies analyzed in the DAWN research emerged and gained institutional legitimacy in the 1980s and 1990s. More detailed analyses of how these have evolved in each context will be provided in subsequent chapters. In this section, a general overview is offered of the synergies and disparities between political and economic trends and the evolution of HSR programs, as well as the linkages between political processes and factors and S&R H&R issues.

With respect to HSR, in the majority of cases the processes underway have their origins in SAPs, the exceptions being Brazil and Uruguay, where within the democratization processes the strong impulses towards privatization were resisted. But within this general trend, two different cycles of health reform must be considered. The first was generated as part of the stringent social cuts imposed by SAPs in the 1980s, while the second derives from the new approach adopted by the World Bank in the early 1990s, which, as has already been mentioned, allowed for greater flexibility with respect to education, primary health and epidemics (principally HIV-AIDS). Ghana, Nigeria and the Caribbean countries have undergone both the first and second generation of HSRs. In the Philippines and the Latin American countries (apart from Brazil and Uruguay) what prevails is the 1990s adjusted HSR model.

The correlation between political factors and the emergence and legitimization of S&R H&R issues and policies is much more complex. Democratization or increased political stability, the emergence and development of women’s organizations, the impact of the 1990s UN conferences and the influence of conservative forces are common features across all twelve countries. But variations exist in relation to the time frames

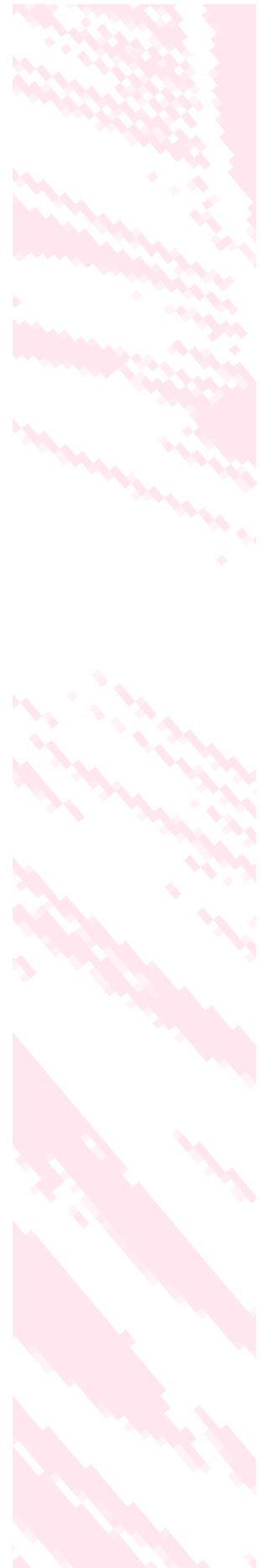
within which these different aspects come to bear and the particular relevance of each one in the different country contexts. In all contexts the negative or positive implications of pre-Cairo policies must also be taken into account.

BOX 1: GENDER EQUALITY AND WOMEN'S RIGHTS

Regardless of the long-term historical and political transformations briefly described above, in all twelve countries the structures of gender inequality would remain practically unshaken until the last decades of the 20th century. Although religion and culture are clearly two main factors that explain the persistent disregard for women's rights, it is worth remembering that the main actors behind anti-colonial struggles – both in the 19th century in Latin America and in the 20th century elsewhere – though “modernizers” with respect to state and sovereignty, were not always so modern when it came to women's rights. In Latin America women started struggling for the right to education almost immediately after independence, and later on had to fight hard to win the right to vote. In those countries that became independent after World War II, benefits derived to a certain extent from changes that had already occurred within society in the colonizing nations, as well as from the principle of sex equality enshrined in the 1948 UN Declaration of Human Rights. But even in these cases the general principle of gender equality remained confined to the right to vote, to work and to have access to education, and did not usually extend to sub-constitutional codes where the main obstacles to gender equality remained untouched: marriage laws, property rights (particularly relevant in Africa), violence against women. One exception in this DAWN sample seems to be the Caribbean, where wider ideas about gender equality have apparently circulated long before full de-colonization. In most cases, women's political participation would also remain extremely limited, either because it was restricted by formal norms or because the climate prevailing in politics did not allow much space for women.

In most areas important steps forward were registered in all twelve countries from the late 1970s, in particularly during the 1980s and 1990s. Female education and labor participation increased everywhere. As a result of both internal political change and the influence of the UN conferences and the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), discriminatory laws were reformed (including in the sensitive areas of family and property rights) women's political participation greatly increased (among other reasons, as result of the adoption of electoral quotas), and gender-based violence gradually became recognized as major social and health problem. The gender indicators provided in the next sub-section confirm these positive trends.

In all twelve countries studied the transformations in terms of gender relations and the expansion of women's rights was a crucial factor enabling the emergence and development of a S&R H&R agenda. However, the full S&R H&R agenda had to wait until the 1990s to gain visibility and legitimacy. Despite recent positive advances in all the twelve contexts examined by the DAWN research, there is still strong resistance to recognizing S&R self-determination as a critical dimension of gender equality, which is best exemplified by the continued criminalization of abortion. This is also the dimension of gender equality most systematically and directly attacked by fundamentalist forces at both national and global levels.



In the 1980s in all the Latin American countries and the Philippines democratization processes fueled the emergence of women's organizations and opened up space for gender equality and women's health issues to be raised and debated in public arenas. In Brazil and the Philippines this occurred earlier in time and in both cases, women's health policies were then designed which would remain in place in the years to come. But in the case of the Philippines they would not evolve as consistently as in Brazil and most importantly a major political battle was lost with respect to the legalization of abortion in the constitutional debates of 1987, whereas in Brazil the Catholic Church lobby for "the right to life from the moment of conception" was defeated in the context of the 1988 Constitution debates.

Box 2: Population Policies and HIV-AIDS

In addition to the political and economic developments described above, the overview of the last four decades must take into account two other relevant health policy related trends: population control agendas and the spread of HIV-AIDS. Politically legitimized in the 1960s, fertility control policy guidelines were not easily nor immediately accepted by developing countries. But by the late 1980s they had been adopted quite widely across the South. In the case of our specific sample, two countries – Mexico and the Philippines – adopted fertility control policies in the 1970s (Petchesky and Judd 1997).

In contrast, there was great resistance to population policies and even to family planning in Bolivia and Brazil (before the mid-1980s) and in Ghana and Nigeria (before the 1990s), on cultural and religious grounds, but also fed by nationalist approaches to development that valued a "large population". The Caribbean countries present a different pattern: since the 1970s policies have been implemented combining mother and child health (MCH) and non-coercive family planning. In Argentina and Uruguay population control measures were never imposed or adopted because by the 1960s fertility rates were already quite low (for all these latter case see Corrêa and Reichmann 1994).

As for HIV-AIDS, Brazil and the African countries experienced a surge in the epidemic in the early 1980s. But, apart from in Brazil, a climate of cultural and policy denial would prevail until the 1990s. In other Latin American countries and the Caribbean, the spread of HIV happened in a later period and in most cases policy denial has been observed, although with less intensity than in Africa. At present, the highest incidence is registered in the Caribbean and Nigeria, while in Brazil infection rates stabilized in the 1990s. In all cases early in the 21st century reproductive health policies cannot be analyzed without reference to what is happening on the HIV-AIDS front.

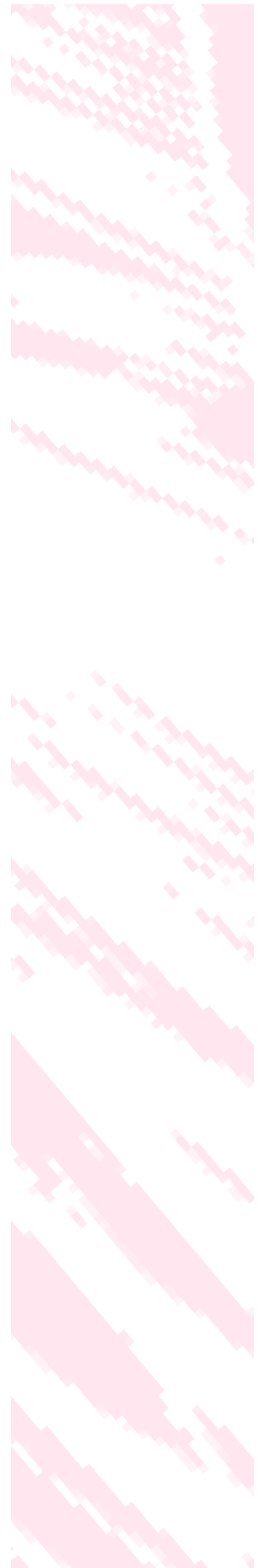
In the Philippines and Mexico, women's health agendas were forcefully mobilized in the 1980s by feminist and left-wing critiques of the population control policies that had been implemented since the previous decade. In contrast, in Uruguay and Argentina women's movement activists mostly had to face up to and challenge explicit or implicit pro-natalist stances, such as the

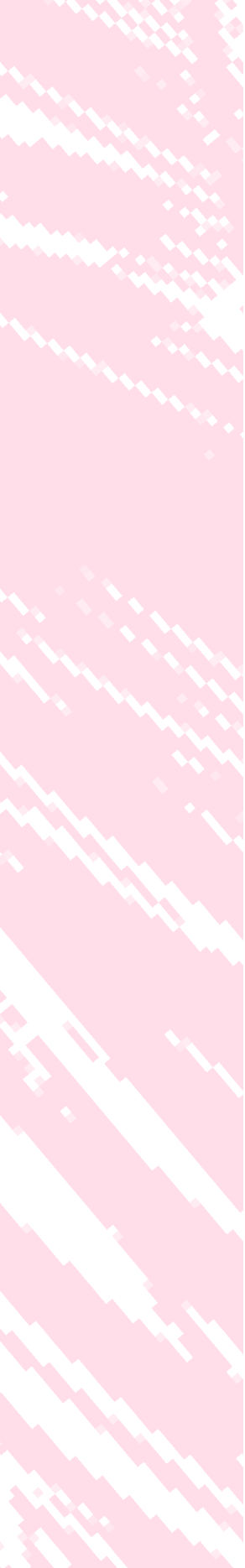
prohibition of sterilization (in both cases) and of commercialization of contraceptives (in the latter). In Brazil and Bolivia, the new feminist discourse on reproductive self-determination was constructed in opposition to both neo-Malthusian proposals and the pro-natalist ideology of the Catholic Church and other sectors (such as certain voices among the military in the case of Brazil, and left-wing unions in Bolivia).

The pattern observed in the Caribbean and Africa is in many ways different from what was happening in Latin America and the Philippines. In the Caribbean, as has already been mentioned, the expansion of family planning and MCH programs went hand in hand with gender equality reforms and did not take place in a coercive manner. The case studies are critical of these early programs for being too medically oriented and not strongly informed by principles of women's S&R self-determination. But in comparison to other countries they are to be considered a positive precedent, as they appear to have favored a progressive climate that would be reflected in the Barbados abortion reform of 1985 – in which female political leadership played a key role –, as well as in the positions adopted by CARICOM countries at Cairo and Beijing.

In contrast, in Ghana and Nigeria during the 1980s the pressure for population control was quite evident, even though it did not translate into concrete and effective policies, probably because of prevailing cultural patterns and enduring post-colonial attitudes favoring “large populations”. But the case study findings also suggest that medical concern over abortion and maternal mortality was already visible long before Cairo, a positive trend that would explain the first legal reforms on abortion in Barbados (1984) and Ghana (1986). In the case of the African countries it is also important to mention the Nairobi Safe Motherhood Conference (1987), which had a policy impact in the continent quite early on, even if implementation would lag far behind the formal commitments and good intentions expressed by governments.

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





women's organizations to keep the agenda visible and alive in the public arena.

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

In the Philippines the period of the Conferences and their aftermath (until 1998) can also be regarded as positive on the whole, since, as Viado (2004) points out: *"The Ramos administration was bound to institute what were yet to be relatively the most progressive population concerns in the country's history, particularly with its liberal attitude to contraception and focus on women's reproductive health. The liberal environment brought about by these various factors gave the women's movement room to advance advocacy not just for reproductive health but also for reproductive rights"*.

The case study reminds us that the 1980s political defeat on abortion remained a key obstacle for the implementation of the Cairo and Beijing agendas. It also points out that, because issues of S&R autonomy had never been very high on the women's movement's agenda, there was no strong political force to overcome this impasse. In addition, the Ramos administration initiated a World Bank sponsored HSR process and, during the same period, the women's movement's engagement with policy arenas related to population and health issues would in many ways negatively affect its ability to push the agenda forward (Francisco in Corrêa, 2000).

In the Caribbean the post-Cairo and Beijing era is regarded as being still less positive, since the women's health and reproductive rights agenda would gradually lose strength and visibility. This reversal can be partially attributed to the low priority given to S&R H&R issues by women's organizations in the 1980s and 1990s. But other factors have also been at play, such as the ongoing and unresolved negative impacts of SAPs, the lack of funding and the growing legitimacy of policy assumptions regarding male marginalization (Ahmed 2005). In relation to the Caribbean countries in this sample it is also worth mentioning that while they escaped the detrimental effects of population control policies, from the late 1990s on the HIV-AIDS epidemics would entirely reframe the policy context, in a manner that is not always productive for gender equality and reproductive health programs. Given this overall climate it is, therefore, extremely positive to see in the early 21st century the issue of abortion being forcefully raised in Trinidad and Tobago and Saint Lucia.

In African countries, on the other hand, policies can be said to have progressed in the 1990s, particularly when the great instability and severe economic constraints of domestic environments are acknowledged. In Ghana, while increased political stability may have been an enabling factor for

implementation of the ICPD and Beijing agendas, economic adjustment was extremely stringent. The Nigerian policy scenario was much more complex as the preparations for and the aftermath of ICPD and Beijing coincided with a dictatorship and an extremely problematic economic environment. But even so S&R H&R advocates were able to keep the outcomes of the conferences visible on the public agenda and to push the government at least to draw up guidelines in line with what had been agreed upon at the international level, as for example in the case of the National Population and Sexuality Education policy papers.

2000-2004: SHIFTING LANDSCAPES

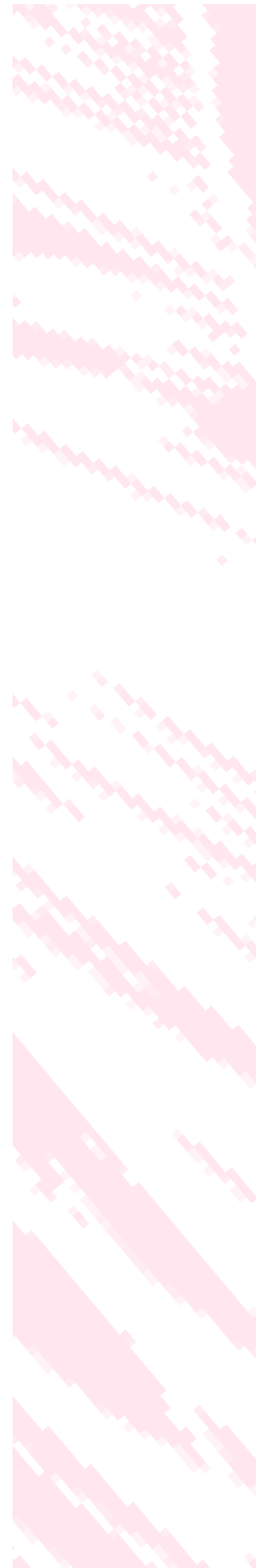
In the global research guidelines it was suggested that the period 2000-2004 should be taken as the time frame to collect and organize country data. However, context-specific dynamics led to some variations. While in all the cases a broad review of this four-year period was carried out, most studies concentrated on the 2002-2004 period, while the Bolivian case study centered on 2001-2003, and in Brazil greater attention was given to the years 2003-2004.


Distinctive patterns emerge when a cross-country comparison is made of the political and economic landscapes prevailing in the twelve countries during this period.

A first group of countries, which includes Ghana and the four Caribbean countries, can be characterized as “stable”, since between the year 2000 and 2004 no major shifts or trends dramatically affected the evolution and performance of S&R H&R policies. This does not mean that conditions in these countries were necessarily favorable, but simply that the conditions previously described by and large continued unchanged in the period under examination.

In the same period a second group of countries – Brazil, Mexico, Nigeria and the Philippines - experienced relevant political electoral shifts that, to a different degree in each case, had implications for the policy issues under examination. Moreover, it should be remembered that in all these cases financial instability or economic recessions were also at play. In the case of Brazil and the Philippines economic instability derived mainly from the global financial crisis of 1997-1999. Mexico was deeply affected by the post-9/11 US economic recession, while in Nigeria economic problems were simply a continuation of the profound 1990s crisis.

Two countries – Argentina and Bolivia – went through major political and economic crises precisely while the research was in progress and in both cases S&R H&R policies were directly affected. Uruguay may also be partially included in this category as the country was strongly affected by the Southern Cone financial and economic crisis of 1999-2001. But, in contrast to Argentina and Bolivia, it did not experience parallel political instability. On the contrary, as the research progressed, it was smoothly approaching major elections that would take place in October 2004.





A closer examination of those countries affected by crises and political shifts in many ways illuminates the relevance of macro political and economic dynamics for explaining progress and regression in relation to HSR, maternal mortality and abortion-related policies and debates.

THE COMMON IMPLICATIONS OF CRISES

The Argentinean crisis of 2000–2002 was triggered by the government's unsustainable macro-economic policy based on parity between the US dollar and the peso, and high levels of both public and private external debt. It combined both economic and political-institutional aspects and entirely reshaped the Argentinean political landscape. During the research period the social situation was characterized by a rapid rise in unemployment and poverty levels, and continuous mobilization and protest by civil society organizations.

After Menem's decade-long stint in the presidency, Fernando de la Rúa (from the same Justicialista Party) won the 2000 elections. But he was thrown out in late 2001 under pressure from a broad and powerful political mobilization opposing the continuation of neo-liberal economic policies. De la Rúa's replacement, interim president Eduardo Duhalde, who was president of the National Assembly, held office until May 2003 when new elections took place. After Menem, who once again was standing for the presidency, stood down, Néstor Kirchner, from a different faction of the Justicialista Party, was elected. The economic recovery and political reconstruction of the country since then is quite remarkable and over the last two years the Kirchner administration has by and large retained its level of popularity.

From the point of view of the DAWN research, however, the most relevant aspect to be stressed is that the Sexual and Reproductive Health Bill, aimed at regulating the State's role in contraceptive provision, which had been on hold in Congress since 1996 as a result of pressure from the Catholic Church, was finally passed in October 2002. This meant a major breakthrough both domestically and internationally since, as has been mentioned before with respect to the ICPD+10 regional debate, it would entirely modify the country's position in global arenas, a step that for the first time favored the construction of a South American regional consensus on S&R H&R.

Though sustained advocacy by women's organizations is clearly behind this major step forward, at least two other factors must be taken into account. The first factor was the economic crisis itself. In parallel to the increasing levels of economic deprivation, teenage pregnancy rates among the poorer sectors increased, as did maternal mortality. This epidemiological evidence would become a key argument to overcome remaining ideological resistance to a state policy of contraceptive delivery. In addition, in the course of the deep institutional and economic crisis, conservative actors – and particularly the Catholic Church – somehow lost their influence in the definition of state policy, because of their previous close links to the Menem administration.

It must be said, however, that these developments were not so smooth or

linear. In 2004 the Foreign Minister made several visits to the Pope to seek support for the country's debt restructuring, but in early 2005 a serious clash occurred between the Kirchner administration and the Catholic Church when the Armed Forces chaplain (nominated by both the government and the Vatican) publicly said that the Minister of Health should be "thrown from an airplane" – a method of political assassination that had been used by the military regime – because he supported the Sexual and Reproductive Law as well as the legalization of abortion. This prompted a major societal uproar and, in fact, led the MoH to make a greater effort to ensure full implementation of the law.

Uruguay was also badly affected on the economic front, and although it did not go through a similar political upheaval, a rather similar pattern is observed. The hypothesis raised in the study is that the number of maternal deaths due to unsafe abortions increased after 2001 under the impact of a steady rise in unemployment and poverty rates, and of "migration" of users from the private to the public health sector (although in 2004 exact data was not yet available). Nonetheless, these negative factors enhanced progressive trends in S&R rights. Since the return to full democracy in Uruguay in 1985, several bills had been presented to legalize abortion, but none had ever reached discussion in the chamber. But in 2001 wide dissemination by the media of cases of abortion-related maternal deaths generated a renewed wave of public debate. This led the Committee for Health and Social Security of the House of Representatives to present a new bill on reproductive health, which included the legalization of abortion. The proposal was approved by the lower House in December 2002 and taken to a vote in the Senate in May 2004, when the bill was defeated by just four votes.

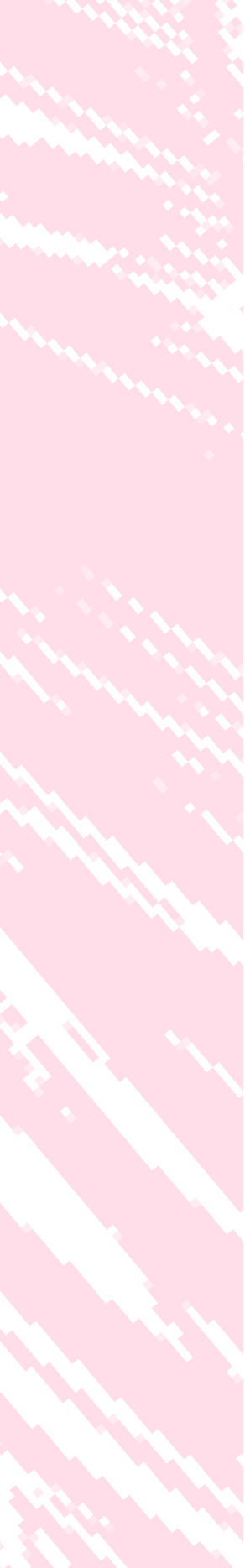
The triumph of the Progressive Encounter-Broad Front-New Majority (Encuentro Progresista-Frente Amplio-Nueva Mayoría, EP-FA-NM), a broad-based left-wing coalition, in the 2004 elections created expectations that the bill would be swiftly re-presented and passed, since it was the EP-FA-NM's legislators that had been the main supporters of the bill the first time around. However, even before his inauguration the new president, Tabaré Vázquez, announced that as a medical doctor he was against legal abortion and, since then, the issue remains a main controversial topic in Uruguayan politics in 2006.¹⁴

In both the Argentinean and Uruguayan cases the structural crises – despite their many negative effects – unexpectedly created a window of opportunity that favored progress in the areas of maternal mortality, adolescent reproductive health and even abortion. But after 2004 the evolution of policy varied from case to case. While in Argentina conservative sectors appear to be losing influence, in Uruguay one of the most lively and far-reaching debates on the legalization of abortion was stalled after a progressive government was elected.

The Bolivian panorama, on the other hand, provides a striking contrast. Between 1995 and 2000 a wide range of policy mechanisms and instruments were adopted in the areas of both gender equality and S&R health. The period



¹⁴ Tabaré Vázquez's position appears to be influenced by family connections, as his son is a Catholic priest and his wife has close ties to the Church. But conservative sectors have also systematically targeted the administration to avoid the Reproductive Health Bill from being voted on again.



was also marked by a wide range of institutional and social reforms in terms of administrative decentralization, mechanisms for popular participation and the political inclusion of the indigenous population.

In the early 2000s the greatest novelty on the political scene was the emergence and growth of two indigenous political parties, the Movement to Socialism (Movimiento al Socialismo, MAS) and the Indigenous Pachacuti Movement (Movimiento Indígena Pachacuti, MIP). On the economic front levels of inequality and poverty increased both due to structural adjustment policies and the inability of Bolivian political forces to respond to the demands of poorer sectors, the majority of them indigenous. Therefore, despite important policy progress in terms of gender and S&R H&R in the immediate past, the 2000-2004 period was one of profound instability and institutional crisis.

In 2002 the MAS candidate received the second highest number of votes in the presidential elections and went on to dispute the second round. In the end the liberal conservative Nationalist Revolutionary Movement (Movimiento Nacionalista Revolucionario, MNR) won the elections but did not win a parliamentary majority. In addition, immediately following the elections there were accusations of electoral fraud. Thus governance was highly compromised from the start. Throughout the year the MAS blocked the congressional process. In early 2003 a crisis erupted involving the police and the army, after which even the Executive branch was permanently paralyzed. In late 2003 the President resigned and a transitional government was established that would also be ousted in late 2004. Following this the head of the Supreme Court assumed an interim presidency until new general elections were held in late 2005, in which the MAS leader Evo Morales was elected. The new government, which took office in January 2006, is engaged in bold economic reforms, in particular in the area of the gas sector and land reform.

No systematic information was available about the S&R health policy area, but most other policy areas were paralyzed as the country moved towards the Congressional electoral process that would lead to the drafting of a new constitution. The new Constituent Assembly was elected in July 2006 and the feminist movement expected the new bill of rights to redefine principles and institutional arrangements that are key for the positive evolution of S&R H&R in the country, such as: the secular nature of the Bolivian state, the reconfirmation of gender equality premises, the structure and functioning of the health system, as well as other aspects regarding S&R self-determination. However, as the DAWN analysis was being finalized the Constituent process remained concentrated on other issues such as the definition of rules and the structural debates about the State role in gas production and regional autonomy.

POLITICAL TRANSITIONS: MIXED RESULTS

Four countries in the sample – Brazil, Mexico, Nigeria and the Philippines – experienced important political-electoral shifts between 2000 and 2004. In all these cases the studies provide quite extensive information relating to the

specific impacts of these changes on the functioning of the health system and S&R H&R, although the main trends and outcomes vary widely across countries. The lack of emphasis on this particular aspect in the case of Nigeria seems to relate to the fact that the country's profound institutional crisis continues unabated and has not been substantively transformed either by the political transition initiated in 1993 or by subsequent presidential elections.

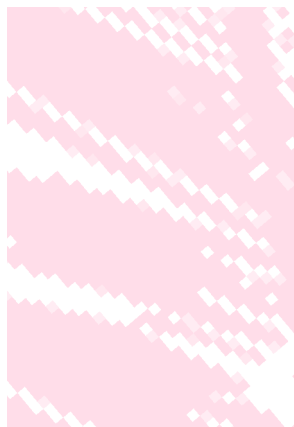
But common traits can, for instance, be identified in terms of the effects of political transitions in the Philippines and Mexico. In 1998 Joseph Estrada, a popular movie actor, was elected president of the Philippines. Continuing what had been started by the Ramos administration, Estrada pushed further the Health Sector Reform Agenda (HSRA), which gave shape to the administration's privatization endeavors in the public health sector, even while social justice groups and the women's movement were resisting privatization. However, his term in office would be cut short by a popular uprising in January 2001 amidst accusations of corruption, and an impeachment trial followed. Estrada was replaced by Gloria Macapagal Arroyo, his vice-president, who would subsequently be herself elected president in early 2002. Arroyo pursued the emphasis on economic liberalization, deregulation and privatization. But most importantly for the policies examined by the research, she re-established strong connections between the government and the Catholic Church. Arroyo is also a strong ally of the Bush administration both as far as the "war against terrorism" is concerned and with respect to the US moral conservative agenda. Not surprisingly, since 2002 she has strongly moved the national reproductive health policy towards "natural family planning".¹⁵

In the case of Mexico, as previously mentioned, civil society mobilization calling for electoral-based political change and party plurality started in the 1980s and gained strength in the first half of the 1990s in the context of the economic and institutional crisis of the Salinas administration (1988–1994). The culmination of this process was the first multi-party general election of 2000 that would be won by the National Action Party (Partido Acción Nacional, PAN) a liberal conservative party, which had historical links to right-to-life sectors and the Catholic Church hierarchy. Although from the Salinas administration in the early 1990s onwards, the Mexican state had initiated and maintained a dialogue with the Church hierarchy, the 2000 elections represented a political turning point with respect to the strong principle of separation between Church and State which had been established by the first leaders of the Mexican revolution in the 1920s.

Since the year 2000, conservative moral forces have made important inroads in terms of their influence on public policies in the areas of gender, families and S&R H&R. This includes the growing influence of the First Lady's office in these policy areas. One example was a program launched in 2001, titled "Arranque Parejo en la Vida" (Fair Start in Life), which is linked to the national poverty reduction policy. The program aims to expand and improve the quality of antenatal, obstetric, post-partum and childcare. On the



¹⁵ "Natural family planning" is kept in quotation marks because from a DAWN perspective natural contraception does not really exist. What is named as such are behavioral methods that require human agency and decision and consequently are not at all "natural"



16 In April 18th, 2005, the Internet news services NotieSe informed that: “The former president of the National Committee for the Right to Life, Jorge Mountain Lemon, was sanctioned with a fine of more than 13 million pesos by the Office of the Secretary of the Civil Service (SFP) because he has mismanaged the use of public fund delivered through the Patrimony of the Public Charity, that is a branch of the National Department of Health. The SFP determined that the legal representative of the conservative organization had handled these federal public resources in a way that widely differed from the justification of the proposal presented to the Department of Health. SPF considered that the National Committee for the Right to Life false documentation as well invoices previous to 2003, which was the year in which the organization should have expended 30 million pesos destined to open new Centers to Support Women. These centers were aimed at dissuading women that have decided to abort. One main problem identified by SPF was that those resources were initially destined to HIV/AIDS and not to the objectives of the approved proposal. This reassignment of funds have been made possible by a legislative maneuvering performed by the PAN Congress representative Luis Pazos”

whole, the connection between maternal mortality reduction and poverty alleviation can be considered positive. But the content of the program breaks with the policy agenda adopted in Mexico under the impact of Cairo and Beijing, as it basically restores a conventional MCH-family planning approach, with a stronger emphasis on maternal mortality and prevention of HIV/AIDS vertical transmission.

These trends were reflected in the international arena, as the position taken by Mexico at the regional ICPD+10 Review was quite cautious, in comparison to its position in 1994-1995 and at the Plus Five Reviews. The country's diplomatic position would be even more hesitant and problematic at the Regional Beijing+10 Review that was hosted by Mexico itself. On the other hand, it is important to note that feminist organizations and the women's movement in general have over the last few years expanded their capacity to react politically to these regressive trends. One major breakthrough occurred right after the Beijing+10 Review in June when these organizations widely denounced the transfer of a huge sum of money from the National Health Department to right-to-life organizations for HIV prevention work, which however was used the money in highly discretionary.¹⁶

While recent political transitions in Mexico and the Philippines can be seen to have resulted in policy regressions with respect to S&R H&R, in the case of Brazil – which also underwent presidential elections in 2002 – the outcomes are somewhat more mixed. Among the countries in the sample Brazil stands out as a case in which S&R H&R policies were defined early on (1984) and – in spite of a certain degree of instability – did not lose their orientation, but rather gained greater policy status and consistency. It is also one of two countries where HSR did not follow the dominant privatizing trend and in which virtuous connections do exist between S&R health initiatives and HSR. Last but not least, Ignacio Luiz “Lula” Da Silva was elected on a platform that was strongly critical of the neo-liberal traits of the previous administrations; his election therefore held the promise that important changes would take place with respect to the macro-economic model.

From 2003-2004, a positive move was made to expand the scope of the National Policy on Women's Health. From the point of view of the DAWN research effort, the most relevant aspects of this change were the establishment of a strategy for maternal mortality reduction and the adoption of guidelines for post-abortion care. In Brazil, since 1985, the main federal women's affairs body was the National Council on Women's Rights. In 2002 a new body was created the National Secretariat on Women's Rights (Secretaria Nacional dos Direitos das Mulheres), which had ministerial status though still remaining under the Ministry of Justice. In early 2003, this body was transformed into a Special Secretariat for Women's Policy (Secretaria Especial de Políticas para as Mulheres, SEPM), with higher ministerial status and that responds directly to the Presidency. In 2005, the SEPM convened the First National Conference on Women's Policies (Conferência Nacional de

Políticas para as Mulheres, I CNPM), in July 2004, of which one main outcome was the recommendation to reform punitive legislation on abortion. This led to the creation of a special committee to review Brazil's abortion laws, which by August 2005 had drafted a bill to legalize abortion. During the same period a national program against homophobia was launched.

However, at the same time the Lula administration broadened and deepened the macro-economic orientation of the previous government. It raised the fiscal surplus target while, at the same time defining poverty alleviation as its main priority. In order to by-pass resource constraints, the Finance Ministry constantly devised strategies to avoid earmarked budget allocations, as was the case with health. In late 2003, for instance, the Executive branch tried to extract one billion dollars from the MoH budget – which is constitutionally protected – to fund the poverty reduction program. Broad-based and vocal protests by Congress members and the National Council of Health (Conselho Nacional de Saúde) halted the maneuver. This issue would re-emerge during the National Conference on Women's Policies, when a motion against the flexibilization of earmarked budgets was approved.¹⁷

Lastly, as is the case in other countries, the current Brazilian scenario is witnessing a clear advance of conservative moral forces. The Catholic hierarchy has been always influential in Brazilian politics, and since its origins the PT has had close connections to Liberation Theology, so the chances for the Catholic Church to influence the direction of policies have increased. But a new trend in recent years has been the growth of Evangelical voices in society, in the Parliament – many within the ranks of the PT and the Lula government majority – and even among governors and mayors. The PT itself has also expanded its base among Evangelical sectors.¹⁸ In February 2005 a known anti-abortion and homophobic Member of Parliament was elected President of the House of Representatives. This outcome was the result of bad management of the relationship between the Executive branch and Congress, and would later be recognized as the first sign of the wider and deeper corruption crisis that finally erupted in June 2005.

The scandal involved, among other aspects, illegal campaign funding for the 2006 municipal elections and the buying of votes in Congress, and it shook the Lula administration and the PT, leading to major shifts in the cabinet, the resignation of representatives and a high degree of instability in the political alliances underpinning democratic governance. Though President Lula's charisma survived intact and he retained the support of the electorate, the impact on Brazil's democratic institutions has been far-reaching and as yet has not been fully analyzed. From the point of view of the policy areas under study in the DAWN research effort, the 2005-2006 crisis led to ministerial shifts that created a climate of uncertainty. By mid-2006 the wider S&R health agenda had not been structurally affected, but a clear shift by the administration towards regressive positions would dramatically affect the originally positive outcomes of the special committee on abortion.



¹⁷ The vote on this particular motion has, in fact, provoked more controversy and tension than the adoption of the recommendation on legal abortion.

¹⁸ The Vice-President from the Liberal Party and two of the five female ministers nominated in 2003 are professed Evangelicals. One of them, the Minister for the Environment, agreed an alliance with the Evangelic Bench in Congress when the Law on Bio-Security was voted in 2004, which led to the defeat of progressive provisions regarding stem cell research. In addition, Lula appointed a very conservative practicing Catholic to the post of Attorney General, and one new member of the Supreme Court has expressed his opposition to abortion even in cases of anencephaly.



Box 3: The Presence and Role of Conservative Moral Forces

In the complex and unstable political scenarios described above, an unmistakable trend is the expansion of conservative religious positions both within society and at the level of policy influence. This tendency is clear in all the Catholic countries in the sample: Argentina, Bolivia, Brazil, Mexico, Uruguay and the Philippines. In all the other contexts, though to different degrees, the years 2000-2004 have also witnessed significant inroads by conservative forces in state policy-making, as well as their development of a more aggressive stance within society. The Philippines provides one extreme illustration as, in addition to the adoption of natural family planning guidelines by the Arroyo government, Bishops have banned women who use IUDs from taking communion. But also in Brazil, between 2002 and 2004, a wave of denunciations of women who had resorted to having an abortion started that is an entirely new phenomenon.

In other countries, even though such extreme situations are not so common, religion has an increasingly pervasive influence, as compellingly analyzed by Ahmed (2004): “In the Caribbean the Catholic Church and other religious institutions act as a ubiquitous and often undefined presence in the lives of those people charged with advocating for and driving particular policies. In regard to sexual and reproductive health and rights, religious discourse has been influential in recent debates including those around the decriminalization of homosexuality and sex work in Barbados, abortion in St. Lucia and discrimination on the basis of sexual orientation in Guyana. Social economic factors are critical to understand the role played by religious forces, but the co-optation of many churches by evangelistic forces from North America as well as the connections with of Hindu and Muslim fundamentalism in South Asia”.

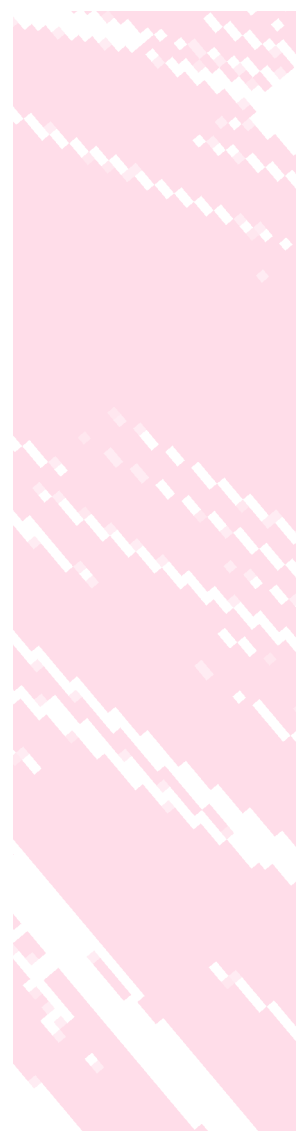
Hesse’s (2006) description of the obstacles to effectively implementing Ghana’s relatively liberal abortion legislation mentions pervasive religious morality as one factor explaining why doctors do not like to talk about the law and why women do not have access to services. In the 2004 global research discussions, mention was also made of the rapid expansion of “virginity clubs” in Ghana, that derive directly from conservative US influence. Lastly, in Nigeria, while the research was in progress the tension between the Northern Islamic states and the central government involving the application of Sharia intensified and reached the front pages of the global media because of the condemning of Saffyia Hossein and Amina Lawal to stoning.

V - Health Sector Reform: What Have We Learned?

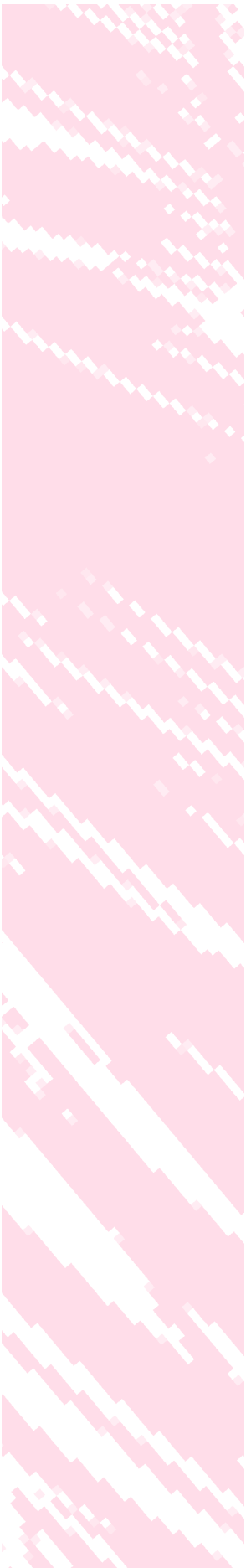
DAWN's policy assessment of ICPD implementation highlighted, among other aspects, a dissociation between actors and processes relating to S&R H&R, on the one hand, and the transformations in health systems under the impact of state and health sector reforms. Out of a group of twenty-two countries examined in that research effort, only in the case of Brazil and Bolivia was clear mention made of connections between reform processes and the implementation of S&R health policies as a result of ICPD and Beijing. At that point in time, and in line with other analyses, DAWN identified this disconnection as one of the main factors hindering the evolution of the Cairo policy agenda in developing countries. This analysis was backed up by the final document of the ICPD Five Year Review, which included a paragraph explicitly calling for the creation of positive synergies between the two agendas.

Since then much investment has been made, at global and regional levels, to fill this critical gap. At the global level, one significant effort dedicated to exploring the linkages between S&R health and HSR in Southern regions was sponsored by the South African Women's Health Project (Ravidran and de Pinho, 2005, Murthy; Ranjani and Klugman, 2004; Ravindran, Murthy and Alvarez-Castillo, 2005; de Pinho, 2005). Another research program took place under the sponsorship of the Institute for Development Studies' Research Initiative on Reproductive Health and Health Reform (Standing, 2002). The subject also started being explored by mainstream organizations, as in the case of the training program implemented by the World Bank Institute. In 2003, *Reproductive Health Matters* published an entire issue on Health Sector Reform and Reproductive Health that brought together the work emerging from these various research initiatives.¹⁹

At regional levels, it is also worth mentioning a series of initiatives that have taken place in Latin America and the Caribbean. The Latin American and Caribbean Women's Health Network (Red Latinoamericana y del Caribe de Salud de las Mujeres) organized an internship program on HSR in Latin America. The Population Council and the Inter-American Development Bank (IDB) developed a series of country analyses (Langer and Nigenda, 2000), which would develop into a training program sponsored by UNFPA, the World



¹⁹ *Reproductive Health Matters: Health sector reforms: implications for sexual and reproductive health services*, Vol. 10, No. 20, November 2002.



Bank Institute and Funsalud (Mexico). During the same period the Pan American Health Organization (PAHO) invested in gender and health reform, a policy step particularly relevant for the Caribbean.

As a result, much more information and analysis is currently available about the linkages between HSR and S&R health. At global level and in a few national contexts bridges have been built between these two policy agendas and dialogues have taken place between the actors involved. But despite the progress made since 1999/2000, the present DAWN research effort suggests that important gaps still remain. In the majority of the countries analyzed in this project close connections were not found to exist between the two fields. The experience of data collection on health reform was regarded by local teams as a privileged opportunity for S&R H&R advocates to get better acquainted with the institutions, actors and existing data about HSR.

A combination of factors seems to explain the difficulties in overcoming these gaps and problems of communication. The first is that the bottom-up, democratic orientation of S&R H&R policy proposals contrasts with the top-down, technocratic nature of HSR. While the S&R H&R agenda emerged and evolved as a political struggle within civil societies long before being legitimized in ICPD and Beijing, health reforms implemented in almost all the countries studied were initiated by international institutions and “imposed” on countries as part of the broader state reform and structural adjustment policies. While the logic and language of the health reform proposals and evaluations is technical and complex, the S&R H&R language is mostly political and rights-oriented and it is not always easy to bridge these two discursive arenas.

Lastly, not everywhere have health reform processes been the subject of broad-based public debates. In Brazil the reform resulted from a long-standing process of social mobilization. In Uruguay the HSR needs to be situated in the broader context of state reform because in 1992 a wide-ranging bill to privatize State functions was defeated in a public referendum. In Mexico and Bolivia the connection between HSR and the ICPD agenda spurred greater engagement by social actors, and in the Philippines social movements protested against the privatizing goals of the HSR. Elsewhere, HSRs were “silent” processes, confined to high-level policy arenas involving national officials and the technical teams of the World Bank and IDB.

Inevitably, these variations are reflected in the outcomes of this specific dimension of the research. Data and information gathering was quite uneven across countries, ranging from the detailed and in-depth analysis carried out by the Uruguayan team, to the extreme difficulties observed in collecting relevant information about the HSR agendas in the case of Three Rivers State in Nigeria. In the majority of cases the treatment given to the health reform dimensions is more descriptive than analytical. With few exceptions, the analysis is limited to a general critique of the association between the HSR processes underway and the negative impacts of structural adjustment and privatization trends. Consequently, for this global report, the analysis of HSR

global trends and national dynamics, as well as of the gaps and problems observed between HSR and ICPD implementation, is supplemented by information gathered and processed by other researchers, in particular the work of Almeida (2005) and a few of the studies published by *Reproductive Health Matters* in 2002.

HISTORICAL BACKGROUND: A MISSING LINK

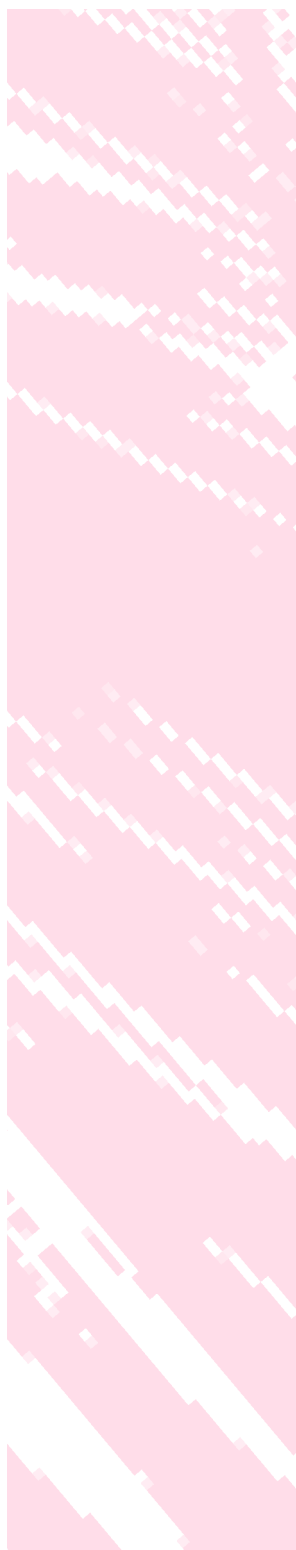
One salient feature of recent literature on HSR and S&R R&H is that, with very few exceptions, the studies and analyses do not provide substantive information on what has preceded the health reform processes starting in the late 1970s and early 1980s. The DAWN case studies, by and large, suffer from the same defect. One reason for this lack of historical contextualization is the large amount of work implied in collecting information about contemporary HSR proposals and processes. However, in DAWN's view, this "lack of historicity" is quite problematic because, as Almeida (2005) points out, it poses several "difficulties for fully understanding all sectoral reforms, and health reform in particular, as part of a broader process of transformation of nation States". This failing is a by-product of the technocratic approach that prevails in dominant thinking on HSR, perpetuating among analysts and advocates a distorted impression: that HSRs were initiated roughly twenty years ago when the World Bank and especially health economists entered the policy-making arena.

In order to attempt to counter this distorted view we need to recap briefly the multiple and varied historical health reform processes that preceded the current wave of reforms. These previous waves can be traced back to the late 19th and early 20th centuries in Europe and the United States. One example of an early health reform initiative, mentioned by Almeida (2005), is the German experience of the 1890s where for the first time in Europe state subsidies were provided to fund health care for poor communities and low-income workers. Less well-known, but also worthy of mention is the network of welfare and health institutions created in the United States right after the Civil War, which is analyzed in *Mothers of a World* (Koven and Michel, 1993) as the first layer of the welfare state that would mature post-1930s.

But early records of investment in public health can also be identified in developing countries, in particular in Latin America. In 2006, the Inter-American Development Bank published a full historical analysis of pension and health systems in the region, which provides a complete and rich overview of how current health systems have been constructed. This long cycle is clearly reflected in all countries studied by DAWN region. The Uruguayan report, for instance, points out that one main contemporary source of pre-paid health insurance in the country – the Collective Medical Care Institutions (Instituciones de Asistencia Médica Colectiva, IAMCs) – "emerged at the beginning of the century as a social and collective response by Spanish and Italian immigrant populations to their health needs. Over time these institutions would start expanding their services to the general population".²⁰



²⁰ Similar experiences of immigrant communities' self-reliance with respect to health and education can be identified in Argentina and Chile, as well in the Southern region of Brazil, which also received large numbers of European migrants.



In Brazil public investment in sanitation and control of endemic and epidemic diseases started early in the 19th century, when European scientists and doctors arrived in the country with the exiled Portuguese court, a “modernizing” current that would be maintained after independence in 1822. During the Second Empire (1850-1889) important investments were made in biomedicine in general and specifically in the sanitization of Rio de Janeiro. This was followed by the fight against yellow fever and small pox in the first decade of the early 20th century, a broad State-led initiative that is generally considered to be the first wave of sanitary reform in Brazil.

One specific study of this historical period (Faria 1995) is particularly relevant to our analysis, as it examines the experience of the Rockefeller mission that arrived in Brazil in 1916 to offer a package of public health interventions to eradicate endemic diseases (malaria, yellow fever and ancylostomiasis). The author points out that in 1916, when the mission disembarked in Rio de Janeiro, *“the country had an explicit tradition of biomedical research in two major institutions – Manguinhos in Rio and Butantan in São Paulo – and the Rockefeller team had to establish partnerships with Brazilian scientists to define its objectives and plan of action. They also faced considerable political opposition mobilized by nationalist political forces. These exerted great pressure on the Federal Government, demanding that it exert greater control over health policies in all regions of the country, including over the activities sponsored by the Rockefeller Mission.”*

Faria’s analysis of the Rockefeller Mission’s motivations and investments in international health in general is also illuminating in terms of identifying early currents of international influence on the design of public health initiatives in Southern countries other than Brazil. The idea of an international public health program coincided with the creation of the Rockefeller Foundation in 1909. US Congress authorization for the institution to operate in other countries was issued in 1913 and almost immediately the Foundation initiated contacts and public health campaigns in the following countries: Colombia, Chile, Paraguay, Peru Uruguay, Venezuela, Costa Rica, Cuba, Ecuador, Guatemala, Haiti, Nicaragua, Panama, El Salvador, Jamaica, Trinidad and Tobago, Granada, Sri Lanka, India, Malaysia, Korea, Thailand, Japan, China, Turkey, Palestine and Lebanon.²¹

This early, widespread international investment in public health evolved hand in hand with the expanding political and economic influence of the US in Southern Countries, particularly in Latin America and the Caribbean. While some authors see this as a mainly philanthropic endeavor, others emphasize the Foundation’s interest in improving the quality of the labor force and productivity to facilitate the expansion of American capitalist investments in these countries. In Latin America between 1916 and 1949 the Foundation invested 13 million US dollars in the creation of medical schools and the financing of public health initiatives. Its impact certainly contributed to establishing a first layer of public health services, many of which would still be in place when a new wave of HSRs started after World War II.

21 It is worth noting that these investments were not restricted to colonies or ex-colonies in the South, but were also made in European countries such as Ireland, Scotland, Portugal, Spain and Albania. Even Canada received investments from 1920 onwards.

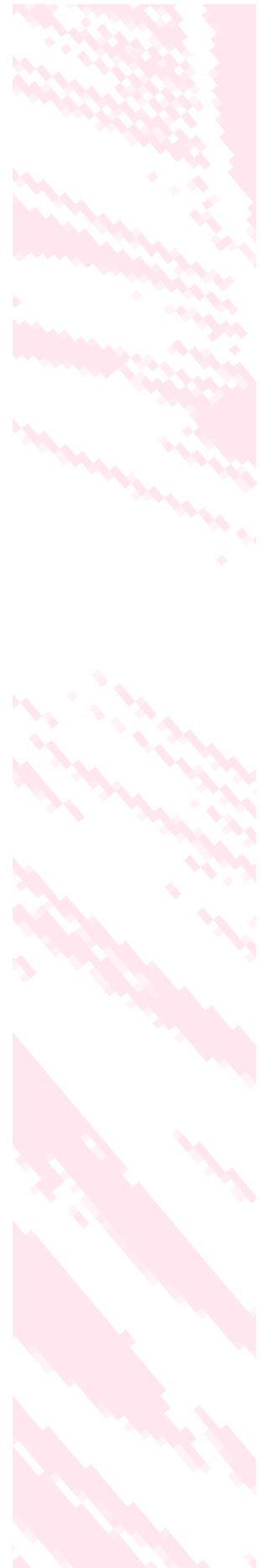
However, in order to understand more fully how health systems evolved in Southern countries in the first half of the 20th century, other trends need to be looked at more closely, a broader task which we lacked the capacity to undertake as part of this particular research effort. In the case of Asia, Africa and the Caribbean one important dimension are the public health strategies adopted by colonial administrations. In Latin America the impact of policies adopted during the period of rapid industrialization in the 1930s and 1940s would also merit examination. For instance, in the case of the Caribbean, information is available suggesting that as early as the 1930s the Barbados health services were considered the best in the region and very early in time received people from other islands that needed more complex levels of care. In all Latin American countries – although there are differences in terms of the amount of public funding – labor protection measures adopted from the 1930s and 1940s onwards included important health measures.


1950-1970: THE WELFARE STATE REFORMS

Following World War II two new waves of health system restructuring emerged. The first was the socialist model adopted by the USSR, China and subsequently Cuba and Vietnam. The second were the health policy initiatives adopted as components of the social welfare contract, as from the late 1940s onwards industrialized countries gradually adopted models of publicly funded universal care that would lead to the creation of national health systems aimed at ensuring access to health as part of workers' and citizenship rights.

These novel policy approaches were not confined to Europe, the US and the socialist world, but spread worldwide through diverse channels of dissemination. The socialist health care models combined with welfare approaches were extremely influential in the context of decolonization in the Caribbean, Africa and Asia. The successful histories of expanding health care in other countries have also prompted and inspired national debates and experiments in health reform in Latin America. One clear example is Brazil, where the social mobilization around health reform that began in the 1970s, looked into the British National Health System, the Canadian model and the Cuban and Chinese primary health programs as sources of inspiration. Another experience that strongly influenced the Brazilian sanitary reform movement was that of the Italian Euro-Communist administration of Bologna.

But very clearly, between the 1950s and the early 1970s, the most important source of influence and inspiration with regard to the structuring of health systems was, at global level, the World Health Organization (WHO), and in the Americas, the Pan-American Health Organization (PAHO). The WHO-PAHO agenda was mainly informed by the traditional public health approach and therefore privileged epidemic and endemic disease control and treatment, and both institutions were dominated by a biomedical approach. But already by the late 1960s, the WHO-PAHO reform frameworks started to be questioned. One main factor behind this early contestation was the realization that conventional low-cost public health





approaches were not as effective in developing countries as had been predicted, because they did not take into account or address structural factors impacting on health (like income inequality or labor health impacts).

This would lead to important internal debates and changes. Within both institutions the early hegemony of biomedical and campaign models would gradually be reframed and both institutions incorporated social science paradigms for health analysis that emphasized the notions of social medicine and collective health. In the medium term this shift would open up entry points for the incorporation of gender and S&R health perspectives that contested the population and contraceptive delivery policy dominant in the 1960s.

At the same time, WHO and PAHO incorporated new methods of health planning as an integral part of broader development programs. During the 1970s developing countries themselves would press for a broader and more structural agenda in health planning, a trend consistent with the creation of G77, the population debates of Bucharest and the basic needs approach for development and poverty alleviation prevailing at the time. This would culminate in the 1978 Alma Ata Conference, from which the best-known outcome was the special emphasis on primary health care.

The health and development agenda emerging from Alma Ata would, however, start to be eroded almost immediately after the conference. In both industrialized and developing countries, low growth and high inflation rates fuelled the systematic critiques of excessive fiscal deficits and “state economic inefficiency” that would finally crystallize in the policy prescriptions of the Washington Consensus. In the 1970s in industrialized countries one main argument used to reduce public investment in health was the rising costs of health care. This argument would automatically be incorporated into the structural adjustment programs imposed on developing countries, where epidemiological and demographic trends were radically different and public health expenditures were much lower. In fact, at that point in the developing world the debate over health needs and health reform was mainly focusing on the limits of vertical low-cost public health interventions and on the search for new approaches that would allow the structural causes of ill health and disease to be addressed. But, from the 1970s on, cost-effectiveness arguments would gain precedence and legitimacy at institutional levels. While the WHO-PAHO system gradually lost support, the World Bank approach systematically gained ground in the international health and development agenda. For those engaged in the discussion around HSR and S&R H&R it is worth observing that the one main entry point for the expansion of the World Bank’s health agenda was its direct involvement in population policies and family planning.

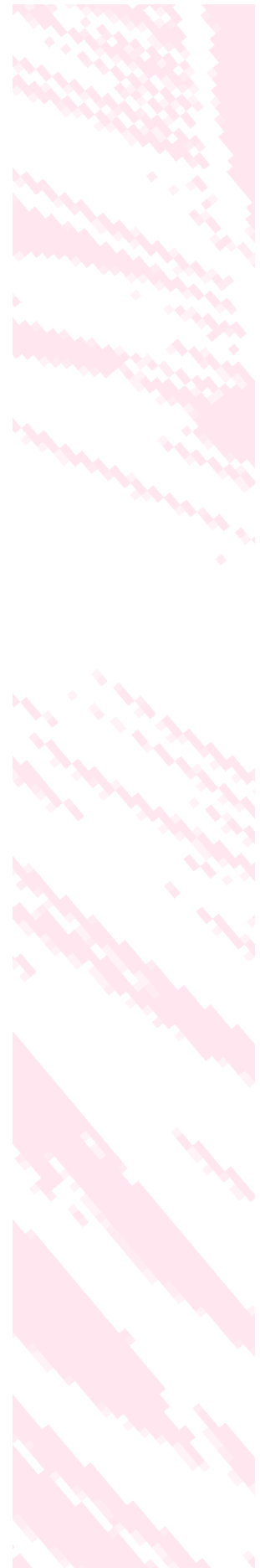
Almeida (2005) suggests that in order to understand more fully the rapid hegemony gained by the Washington Consensus approach to the restructuring of health systems it must be recognized that in the 1970s the policy consensus on health systems and models was not so strong among the other main institutional actors in this field – WHO, PAHO, other UN agencies and national

health bureaucracies. This growing lack of cohesion undermined the ability of progressive voices to contain more effectively the advance of the economic driven approaches to health care that would prevail from the 1980s onwards. One example of this lack of unity is the 1987 Bamako Initiative proposed and implemented by UNICEF in ways that marginalized WHO. In the case of Latin America the direct provision of health services by the public sector came under attack from policy-makers in military regimes long before the World Bank-led model gained full hegemony in the 1990s. The paradigm of this ideological shift in the region was the Chilean reform experience under Pinochet.

Box 4: HSR in Latin America: A Brief Historical Overview

The five Latin American countries' health systems in their current format evolved from a first wave of public health interventions adopted in the early 20th century and were mainly shaped by the social security models that started being established in the 1930s and 1940s. Although with slight variations, these social security models were heavily influenced by European models of workers' protection either through self-reliance schemes or public interventions, often transported to the region by migrant workers themselves. In a later period this progressive health and welfare agenda would be incorporated by the labor movement, which gained leverage and vitality after the 1940's. While during the period of economic growth in the 1950s and 1960s, in most cases these systems expanded, the institutional architecture of the health system as a whole was fragmented. Those who could pay used private medical services. The formal labor force had access to health services funded and managed by Social Security Systems and/or their associates. The rest of the population – rural inhabitants or informal sector workers – came under the responsibility of Ministries of Health. These, though under-funded in comparison with Social Security Systems, were also in charge of public health measures such as sanitation, nutrition, vaccination and control of epidemics, and often lacked sufficient financial resources to maintain services at more complex levels of intervention.

In Uruguay and Argentina, where until the late 1990s income levels were more homogeneous and formal employment was practically the norm, this fragmented logic did not imply extreme distortions, except in terms of urban-rural disparities. But in Bolivia, Brazil and Mexico, which historically presented high levels of income inequality and large sectors of the population remained excluded from the formal labor market, this fragmentation was extremely problematic. In the case of Brazil, the great inequities resulting from this model were, in fact, the main catalyst for the emergence of the Brazilian Health Sector Reform Movement in the 1970s, leading to the construction of the current Unified Public Health System (Sistema Único de Saúde, SUS), that did not follow the Washington Consensus prescriptions. In Uruguay, distortions in terms of access and quality were not so great until very recently and this may explain the differential pace of the country health reform as well the persistent resistance observed in regard to deeper privatization. In Argentina, Bolivia en Mexico the tri-partite model of the 1950-'s and 1960's remained in place until the 1990s when contemporary health reform frameworks started to be adopted. It should be said as well that, the inherent inequities and disparities of these fragmented health models have been widely criticized by the World Bank and IDB and used as one of their main arguments for countries to adopt the neo-liberal reform frameworks.



CONTEMPORARY HEALTH SECTOR REFORM TRENDS

The main aim of HSRs proposed in the late 1970s was to ensure the reduction of fiscal deficits in order to control inflation and supposedly improve national savings. This implied a drastic reduction in public funding for health, and “privatization” in a variety of forms: adoption of user’s fees in public health services, expansion in the number of private providers or pre-paid health insurance schemes.

Though these conceptual foundations are still alive and active, it is critically important to acknowledge that the health reform guidelines pushed by the World Bank and other powerful international institutions have changed since the first framework was made public in the late 1970s.

By the mid 1980s the detrimental effects of the stringent reduction of public investment in health and education, as well as of privatization, were already evident, particularly in Africa. From then on a series of systematic critiques of the poor health and education outcomes of the SAPs was developed, publicized and used to pressure the World Bank and IMF. This pressure had an impact, albeit minor, on the global health reform agenda. In 1993, the World Bank launched the report “Investing in Health”. After almost fifteen years of implementing the SAP health model, the World Bank recognized that the outcomes were not positive and that public investments would be required to improve critical health indicators – such as infant and child mortality, HIV-AIDS and other epidemics – in the developing world and transition economies. This “breakthrough” led to a new global policy agenda that became known as the “reformed health reform”. But this did not mean a revival of the publicly funded universal models of the 1950s and 1960s. Instead, under the new guidelines, public funds were to prioritize the basic needs of the poorer sectors – the so-called basic packages – while higher income groups would still pay for their health costs.

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

Though limited and still economics driven, the new policy agenda was less stringent than the original SAP version and contained some windows of opportunity in terms of social concerns and participation. Specifically in terms of the S&R health agenda its impact was contradictory. On the one hand the DALY calculations demonstrated that priority should be given to neonatal and infant mortality – which implies antenatal care and obstetric interventions – and most important of all, HIV-AIDS. On the other hand, the DALY method did not immediately favor the prioritization of other critical issues, such as maternal mortality, access to contraception, abortion or gender-based violence. Since

1993 much research investment has been made within and outside the World Bank to demonstrate the cost-benefit relevance of a broad S&R health agenda.

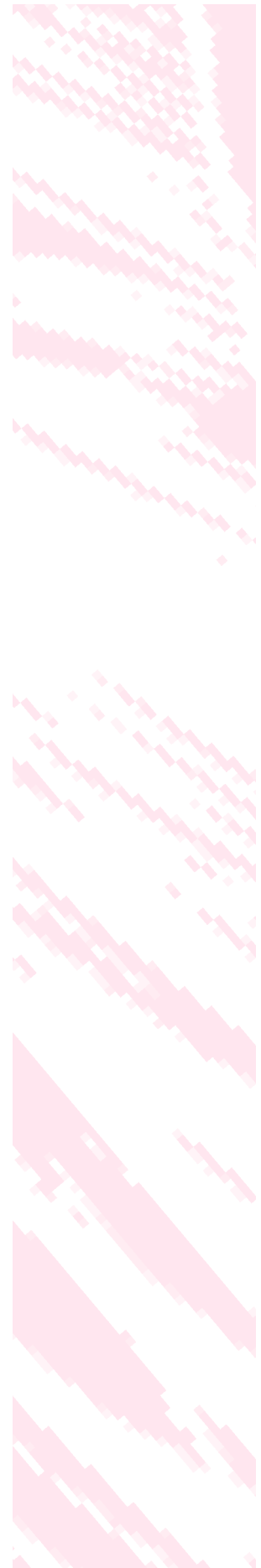
In the late 1990s, as new proposals for debt relief gained legitimacy, a second important shift was observed in health investment in Southern countries. Sector Wide Approaches (SWAPs) were adopted as part of the Highly Indebted Poor Countries Initiatives (HIPC) and, later on, of Poverty Reduction Strategies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


These distinctions are useful for a better understanding of the HSR processes underway in the countries included in the DAWN sample. Caribbean and African countries were immediately and deeply affected by the first reform wave that imposed draconian rules in terms of reducing public investment and privatization. But the health reform initiatives currently underway in practically all the countries in the sample mostly derive from the policy guidelines proposed after 1993. Brazil and Uruguay differ from the general pattern, as their health systems are not structured according to the World Bank framework, even if from the mid-1990s pressure has been brought on these two countries to adopt elements of the dominant guidelines, particularly as far as basic packages are concerned. It is also important to mention that Bolivia and Ghana are also implementing a PRSP-SWAP reform agenda.

THE PUBLIC-PRIVATE BOUNDARY: WHERE DOES IT REALLY LIE?

To a large extent critiques of dominant macroeconomic policies on health focus on the demise of the State's role in the provision of care and on the reduction in public funding. This is clearly one aspect of the contemporary health reform agenda that deserves to be looked at more closely. The emergence of universal health programs and national health systems in the golden era of the welfare state (1950-1970) implied an increase in public funding for health, higher levels of state regulation and, in some cases, the expansion of a service network managed directly by the public sector. This was a general trend in Europe and Canada, but also in those Latin American countries that by the 1950s had more or less consolidated social security systems and national health networks. The same approach seems to have inspired the health models adopted immediately after decolonization in Africa, the Caribbean and the Philippines.

However, it is worth remembering and emphasizing that even then a model in which health services were entirely funded and delivered by the State was restricted to socialist countries like Cuba, China and the USSR. In all other cases, the expansion of public funding and public delivery of services co-existed with other forms of health care financing and provision. In terms of service delivery the spectrum ranged from private doctors and clinics (paid





out-of the pocket), to religious or other not-for-profit organizations, which either collected donations or relied on public funding. This plethora of providers could also include other modalities of health care as in the case of the Uruguayan health cooperatives created by immigrant communities.

Before the 1980s ideas and proposals to improve the functioning of health systems in developing countries generally concentrated their attention on the restructuring, improvement and eventual expansion of the public sector. In some contexts, in fact, the 1970s health reform agenda openly called upon the state to take over full responsibility for health care. But in almost all cases the reality remained one in which a public-private mix has always been there. At least in the Latin American countries – for which the information is more precise – as early as the 1970s non-state provision of health care started expanding either through public contracting or through other schemes.

For example, during the dictatorship in Brazil (1960-1970) the Social Security health network greatly expanded by contracting private services and Church-related institutions. At the same time pre-paid health insurance schemes started expanding among the higher income groups. This public-private mix remains in place today, even though it is regulated by an entirely different set of principles and operational rules. Though SUS is defined as universal and free of charge the role of private providers remain dominant in many aspects. Private hospital and clinic contracted by SUS are more numerous than state owned facilities and tend to be concentrated on the tertiary level hospital and more complex procedures. In addition, the private sector financed by health insurance schemes and out of the pocket expenditures have enormous influence on policy definitions.

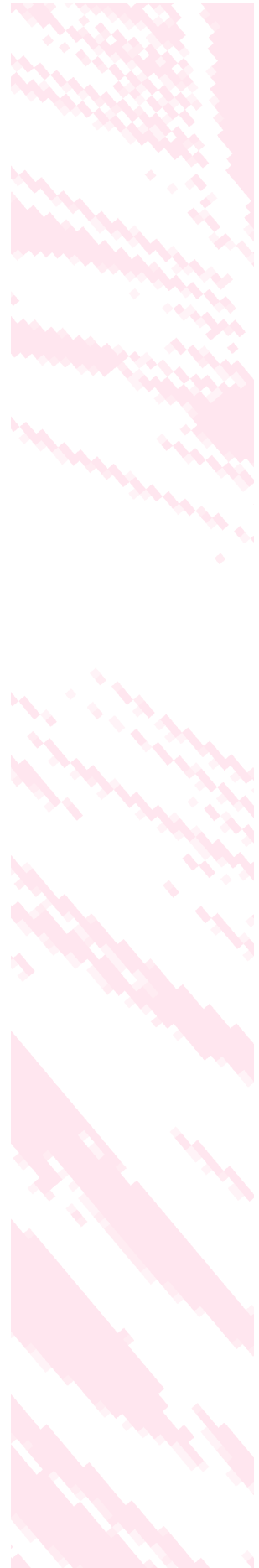
Market-oriented policy frameworks have undoubtedly influenced late 20th century health reforms. In all the cases studied by DAWN, health reforms have meant a profound modification of the public-private balance, affecting financing, regulation, provision of services and payment of health personnel. But this shift cannot be simplistically described as a straightforward switch from public to private health care provision or from free to paid access to services. The research findings suggest that what is underway is much more subtle and complex.

This means that critical assessments of HSR reform should not only consider the extent to which the State remains responsible for health care provision. Historical experience indicates that publicly provided health services are not inherently better and that it is not impossible to conceive and implement a model based on a public-private mix that would not suffer from the distortions observed in contemporary HSR processes. As Almeida (2005) suggests, critiques of such processes should not exclusively concentrate on the “role of the state as provider” but rather pay more attention to other structural aspects, such as:

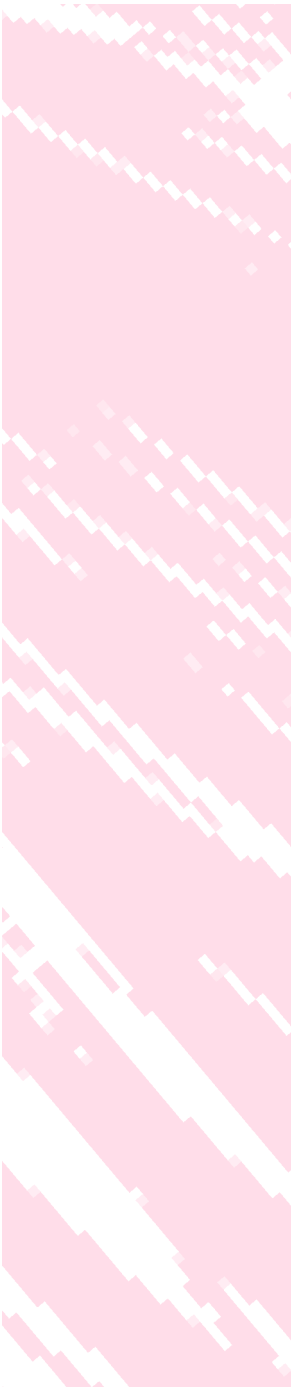
- The need to identify new and creative sources of public funding for health in order to compensate its persistent reduction over the last twenty years;

- The abandoning of solidarity and equity values in favor of a utilitarian approach based on each individual's capacity to pay for health services;
- The shift from a focus on health needs and rights to the notion of “health risks”, which supposedly are to be managed by individual behavior and payment capacity;
- The fragmentation of health systems – among different types of clients and interventions – in a manner that tends once again to emphasize medical care to the detriment of broader public health approaches, despite the constant mention of primary care and prevention in policy documents. In Latin America this aspect has been addressed under the general heading of “integrality”.

In short, it is possible to say that one major challenge facing the Southern feminist advocacy community in the years to come will be to carry out a more systematic review of our critique of HSR in the light of these three insights, particularly in terms of their implications for the S&R H&R policy agenda.



VI - Health Sector Reform: Country Profiles



This section offers a brief overview of the trajectory, current situation and characteristics of the health reform models and processes in the twelve countries. Countries have been clustered in regions, starting with Latin America, followed by the Caribbean, Africa and lastly the Philippines. The data collected for the country cases studies has been completed with information from other sources.

ARGENTINA

BOX 5: CHARACTERISTICS OF THE ARGENTINEAN HEALTH SYSTEM

In Argentina the public health system is made up of three sub-systems: a) the public network managed by the Ministry of Health; b) the social security network comprising the Obras Sociales – a system of health care provision established in the early 20th century by immigrant workers' associations and later incorporated into the pre-World War II social security reform of the 1930s; c) the private sector providing services both through user fees and health insurance schemes. In general terms, until the neo-liberal reforms of the 1990s the Argentinean system was modeled on the welfare social security system widely adopted in Latin America during the political transformations of the 1930s. The three sub-systems still co-exist today and great differences can be observed among them in terms of the type and quality of benefits and services. The effects of the privatizing model adopted during the 1990s are clearly reflected in the figures relating to health spending. The 2002 Human Development Report informs that, in 2000, while public investment was 2.4 per cent of GDP, private expenditure accounted for 6.1 per cent of GDP (annual per capita expenditure of US\$ 654 PPC).

Sources: Domínguez et al. 2005; Human Development Report, 2002.

The 1990s' Reform Process

The HSR was part of a broader State reform process, implemented in the 1990s, by the Menem administration. In the case of the health system, the proponents of the reform stated as their main objective to correct the distortions present in the previous “welfare model”. Their argument was that, under the guise of universality, the model had a “unionist” bias, rather than an

equitable structure, which, while guaranteeing access to health services for the formal labor force, excluded those sectors of the population active in the informal labor market.

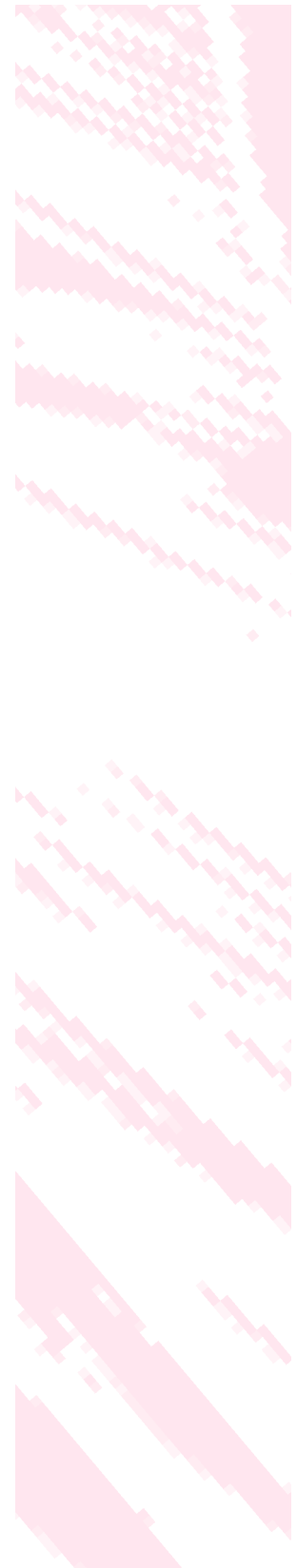
Although this distortion was real and needed to be addressed, under the prevailing political conditions it mainly served to fuel proposals designed to reduce public expenditure. But in the public debate the reform agenda appeared to have mainly technical goals: a) to modify the financial logic of the system; b) to improve knowledge of factors explaining increasing health costs; c) to resolve management inefficiencies, promote technological innovation and better respond to complaints by users regarding quality of care.

In terms of financing, great changes would take place after 1991, when the Minister of Economy came up with a strategy to centralize contributions with the aim of facilitating the central government's control over these resources. The economic deregulation decree (N° 2.284/91) established in its 85th article the creation of the Unified Social Security System (Sistema Único de Seguridad Social, SUSS), under the Ministry for Labor and Social Security. It also established the Single Social Security Contribution (Contribución Única de la Seguridad Social, CUSS) that unified pensions and health care contributions. The decree also established that the new SUSS would collect, administrate and monitor all employer and employee payroll contributions.

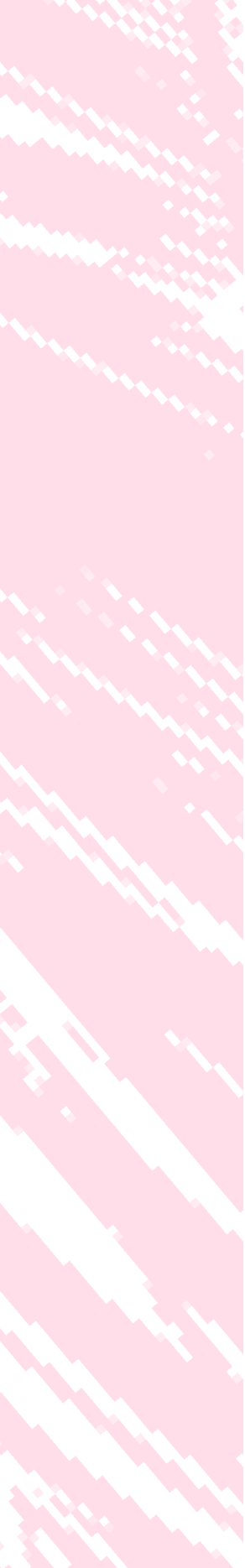
As was the case with the broader state reform, the HSR was heavily influenced by the market-oriented paradigm that prevailed in the 1990s. *"The debate on health reform centered around two distinct conceptual starting points. On the one hand, there was the egalitarian position that considered that access to health services should neither be a matter of individual choice nor depend on the financial capacity of each household. On the other hand, an extreme "market-oriented" position advocated the idea that each individual should consume the health services of their choice that lay within their financial possibilities."* However, under the direct influence of the multilateral financial institutions, by the end the 1990s the wider state reform process, and the HSR in particular, would be clearly inclined towards the market-oriented perspective.

Most importantly, the conceptual foundations of the HSR have not been the object of widespread public debate. In Argentina *"there was little concern for questions of equity, integrality of attention or equal access. The reformers of the 1990s had more limited objectives. They wanted to: re-organize the health system so as to make more efficient use of existing resources; keep some of the "solidarity" features of the system in place to allow for the accumulation of illness funds with an adequate risk pool; stimulate internal cross subsidies to avoid risk selection; guarantee minimum coverage for the whole population; and promote competition among health insurance companies."*²²

The main logic of the reform followed World Bank guidelines emphasizing "basic health packages" on the one hand, and the expansion of paid services on the other. But it is worth mentioning that the model adopted retained the regulatory functions and control by the state over: a) employer and employee



²² Belmartino, S. (1999). *Nuevas reglas de juego para la atención médica en la Argentina. ¿Quién será el árbitro?*. Buenos Aires: Lugar Editorial.



compulsory contributions; b) establishing a solidarity principle to help cover the health needs of low income groups; c) monitoring the fulfillment of norms governing the financial sustainability of private pre-paid health insurance companies.

Outcomes

By 2003-2004 the reform process had not yet been fully completed and it was possible that it could still be subject to important modifications as a result of the profound political transition that the country underwent after 2003. It is, however, possible to signal here the most relevant outcomes of the model adopted in the 1990s. The central aspects of the reform were: deregulation of the *Obras Sociales* that constituted the foundation of the public health network; decentralization of management and services; privatization of access to more complex levels of care. As already mentioned one clear effect of these reforms was that in 2000 private expending was roughly the double of public spending in health.

The implementation of the reform has been quite uneven across the country. This is due to differences in conditions at provincial and municipal levels that existed before the reform started, as well as to distortions resulting from decentralization itself. By and large the transfer of services – originally managed by the central government – to provinces and municipalities was not accompanied by the transfer of the financial resources required. Available research indicates that national transfers did not cover the increase in operational costs observed at decentralized levels. This problem was acknowledged by the reform's architects very early on, but the guidelines they offered to compensate this financial shortfall was to improve the health units' "self-management" skills. This meant that hospitals should generate their own financial resources, through the collection of fees, to ensure the sustainability of the services. These measures led to the flexibilization of health care professionals' contracts and to the sub-contracting of health services by the public and social security networks (tertiarization). One central aspect of the health reform process was therefore the introduction of a "market-oriented" logic that brought with it great emphasis on cost efficiency and recovery.

There were no comprehensive and systematic evaluations of the impact, achievements and flaws of the Argentinean health reform process available in 2003. However, the DAWN research team had access to partial evaluations which indicated that although positive outcomes could be identified with respect to the organization of services and quality of care, in many cases the public health system has experienced difficulties in sustaining these changes because of financial constraints. The most relevant aspect to be underlined here is probably that the financial-economic crisis had a rather perverse impact on a health system that had recently been reformed on the basis of a market-oriented framework. One impact of escalating unemployment rates was that large sectors of the population lost social security protection as well

as the ability to pay for more complex health interventions. As the crisis evolved a significant portion of the population shifted from the *Obras Sociales* to free public hospitals creating a situation of near collapse of the system. Not surprisingly, in recent years, the distortions of the 1990s' reform process have become the target of more systematic critiques and at present a larger number of social actors is involved in the debates concerning the need to re-orient it.

BOLIVIA

Box 6: Characteristics of the Bolivian Health System

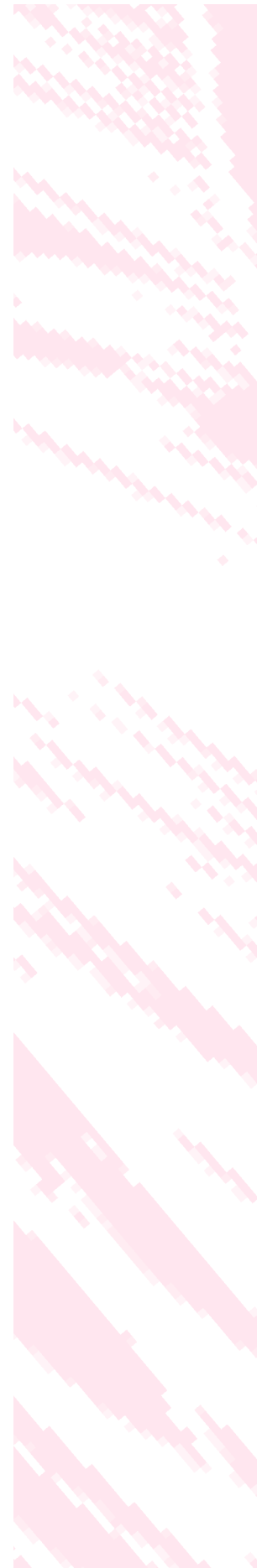
The Bolivian Health System comprises public and private sub-sectors. The public sector includes the services owned and managed by the Ministry of Health and Social Provision (Ministerio de Salud Pública y Previsión Social, MSPS) and the Health Saving Unit of the National Social Security System (Caja de Seguridad Social) that collects contributions from employers and employees. Until February 2003 the MSPS was made up of two Vice-Ministries: the Vice-Ministry of Health coordinated, regulated and supervised the delivery of health services, while the Vice-Ministry of Social Provision coordinated the health services funded by the Social Security System. But under the impact of the first wave of the social and political crisis this structure has been reformed. The Ministry of Health became the Ministry of Health and Sports and the Vice-Ministry of Social Provision disappeared, becoming a department of the MoH.


The private sector comprises private health insurance schemes, not-for-profit organizations, which in Bolivia are often service providers (NGOs, voluntary and religious organizations), drug stores and private doctors. In the case of Bolivia it is also important to note the relevance of traditional medicines, which in 2000 were the only source of health care for ten per cent of the population. In addition, social marketing programs have been designed to expand the production of health services.

As a highly indebted country Bolivia presents high levels of dependency on overseas development aid (ODA), which amounted to US\$476 million in 2000 (11 per cent of GDP). Since 1996 a group of bilateral donors have adopted a joint strategy specifically in relation to S&R health (Dutch Cooperation, DFID and USAID are the most relevant actors). An annual average of 100 million US dollars was projected as the financial basis of the Bolivian PRSP, of which 10 per cent would be allocated to the health component of the policy, which mainly corresponds to the HSR (SWAP).

The Reform Process

Bolivia is one of the countries for which the 1998-2000 DAWN policy research effort already addressed aspects relating to HSR. That analysis mentioned that from 1995-1998 a new wave of HSR was underway as part of overall state reform. The model adopted was the World Bank framework, which recommended the adoption of basic public health packages for poorer sectors of the population, while richer sectors were supposed to have access





to services through user fees or private health insurance. The first phase of the reform comprised the following main elements:

- Establishment of the Basic Health Insurance (Seguro Básico de Salud, SBS). As defined in the mid-1990s, funding for the SBS came from earmarked donor funds and municipal budgets, which were required to invest 6.4 per cent of the co-participatory tributary funds they received from the central government to cover its costs.
- The creation of the National Health Information System.
- Improvement of the management of local health networks, based on the measurement of efficiency and outcomes, which also implied formal agreements between the MoH and decentralized levels.
- Establishment of more effective mechanisms for the coordination, monitoring and evaluation of health policies and programs.
- Creation of the Epidemiological Shield to contain and control the transmission of communicable diseases, particularly tripanosomiasis americana (*chagas*) and malaria.

The core element of the reform in its first phase was the SBS. The Bolivian research team recognizes that this basic package model – though widely criticized in other country settings – had positive results in the Bolivian case. Data collected by the Secretary of Health and independent researchers demonstrated that economic barriers in access to health services have been consistently reduced. More importantly, the 2000 DAWN report indicated as a step forward the inclusion in the SBS of specific investments in reproductive health, especially measures aimed at reducing maternal mortality. Within this area, the inclusion of free and adequate care for first semester hemorrhages (mostly resulting from induced abortion) was seen as a major breakthrough, considering the low levels of access to health care that prevailed before.

Recent Trends

The second phase of the reform started with the new agreement signed in 2001 with the Association for International Development, which is the branch of the World Bank that operates in highly indebted poor countries. This phase was to be implemented through to 2005 and emphasized: the transfer of trained human resources to municipal levels; quality of care, particularly in deliveries; the completion of the Epidemiological Shield and greater investment in primary health care.

Regarding this last aspect, a new primary health program was created (Extensa) to implement a broad Family Health Strategy supported by Health Brigades and Community Health Agents to implement components of the SBS in rural areas and poor communities. Investments were also projected for capacity building for health professionals and the integration of basic health units through the Internet. Another important dimension was quality of care, which included service training, the definition of protocols and best practices certificates, incentives and permanent monitoring.

However, political and institutional changes would affect the scope and spirit of the reform. In 2002 the SBS was converted into a Mother and Child Health Package (Seguro Universal Materno Infantil, SUMI). The financial basis of SUMI is more solid than that of the previous SBS as it receives additional earmarked donor resources, funds from the National Treasury and an increased contribution from the co-participatory tributary funds (now 10 per cent). SUMI did continue to prioritize antenatal and obstetric care as well as interventions regarding second semester hemorrhages. But it has restricted access to other S&R health procedures.

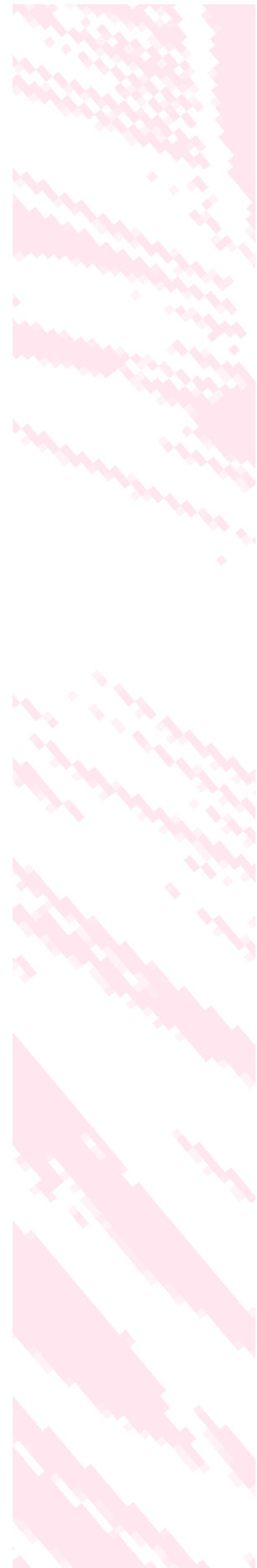
As part of the second phase of the reform in December 2002 a new institutional rearrangement occurred under which the Ministry of Health was separated from the Social Security framework and became the Ministry of Health and Sports. Neither the rationale behind this change nor its implications for the reform process have yet been fully assessed. Following these changes the political-institutional crisis deteriorated further, which made it yet more difficult to monitor and assess the health reform process.

Outcomes

As has already been mentioned, the DAWN 1998-2000 research (Corrêa, 2000) signaled some merits of the health reform in its first phase. In addition to the emphasis on reproductive health, the rationalization of existing health systems is seen as positive, most particularly with regard to the clarification of MoH functions on the one hand, and Social Security on the other. The reform also established clearer rules for differentiating between sectors of the population: a) those unable to pay for services, who would be covered by the new public health insurance scheme (the SBS); b) those who would remain under specific social security schemes (Cajas de Salud); c) those who could pay for health services out of their own pockets or who would rely on private doctors and hospitals or private health insurance.

Another positive aspect mentioned was decentralization of health management and funding responsibilities from the federal level to the provincial level (*Departamentos*) and municipalities. This implied a new hierarchy of services, with the creation of provincial health departments and health districts at the local level and the establishment of a joint management system involving the MoH, Social Security, provincial administrations and municipal governments. On the whole this has meant greater access to health care and improved coverage. Between 1997 and 2001, access to public health has effectively expanded, particularly in the case of hospital-based care. However the report also underlines that in this first phase no significant impact was observed with respect to primary and secondary health care, particularly in rural and poor urban areas.

In 2003 an assessment of the health reform process was carried out during a seminar on "Health and the Bolivian Strategy for Poverty Reduction" in which the following problems and flaws were identified:





- The commitment of municipal contributions to the Basic Health Insurance was not always met and where municipalities did fulfill these commitments, the investments were not cost-effective;
- The population lacked proper information about the new insurance scheme, in particular regarding which procedures were or were not free of charge. In many places this has fuelled distrust and discredited the public health system;
- A wide range of problems was observed with respect to the contracting of health personnel with SWAP funds.
- Despite investments, the implementation of primary health programs remained rather weak, specially in more remote and poorer areas;
- The new strategic focus on family health has minimized the comprehensive approach that prevailed previously, in particular sidelining those aspects relating to individual health needs and rights;
- There were no clear indicators to measure properly the impact of the health reform initiatives on poverty reduction.

Since 2003, in addition to the institutional rearrangements mentioned above, the Bolivian HSR process has clearly been affected by the profound political crisis that is still gripping the country. In this respect it is important to remember that tensions between provinces and the central government include problems with the decentralization process and the inequitable transfer of resources, which was also one key element/problem of the health reform itself. The 2003 report also stressed that the HSR process remained heavily conditioned by donor funds, and that this fact was particularly critical in the case of S&R health programs, among other reasons because of the relative weight of USAID in the group of donors that provide funds for this area.

BRAZIL

Background and Contemporary Processes

As already described, Brazilian health reform processes can be traced back to the beginning of the 20th century. These long-term sequential waves would shape the health system until the 1970s, when its inherent inequities and distortions started to be publicly debated. As in other countries in the region, one key disparity in access could be observed between those sectors of the population active in the formal labor market and covered by social security, and those that lacked formal labor contracts and had to use services provided by the Ministry of Health (which was also responsible for the control of pandemics and epidemics). Another negative feature of the system was the concentration of services and health professionals in more industrialized regions and urban areas. Lastly, since during the 1970s the social security health network expanded mostly through the contracting of private service providers, who preferred to invest in hospital-based care and more complex procedures, the system was marked by a strong hospital-based treatment bias and a parallel lack of investment in prevention and primary health care.

Box 7: Characteristics of the Brazilian Health System

The Brazilian health system is mixed, combining public and private sources of funding and structures for delivery of care.

PUBLIC SYSTEM

The public health system is structured within one main framework – the Unified Health System (SUS) – established by the 1988 Constitution, which aimed to resolve the previous fragmentation and inequities in health financing and provision of care. SUS is a universal publicly funded system that provides services free of charge to approximately 75 per cent of the Brazilian population. Health care is delivered both by government owned and managed units, as well as by contracted private ones. In Brazil, considering the public sector, while the Federal level retain a relatively small number of health facilities, the bulk of services is managed by state and municipal health departments. But it must be also said that 67 per cent of all SUS hospitals are privately owned facilities contracted by MOH in contrast with 8 per cent and 23 per cent of hospitals owned by States and Municipalities. In contrast, municipal governments owned 69 per cent of basic health care units, while only 27 per cent were private. The same set of financial rules and program norms apply to both types of provider.

Functions and Responsibilities

Ministry of Health: Establishes norms and regulations, controls pandemic and endemic diseases and basic sanitation, procures and delivers high cost drugs. Until today the MoH has control over its own network of hospitals (cancer hospitals and teaching hospitals), particularly in capital cities.

State governments: Their main function is planning and supervision, but as happens at Federal level, states still run hospital units.

Municipal governments: Provide health care through hospitals, basic care units and primary health programs. The Family Health Program (Programa de Saúde da Família, PSF) that provides door-to-door assistance from teams consisting of a general practitioner, nurse, auxiliary and community agents. Each unit is responsible for 600 to 1,000 households. The scope of managerial functions assumed at municipal level varies according to the degree of decentralization achieved.

Management Structures: The SUS is managed by bodies known as Cross-Management Commissions (Comissões Intergestoras), on which the Health Ministry and state- and municipal-level Secretaries have seats. At the Federal level the Commission is tripartite, involving all three levels, while at state level they are bipartite, involving state and municipal Health Secretaries.

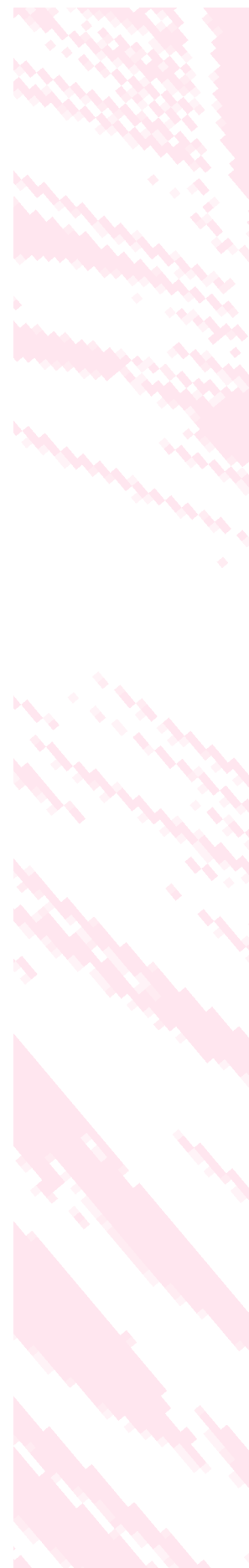
Accountability mechanisms


At the federal and state levels and in most municipalities there are health councils, half of whose members are users while the other half consists of government officials, service providers, and health workers. The councils are charged with monitoring the implementation of programs and expenditure of health funds.

PRIVATE SYSTEM

The private sector is currently dominated by pre-paid health insurance schemes, although pay-by-use services do exist. There are two types of scheme, one contracted by employers to which employees also contribute and the other contracted by individuals or families. Coverage also varies: while some insurance schemes cover all types of health intervention, others are limited to clinical or hospital care. Until 1998, when the National Supplementary Health Regulatory Agency (Agência Nacional de Saúde Suplementar, ANS) was established, the sector was entirely unregulated. Though enforcement is not fully effective, private provision of health care is subject to the same technical norms and protocols applied in the SUS.

Source: Corrêa et alii (1998)





By the end of the decade public health care professionals and academics as well as broad-based social movements started mobilizing around an agenda that called for a total reform of the entire health system. This movement engaged in public campaigns and systematic advocacy work that was further fuelled by the dynamics of democratization. By the early 1980s, this mobilization enhanced local experiments of retransformation of the health system that were already guided by the principles of universality and integration of services that would be adopted by the constitutional reform of 1988. The new constitution defined health as a right and set out the SUS as a universal, integral and decentralized policy with built-in public accountability mechanisms through health councils at national, state and local levels.

The implementation of these proposals was hampered by the political-institutional crisis of 1991-1993. But despite these obstacles, in 1991 Congress passed the National Health Law, and from 1993 the system was rapidly consolidated through a series of cumulative measures. The first was the establishment of a complex management system involving federal, state and municipal levels and providing spaces for “consensus building” on matters such as priorities, technical rules and financing (the Inter-Management Commissions).

In 1996 and again in 2001 operational and financial norms to guide SUS decentralization and other aspects of implementation were approved (the Normas Operacionais Básicas - NOB), which determined the different status and functions of the municipal health management systems. The status of local-level management depends on the capacity of the local health system to fulfill its responsibilities. In parallel, a start was made on implementing clear and well-funded primary care strategies to correct the hospital-centered bias, particularly in the poorest states and areas. This was done through the Family Health Program (PSF) and the Community Health Agents Program (Programa de Agentes Comunitários de Saúde, PACS).

The norms set out in 1996 and 2001 classify municipalities in two categories: (i) Basic Care Management, where the municipality manages the provision of basic or primary health care, while the state government retains control over more complex types of provision; (ii) Full Municipal Management System, where the municipal Health Secretary manages the provision of basic as well as complex care. The NOBs have also defined more clearly the planning and supervising role of State Health Secretaries, and lay out the steps municipalities must follow in order gradually to assume greater responsibility for the local health system.

Financial Aspects

Despite important institutional progress, until 1996 the system remained financially unsustainable for a variety of reasons. These included on the supply side the prevailing fiscal stringency guidelines and on the delivery side the relative weight of hospital costs. To resolve this bottleneck, in 1996, under pressure from the MoH and the public health movement, a new source of health funding was created – the Financial Transactions Tax (CMPF), which

charged 0.20 per cent on all bank transactions. The law stated that all funds raised through this tax should be invested in SUS. In 1998 during the currency devaluation crisis the percentage was increased to 0.38 per cent, of which 0.20 was retained to fund SUS while the remaining 0.18 was earmarked to compensate the deficit in the social security budget. In 2000, part of the funds raised from this 0.18 was allocated by law to a Poverty Alleviation Fund.

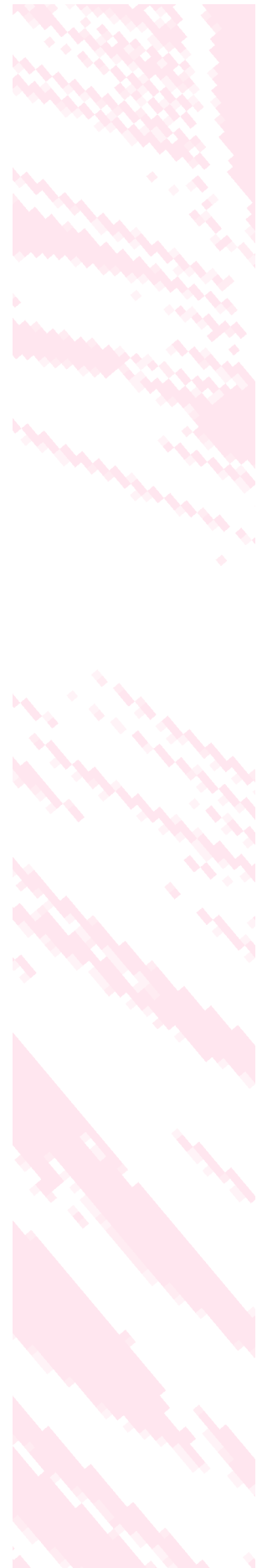
Though CPMF provided SUS with an unprecedented degree of financial sustainability, problems remained with respect to resource allocation. Since the transfer of funds from federal to state and municipal levels was predominantly for the payment of hospital and basic care procedures, the sub-national levels of health management lacked the financial flexibility that would allow them to invest in locally-defined needs. One main improvement resulting from the 1996 and 2001 NOBs was the modification of transfer rules allowing for greater flexibility. In 1996 a Basic Health Care Financial Baseline (Piso de Assistência Básica, PAB), was created that allows for the transfer of a certain amount per capita (10 *reais* in 1996; in 2005) to Municipal Health Secretaries that can be used on locally defined priorities. In the 2001 NOB a new set of financial incentives was established to encourage the expansion of the PSF, basic drug delivery and certain specific interventions, including in the case of women's health care antenatal and obstetric care, contraceptive assistance and cervical cancer screening.

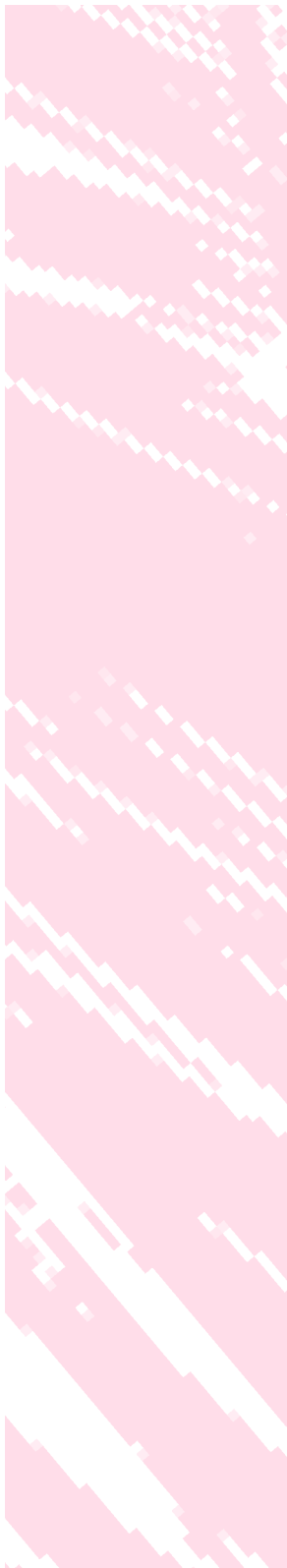
Another persistent problem was the great imbalance between federal investments on the one hand (roughly 67 per cent in 1999) and funds allocated to health by states and municipalities. In order to reduce these disparities, in 1999 a new constitutional provision was adopted determining for the first time the share of financial responsibility for health to be assumed by state and municipal governments. The provision established that 20.6 per cent of funding was to be provided by state level governments and 16.4 per cent by municipalities. It also established that the annual increase in the health budget would be determined by increases in GDP.

In 1998 a new regulatory agency – the National Supplementary Health Regulatory Agency – was established to supervise the financial performance of the private sub-sector and ensure that it also followed the basic SUS technical guidelines. One important norm established by the new regulations is that private health insurance schemes must reimburse SUS whenever a patient with insurance uses a public health facility.

Outcomes

The Brazilian HSR process offers a sharp contrast with what has, by and large, prevailed in other Southern countries. SUS has been correctly portrayed by some authors as a “reform that goes against the current”, as it does not conform to the market-oriented and efficiency-driven basic package model promoted by the World Bank and the IDB since the early 1980s. Brazil is one of the few countries in the region where publicly funded universal access to health care is strongly established as a constitutional right.





After almost twenty years of evolution at least three main positive impacts of SUS can be identified: the overcoming of the fragmentation between social security and MoH outlets; the expansion of the health network and of access to health (mainly as a result of the decentralization regulations adopted in the 1990s); and the gradual correction of the hospital-based treatment model that prevailed until recently, as a result of the expansion of the Family Health Program across the country. The positive evolution of health indicators over the last decade, including a steady reduction in infant mortality rates and HIV-AIDS-related mortality, can certainly be attributed to the consolidation of the system since the early 1990s.

Even the World Bank – which has often criticized SUS principles of universality and full reliance on public funding – has recently started to recognize its merits. A group of World Bank researchers examined data on access to health care in more than 4,000 Brazilian municipalities in relation to a set of policy and political variables, such as the quality of governance and voters' preferences along the left-right ideological spectrum at local levels.²³ One of their findings is particularly relevant as it demonstrates a positive correlation between levels of inequality and better access to health care: *“Holding per capita income constant, municipalities with a less equal distribution of income — suggesting a greater proportion of persons relying on SUS — are likely to have more SUS clinic rooms, and especially more doctors and nurses. A one standard deviation change in the Gini coefficient increases SUS doctors by about 4% (model 4) and nurses by about 5%.”*

Persistent Obstacles and Future Challenges

Despite the positive aspects of SUS and the significant progress made in recent years, problems of access and quality have not been entirely resolved. And the question of financing still remains an important constraint. Despite the sustainability ensured by CPMF, there is still tension between the Ministry of Health and the Ministry of Finance regarding the health budget because of the fiscal stringency imposed by macroeconomic policy orientation.

This tension frequently came to the fore under the Cardoso administration and has not exactly diminished since the PT came to power. GDP growth rates improved, which had a positive effect on the federal health budget. But the fiscal surplus target of 4.5 agreed with the IMF (and achieved in 2003 and 2004) is the highest in Brazilian contemporary history. Under this draconian rule the health budget, though constitutionally protected, has been frequently threatened over the last two years.

In October 2003, when the federal budget proposal was sent to Congress, concerned representatives noted that one billion was extracted from the SUS allocation to cover the costs of the Hunger Zero Program (the national poverty reduction program). The National Health Council and the Cross-party Parliamentary Health Bloc immediately reacted and the proposal was halted. In July 2004 it resurfaced in a policy paper issued by the Ministry of Finance advocating the elimination of all constitutionally earmarked budgets. The paper

²³ Ahmed Mushfiq Mobarak, Andrew Sunil Rajkumar and Maureen Cropper (2005). *The political economy of health services provision and access in Brazil*, The World Bank, Policy Research Working Paper Series 3508.

was made public just before the National Conference for Women's Public Policy where a motion defending earmarked resources for health and education and signed by 224 individuals and organizations was approved, despite abstention by the government officials participating in the debates. Lastly, in July 2005, in the midst of a major corruption-related political crisis, a Zero Deficit agenda – also implying a constitutional reform to eliminate earmarked budgets – was proposed as an urgent strategy to appease the financial markets.

Within the health system itself, the primacy of hospital-based care, dominated by contracted private providers, produces great cost imbalances. Hospital expenditure, especially in the case of complex and sophisticated procedures (like heart surgery, kidney dialysis, transplants etc.) tends to consume the bulk of resources and has become the target of powerful lobbies operating at both Executive and Legislative levels. The competition for SUS resources by private providers and principally suppliers has also been a common cause of corruption and bribery at all levels of the system.

Another aspect to be highlighted is the problem of scale in the decentralization process. SUS is a gigantic machinery delivering services to millions of people across an extremely diverse country. Decentralization has helped to reduce the gaps between managers, providers and users and has favored transparency and accountability. Given the extreme variation in technical capabilities, human resources and ideologies at decentralized levels, federal rules and incentives do not always ensure access to or quality of services. Not infrequently an excellent national policy translates poorly at local levels, either because human and financial resources are scarce (particularly in the smaller municipalities) or simply because it is not prioritized by managers.

Though the 1996 and 2001 NOBs set new parameters to regulate relations between the three levels of management (federal, state, municipal), tensions remain regarding allocation rules and their effects on the flexibility allowed to municipal managers. Political conflict between the various levels is also problematic. The World Bank study indicates that SUS performs better when state and municipal health managers come from the same political party. But when this political convergence is absent harsh conflicts of interest and power struggles can occur, deeply compromising access to health and quality of care.²⁴ Last but not least, up until 2005 a large number of states and capital cities were not fulfilling their new constitutional responsibilities to finance 24 and 16 per cent respectively of health spending.

This combination of factors has systematically compromised efficiency and more importantly the quality of care provided. Periodically, heated public debates have been sparked over the limits and distortions of the public health system. As each new SUS “crisis” becomes visible, more room opens up for the private sector to expand its reach. This results in a permanent tension between, on the one hand, privatizing forces that use marketing strategies to sell “quality of care and quicker access to health technologies”, and SUS fundamental principles of health as a right, universality and public funding, on the other.



²⁴ One illustration was the “quasi collapse” of the Rio health system in early 2005 that derived from an open conflict between the mayor and the Ministry of Health regarding the cost of transferring federal owned hospitals to the municipal level. The crisis was so wide and deep that implied a Federal intervention in the local SUS.

MEXICO

Box 8: Characteristics of the Mexican Health System

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

Source: Sánchez (2005).

Background

Soberón (2001) underlines that the Mexican health reform process is not a novelty of the 1990s. It can be traced back to the 1940s, when the IMSS, the INSTE and the National Health Secretariat were created. In the early 1980s health protection was defined as a right in national legislation and subsequently a National Health Law and equivalent state-level normative frameworks were adopted. New definitions were also established with respect to: decentralization, cross-sectoral coordination, community participation, financing, health information and human resources. Various authors who have analyzed this period point to the fact that decentralization, considered a core element of the 1980s reform, would not be completed until the mid-1990s when the last wave of health reform was initiated. This slow pace of progress was the result of economic constraints at state levels, but also of the long-standing Mexican tradition of centralized policy-making and funding (Langer and Nigenda 2000). The HSR underway (Programa de Reforma al Sector Salud) was prioritized in the 1995 National Development Plan and has been funded mainly by a World Bank loan.

The 1990s' Reform Process

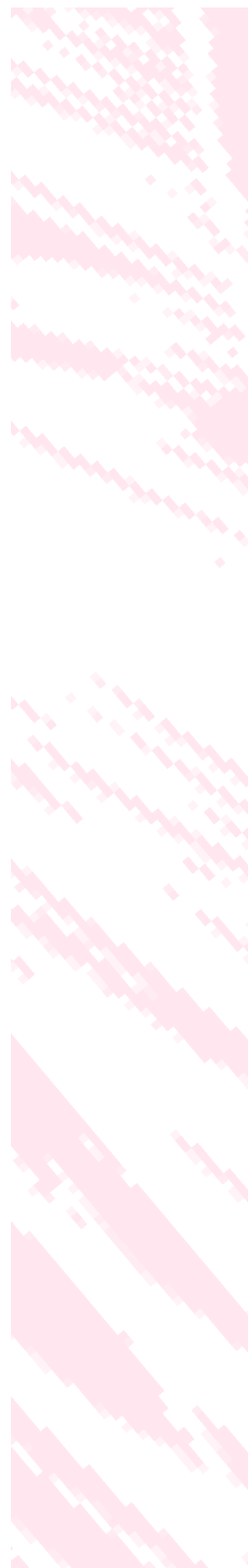
The health reform policy document underlines the need to revitalize the Mexican Health System by reorganizing expenditure and establishing new general criteria to ensure that health institutions and services are more efficient. The main objective of the reform was to improve access to health care in the case of the “general population”, that is, those people not covered by either the IMSS or the INSTE. The advocates of the reform identified as one major

problem the existence of parallel health systems that generated duplicities, gaps and inefficiency in the delivery of services: 10 million people living in marginalized urban areas and distant rural areas were not covered by existing services (Sánchez, 2004). The solutions to this problem proposed by the reform were decentralization, modernization and more efficient allocation of resources.

The greatest challenge for the reform would be the implementation of a basic health package to cover the needs of those 10 million people not covered by the existing health system structures. The new program also emphasized that other costs beyond basic care were to be covered by the clients themselves (user fees), and by partial investments by both federal and state governments. This privatization logic would gain ground as the reform evolved. The National Health Program for the years 2001-2006 is very clear in this respect, establishing that “the promotion of private prepaid schemes in the case of sectors of the population with sufficient economic resources is another strategic action aimed at ensuring the financial protection of families. This action complements the Popular Health Insurance scheme and Social Security (which covers the costs of the basic package)”. The directives also introduced new cost-effectiveness parameters (DALYs) to orient the public health interventions. The 1990s reform also implied new approaches to planning, programming, budget allocation and overall evaluation. Three new institutional structures were created to improve management and operational activities: the National Health Council, the Decentralization and Institutional Coordination Advisory Board and the Decentralization Support Units (Unidades de Apoyo a la Descentralización, UAD).

The Basic Health Care Project (Proyecto de Atención Básica a la Salud) is the basic component of the reform. It is funded by a loan of US\$ 310 million from the World Bank and a contribution of US\$ 133.4 million from the Mexican government. There are two main guidelines governing the policy process:

1. **Expansion of Basic Health Care** – This has the largest budget: US\$ 353.3 million or 75 per cent of total reform costs. This global strategy has three subcomponents:
 - **Public Health Interventions** – Consists of health education and promotion aimed at preventing infectious and chronic-degenerative diseases, as well as raising awareness of health hazards and various forms of addiction. Priority actions are: (a) Women’s health: antenatal and neonatal care; family planning; STD prevention and control; training and better equipment for midwives; (b) Children’s health: healthy child clinics; general child health care; immunizations; (c) health interventions through schools; (d) control of infectious and transmittable diseases (tuberculosis, leprosy, malaria and dengue); (e) water supply and sanitation.
 - **Clinic-based essential care** – Aims to expand access to more complex levels of care, although quite strict limits are imposed regarding what types of procedure are not free of charge.
 - **Institutional development and decentralization** – With a budget of US\$ 61.1 million or 13.8 per cent of total expenses, this policy area



covers the transfer of planning and budgetary functions from the federal level to state governments, in particular by financing UADs in each state. It also funds the training and development of human resources.

2. *Modernization and restructuring of the National Health Secretariat* – With a total budget of US\$ 47 million, or 10.6 per cent of total expenses, this strategy provides support for reforming the central management structures of the public system responsible for the “general population”.

Outcomes

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

Despite the good intentions expressed in the very first reform documents, the national health budget decreased by 12 per cent between 1995 and 2001. In part, this was the result of two periods of low growth of the Mexican economy, first from 1994-1997 and once again in 2001-2002. However, the budget cut can also be attributed to the very logic of the reform, since it aimed to redistribute health costs between the public sector and users. The privatizing model would be further consolidated after the election of Vicente Fox in the year 2000, and the subsequent shift to a much more market-oriented overall policy agenda. Privatization had clear impacts in the area of reproductive health, as it will be analyzed in the next section.

Another aspect worth highlighting is that Mexico is the most striking case in our sample of strong formal articulation between poverty reduction strategies (implemented through the transfer of income to poor families), the health reform process and reproductive health initiatives. This is the kind of articulation that is highly valued by mainstream institutions, such as the World Bank. The country report concludes that this strategy had limited positive outcomes. But it also raises two main concerns about the model. The first is that focalized poverty reduction strategies gradually displaced the universal social rights perspective, promoting within society the perception that there are different classes of citizens: those who can pay for services and those who are poor (who receive income transfers and do not pay for some services), including most of the indigenous population. The second is the fact that the new framework implied a restructuring of relations between the State, the market and households. One of its results was a new centrality of women as recipients (of complementary income and services), but also as “managers”, providers and monitors of micro-level social policies.

URUGUAY

Box 9: Characteristics of the Uruguayan Health System

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

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

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

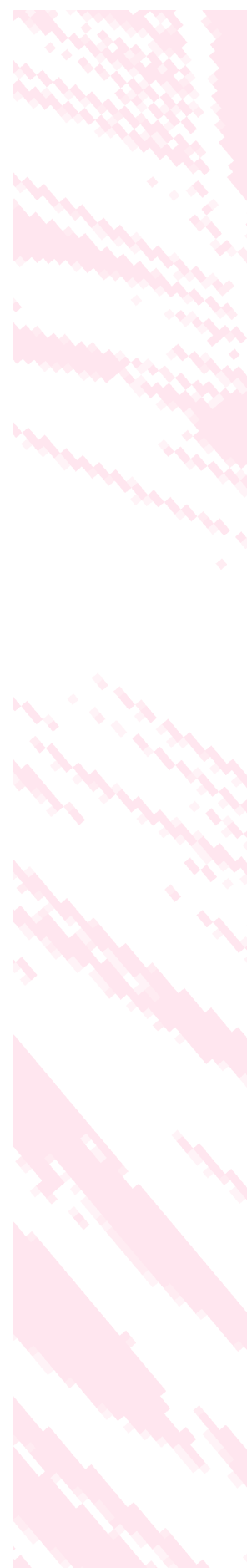
Social Provision Bank (Banco de Previsión Social, BPS) – Coordinates national social security and social protection policies. In Uruguay, all workers with formal private sector contracts and freelance workers have the right to Health Insurance (*seguro por enfermedad*), provided by the Collective Medical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

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

PRIVATE SUB-SECTOR – Comprising the IAMCs, companies providing partial health insurance, Institutes of Highly Specialized Medicine (which carry out high technology procedures paid for by the National Resources Fund), private hospices and clinics, and homes for the elderly. The IAMCs are a fundamental component of the Uruguayan health system. They are private nonprofit organizations that provide pre-paid full-coverage health insurance to almost 50% of the Uruguayan population (2000). Though the IAMCs enjoy a high level of autonomy, the monthly quotas have a ceiling set by the State.

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

Source: López and Abracinskas (2004).



Background and Contemporary Trends

As previously mentioned, the origins of the Uruguayan health system can be traced back to the early 20th century, and it owes much to the IAMCs – founded by European immigrants – as well to state welfare policy frameworks that were gradually established from the 1930s onwards. In the contemporary era a first measure worth mentioning was the creation in 1987 of the State Health Services Administration in the Ministry of Public Health (ASSE – article 275 of Law No. 15903, 10 November 1987). The law creating ASSE authorized the transfer of services to municipalities as well as allowing municipal governments to sign agreements with private institutions and to manage some health units using funds from “Neighborhood Associations” (Grupos de Apoyo Vecinales). Many authors regard Law No. 15903 as the beginning of the health reform process. However, following this first measure not much has happened. As late as 1995 the government sent Parliament a five-year budget plan that included the allocation of resources to implement the decentralization of ASSE as approved in 1987. But this budget line was not approved. In 2003 ASSE continued to exist as a dependency of the Public Health Ministry.

Nevertheless, in the period 2003-2004 a series of projects were underway which, taken together, make up an overall health reform framework. The package includes: the expansion of social security health coverage to all people in retirement; modernization of the public health information system, including the creation of a mechanism that would allow for the identification of users; revitalization of primary health initiatives; improvement of the coordination between public and private sectors; strengthening of the ministerial level policy coordination unit; decentralization of the MoH hospitals. These projects were part of a global program aimed at modernizing state machinery and strengthening social policy sectors. Initiated in 1995, it is basically financed by World Bank and IDB loans.

The logic underlying some of these proposals has provoked critiques and debate, although these did not have much resonance within public opinion at large. The main controversy centered on the role of the State. On the one hand, as also occurred in other countries, some voices supported the transfer of services to the private sector and civil society organizations, and the restriction of public health services to a basic package that would be provided to all, but would mainly be focused on low income sectors. The basic package proposal would gain more visibility and some policy legitimacy during the 2000-2002 economic crisis. On the other hand, there were voices advocating a stronger role for the State in terms of service provision and regulation. These sectors strongly criticized the basic package model, saying that it would create a layer of health care “only for the poor”, which in the medium term would negatively affect the quality of the health system as a whole. But after some debate neither was a policy consensus reached, nor did one position win through over the other. This impasse is

what to a large extent explains the “silent profile” and gradual pace of health reform in Uruguay.

The nature of the health reform process in Uruguay must also be examined in the light of the State reform process in general. The legal framework for it reaffirmed the general principles of the 1967 Constitution and the General Health Law of 1934, which state that the national health system must provide health care free of charge to the low-income population and implement measures to promote health. Although they are positive in many respects, these guidelines do not ensure equity as a core foundational principle of all health norms.

Lastly, the policy proposals presented in the 1990s, both for the public and private sectors, are mainly treatment-oriented and based on a medical model. In contrast, they have little to say about health promotion and prevention. This is problematic both in terms of financing and health outcomes. It is also important to note that the bulk of health prevention both in the past and at present is in the hands of the public sector, with practically no contribution from private sector providers.

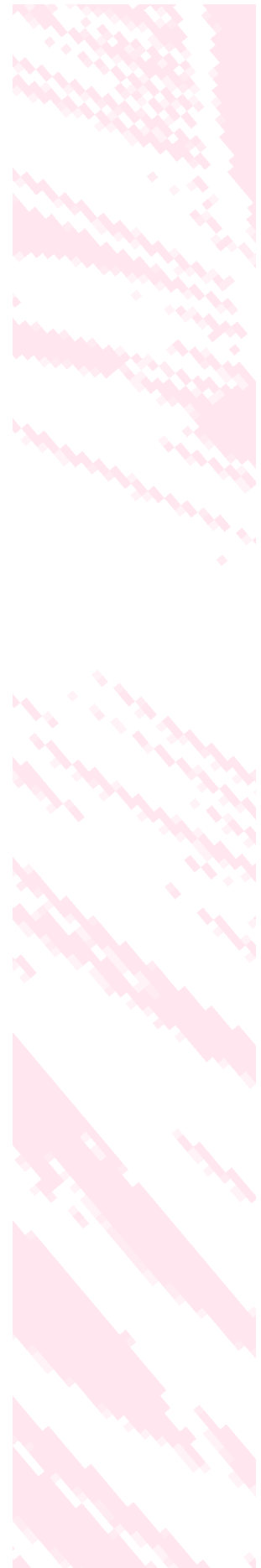
Change and Continuity

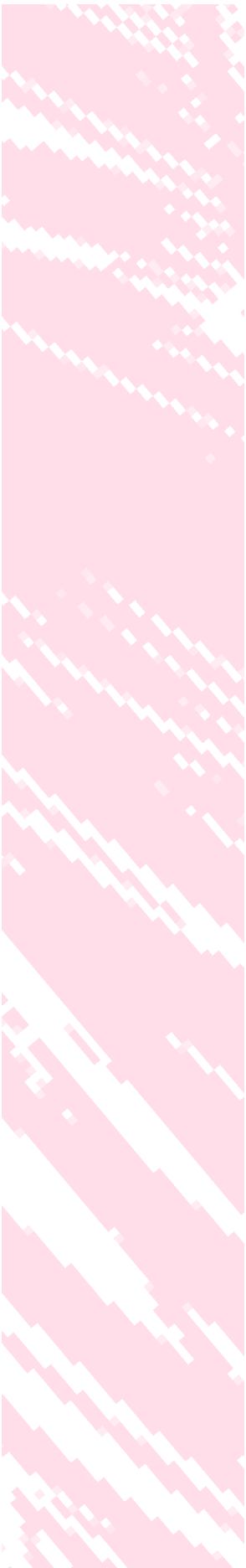
In Uruguay health reform measures have not been so clear-cut as in the other countries in our sample. But changes have taken place. Among these, major changes were brought about by the financial and economic crisis of 2001-2002. A study carried out by the National Medical Union found that in 2003 every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

But there have also been some relevant institutional changes since the mid-1990s such as:

Management and division of labor and functions – In 2001 Parliament approved a restructuring of MoH functions. Three new areas were created under the General Department of Health: (a) Health Services (focusing on quality of care, evaluation and auditing); (b) Products (focusing on equipment, modified food, diagnostic techniques and drugs); (c) Public Health of the Population (Epidemiology and Priority Programs). In 2002-2003 State regulation of the quality of care and evaluation was strengthened.

Decentralization and coordination – Although greater autonomy of ASSE hospitals as defined by the 1987 law had not yet been fully achieved, the MoH was taking some steps toward decentralizing its own services, supported by a World Bank loan. In 1999, a pilot experience of decentralization of four main MoH hospitals was evaluated as being positive. In late 2000, plans were made





to improve management and efficiency at another six hospitals. In 2003-2004, responsibilities for planning and implementation of health prevention and promotion programs were being transferred to municipal levels. At the same time investments were made to ensure better coordination between the various levels of management and adequate referral systems.

Service provision – Substantial changes have not taken place in primary and secondary levels of care. Nor has the number of public and private providers increased. However, IAMCs have started to implement household care for chronic diseases, linked to basic health care centers, and a new Family Health Program is being developed.

Management models – As has already been mentioned, management agreements have been signed between the MoH and ASSE hospitals. In the private sector, because some problems have been detected in the functioning and quality of care provided by the IAMCs, new regulations have been established making future public loans to these institutions conditional on the correction of these problems.

Health information – The MoH has implemented new systems of epidemiological data collection. It has also created a system to collect and analyze indicators of quality of care and of financial-economic performance (SINADI for the private sectors and PRORRECO for the MoH-ASSE subsystem). However, these systems do not process the information or provide feedback, and do not yet function as the main basis for policy decision-making.

Human resources – In Uruguay the proportion of medical doctors per 10,000 inhabitants has steadily increased since the early 1990s. There has also been a feminization of the health labor force and a clear tendency toward greater specialization with a parallel reduction in the number of general practitioners. The MoH has recently introduced changes in the curriculum of medical schools that aim to adjust the share of medical residencies to favor primary health care.

Outcomes

PAHO reports that there are no studies available to demonstrate that recent changes in health indicators in Uruguay can be attributed to greater equity, efficiency, quality of care and community participation deriving from health reform. The piece-meal reform that has silently evolved since the mid-1990s has in many ways made it difficult to understand more fully the changes underway and their impacts. In this particular context women's organizations have played a crucial role in placing on the public agenda policy proposals regarding population development and S&R health with a great emphasis on equity and social justice. Many of the contents of their agenda clearly overlap with aspects of the health reforms described above.

CARIBBEAN COUNTRIES

The Caribbean research was designed in a regional format. Though just four countries were studied, the final outcome was a cross-country summary report complemented by an annex containing more detailed information on specific national settings. For that reason the health sector profiles presented here follow the same format as that used in the regional report.

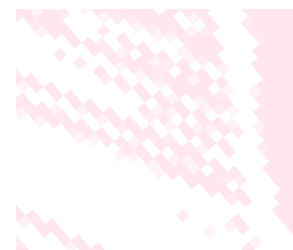


TABLE 2: CHARACTERISTICS OF CARIBBEAN COUNTRIES' HEALTH SYSTEMS

COUNTRY	NO. AND TYPE OF HEALTH UNITS	BASIC HEALTH UNITS / 10,000 POPULATION	PUBLIC HEALTH EXPENDITURE (SHARE OF GDP)	MAIN FEATURES
BARBADOS	Public Sector: 1 general hospital (600 beds); 4 district hospitals for geriatric care; 1 main mental health hospital; 2 rehabilitation centers for disabled; 1 AIDS hostel; 8 polyclinics; 5 outpatient clinics. Private sector: 1 hospital (30 beds); 100 doctors.	<1	3.8% The percentage of GDP spent on health in 1999 was 6.6%. In the 2000-2001 fiscal year the government allocation for health was \$280m, approximately 14% of total government expenditure. Expenditure on health services is increasing in both the public and private sectors. Hospital services consume the largest share of government expenditure (53.9% in 2001).	Health is a fundamental right. The government provides comprehensive health care to all citizens at an affordable cost. The major areas of health service delivery are: primary health care; MCH; family life development; care for the disabled; general medical care; clinics for hypertension, diabetes and sexually transmitted infections (STIs); nutrition; pharmaceutical services; community mental health; 24 hour acute care; secondary, tertiary and emergency care; mental health, care for the elderly; health promotion. 50% per cent of primary health services are provided by the private sector and 20% of the population has private health insurance.
JAMAICA	366 health centers	1	2.3%	Health care is a right. But the 1980s SAP led to privatization. Until 2003 no basic health insurance covered all citizens and many had to rely on private providers and health insurance. The HSR underway includes the creation of a National Health Insurance Fund to provide universal basic care.
SURINAM	16 health centers (11 public) 65 polyclinics (28 public) 49 health posts (all public)	3	1.9 per cent	The Regional Health Service is a parastatal foundation responsible for providing primary healthcare to the poor in the coastal area (peri-urban and rural), and provides services to an estimated 120,000 people. 25,000 people are covered by the recently created State Health Insurance Fund.
TRINIDAD AND TOBAGO	9 Hospitals 104 health centers 5 district health units 2 extended health care units	<1	3.1 per cent	Everyone has access to all levels of care. Primary care is provided at health centers and district facilities and is free of charge. Secondary and tertiary care is provided by three general hospitals. In the private sector, the average cost of a visit to a specialist physician is TT\$200.

Source: Ahmed (2006).

Background

Barbados, Jamaica, Surinam and Trinidad and Tobago are all engaged in HSR. The history of these reform processes is particular to each country, although the current reform processes share common features. The information provided in the country reports on historical aspects is quite uneven.

Barbados – The health system was a model in the region from the 1930s and 1940s and no mention is made of drastic impacts as a result of the market-oriented reforms adopted in the 1980s.

Jamaica – The report briefly describes three waves of reforms. In the 1970s under a democratic socialist regime the country adopted a publicly funded comprehensive “health for all” approach that included: expansion of primary health care facilities by almost 100 per cent; training of human resources; establishment of primary health care regions and districts and of community councils (with health as one of their main concerns); abolition of user fees and construction of a new regional hospital. In the 1980s a new government subscribed to a free market ideological framework and structural adjustment measures. In relation to the health sector, reforms included centralization of some functions in the MoH, the reintroduction of user fees, and a “managerial” approach emphasizing “efficiency” and public-private collaboration. The changes in financing encompassed expanding private health insurance and national health insurance and privatization of public facilities. Family planning and MCH have been central features of the various waves of health system reforms.

Trinidad and Tobago - After the structural adjustment policies of the 1980s under which state spending on health and social service delivery was substantially reduced and food subsidies were removed or reduced, the health system deteriorated. Trinidad and Tobago underwent four general elections in 10 years and these administrative changeovers systematically hindered the restructuring of the health system until 1993, when the current HSR process was initiated.

Surinam – Since the 1980s the functioning of the health system has been drastically affected by structural adjustment programs and political instability. The current wave of HSR started in 1999 funded by an IDB loan. In 2003-2004 under a bilateral agreement with the Dutch Ministry of Cooperation a SWAP model was adopted.

Contemporary Reform Processes

In 1993 Caricom adopted the Caribbean Charter for Health Promotion which was developed in Port of Spain in 1993 at the first conference of Health Promotion. This initiative coincided with the launching of the 1993 World Bank Report on Health, of which the meaning and impact was previously analyzed (the reformed health reform). The pace and evolution of HSR in the countries examined by DAWN was, on the one hand, influenced by the new

trends put in march by the report. On the other hand the rhythm of implementation of new guidelines was rather uneven, with in the case of Surinam the reform process starting only in 1999.

Barbados

In contrast to the other Caribbean countries analyzed in the sample, the Barbados 2002-2012 National Strategic Plan for Health, which reflects the general orientation of the health reform program underway, does not include a public basic health insurance scheme. The report suggests that the transition to such an approach had already been completed at an earlier point and, more importantly, the State is already investing in health to complement user fees (which are relatively low). There is no emphasis either on decentralization, probably because the country is very small.

The framework document of the National Strategic Plan states that *“The vision is to empower individuals, communities, and organizations in the pursuit of health and wellness in a health system that guarantees the equitable provision of quality health care, thus contributing fully to the continued economic, cultural, social and environmental development of Barbados.”*²⁵

The reform process is led by the MoH. Its main external partners are the IDB, USAID, PAHO and it includes strategic guidelines governing the following ten areas:

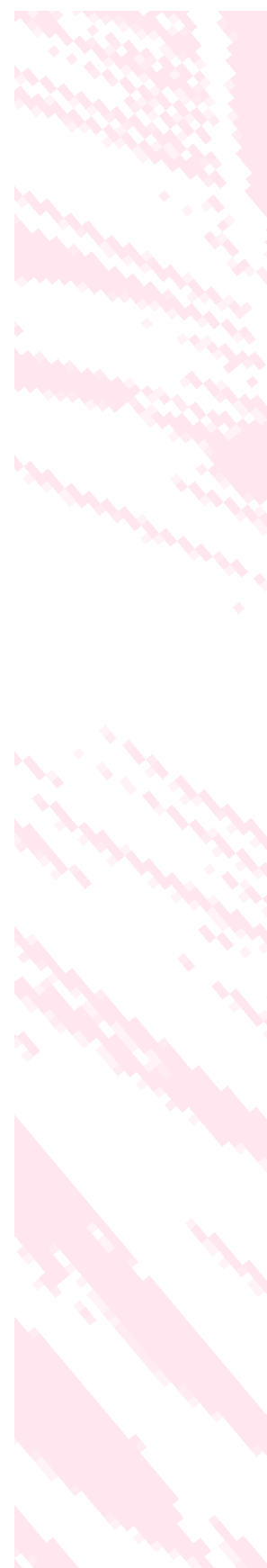
- Health systems development
- Institutional health services
- Family health
- Food, nutrition, and physical activity
- Chronic and non-communicable diseases
- HIV/AIDS
- Communicable diseases
- Mental health and substance abuse
- Health and the environment
- Human Resource Management

One specific goal is to maintain the zero per cent maternal mortality rate.

A core component of the reform is the Continuous Quality Improvement Program, which trains teams in the areas of efficiency, effectiveness, and client satisfaction. The reform program has also incorporated and placed great emphasis on the Family Health Strategy as defined by PAHO, which encompasses reproductive health, women’s health, men’s health, adolescent health, health of the elderly, oral health, and rehabilitation – in other words the main components of the ICPD and Beijing agendas

Jamaica

As already mentioned, the country has undergone several waves of health reform since the 1970s. In the 1990s, epidemiological, technological and



²⁵ Quoted in the Caribbean Countries Report (Ahmed 2006: 55).

social concerns arising from the negative impact of measures adopted in the 1980s converged with the new global trend of “reformed reforms”. In 1997 a new Health Sector Reform Program was initiated, which aimed to enhance a “new public management” approach and revive a stewardship role for the State. The guidelines also included a strong emphasis on decentralization. Major players in the HSR included the World Bank, USAID, PAHO, UNFPA, IADB and the Italian Government. Since then, the main reform measures have been:

- Decentralization of the management and delivery of health services with the establishment of four Regional Health Authorities;
- Restructuring of the MoH Head Office to focus on planning, policy and legal and regulatory functions;
- Implementation of revised user fees (again in 1999);
- Continuing divestment of non-technical and some technical services;
- Increased attention to quality assurance and client-oriented services;
- Proposals for a National Health Insurance Plan beginning with a National Health Fund introduced in 2003;
- Attention to efficiency improvements in the management of facilities and delivery of services;
- Development, deployment and management of human resources;
- Establishment of an Emergency Medical System.

MCH has been a key feature of the reform program.

Surinam

The Constitution of the Republic declares that everyone has the right to good health, and acknowledges the duty of the State to promote healthcare in general by improving living and working conditions, and by providing health information.

In the mid 1990s the Ministry of Health, assisted by the IDB initiated a project for Health Sector Reform. The first step was a series of studies, which were debated in seminars in which stakeholders and key institutions and organizations participated. The first study was completed in 1999 and was used to shape a HSR program that was included in the Multi-annual Development Plan 1999-2003. The document included the following priorities:

- Increase in quality and coverage in the health sector;
- Improvement in access to basic health care;
- Improvement in public financing to cover a basic health insurance scheme;
- Adjustment of the public health legislation where necessary;

In the meantime, bilateral assistance from the Netherlands shifted towards a new approach in which priority sectors were selected for funding. In Surinam health was chosen as a priority sector. This led to new set of studies

that would result in a Health Sector Plan that would be officially launched in the first semester of 2004.

As far as decentralization is concerned, for quite a long time responsibility for health care has been shared by the MoH and non-profit foundations that provide particular types of service in specific areas of the country. The Regional Health Service (RHS) (50 clinics/stations) is responsible for providing primary healthcare to the poor in the coastal area (peri-urban and rural). Figures for 2003 show that the RHS provides primary health care through 62 health posts in 8 districts, covering around 80,000 people. In the interior of the country primary healthcare is provided by the Medical Mission, an NGO entrusted with this responsibility by the Ministry of Health in 1977. Its 45 clinics/stations are supposed to cover the medical needs of an estimated 48,500 persons (80% Maroons, 20% indigenous people).

Trinidad and Tobago

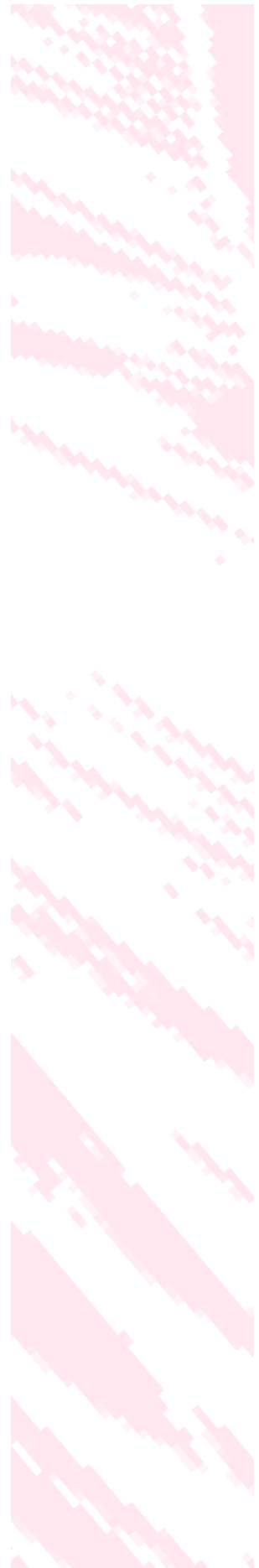
The last wave of HSR began in 1993 as an attempt by the state to resuscitate a failing health care system. It included renovating, upgrading, and capacity building in the case of existing health centers and hospitals, as well as building additional facilities and ongoing training for health professionals. Its main partners are PAHO, the European Union, the IDB and WHO. The reform process has, however, been hampered by political instability and a series of administrative changeovers.

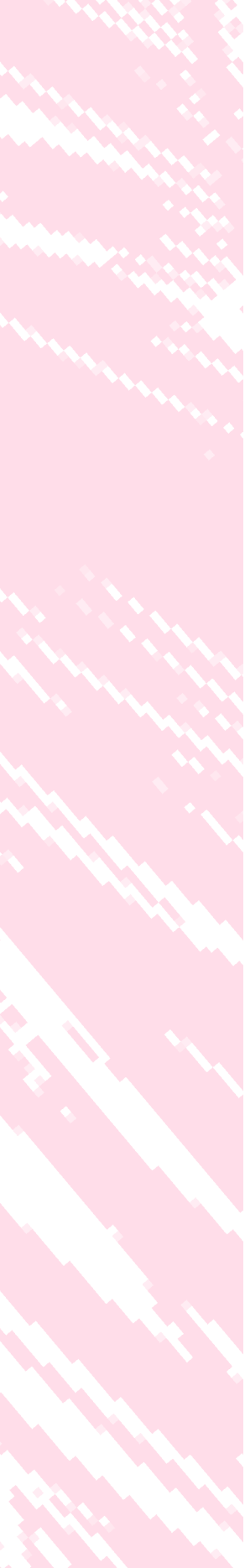
The main objective was the creation of an efficient primary health care system. To this end, the five general hospitals in Trinidad and Tobago, in addition to St Ann's Psychiatric Hospital, were to be supported by a network of some 90 Primary Health Care Facilities, including eight District Health Facilities and four Enhanced Health Centers delivering primary care services. The Woodbrook Health Center in Port of Spain was used as a model for this strategy. Though the reform has been underway for some time, a clear division of labor and responsibility between the different levels of care has not yet been fully established.

Primary care at the health centers is free of charge. Secondary and tertiary care is also entirely free at hospitals in Port-of-Spain, San Fernando, Mount Hope, and Scarborough, and at several district hospitals. However some hospitals charge for procedures, as is the case at Mount Hope Women's Hospital, where deliveries must be paid for (TT\$25 fee).

The health sector is financed in part by international sponsors whose funds are matched by the government of Trinidad and Tobago. A budgetary current expenditure vote is also taken by Parliament, which determines the level of financing for the health sector. The reform package proposes to change the health system's funding mechanisms, arguing that to rely on general taxation is neither sustainable nor equitable.

Therefore alternative models of funding are being examined, principally the introduction of a National Health Insurance Scheme (NHIS) to be funded by





employer and employee contributions, while the government would pay the health costs of the very poor. Another component of the reform program as part of the NHIS is the agreement on a package of basic health care services, combined with user fees for more complex services. In 2004 the reform program was concentrating attention on protocols and standards of care, peer review, systems to capture costs and outcomes in a manner supportive of decision-taking, and the creation of a unique identification system (health card) for each citizen.

Outcomes

As is also the case in other countries in our sample, in the Caribbean recent health reform processes have been by and large “silent” – they have not been subject to wider public debate, nor have they spurred much critical discussion. The trajectory of the reforms in the region may provide some explanation for this “absence of severe critiques”: with the exception of Barbados – where the health system seems to have retained its integrity – the effects of the 1980s’ reforms were so drastic that the “reformed reform” model of the 1990s is generally welcome. This is reflected in the Jamaica report that emphasizes the “revival of State stewardship”, as well as in the case of Trinidad where the potential “reconstruction of the health system” promised by the reform is positively appraised. This does not mean, however, that the reports do not identify any problems with the reforms.

In the case of Barbados, for instance, the report raises concerns about the centrality of the “family health approach” in the reform program, as it tends to reduce the visibility and relevance of the reproductive health agenda as defined in Cairo and Beijing. Similarly, although HIV-AIDS is considered a current health priority, this is not adequately reflected in the reform guidelines.

The Trinidad and Tobago report underlines the fact that, while some consultations have taken place as part of the reform process, no permanent accountability mechanisms monitoring health policy-making, financial allocations, and quality of care exist at any level. However the most problematic area is with respect to decentralization, and in particular the division of labor and responsibilities between the MoH and Regional Health Authorities (RHAs), especially because tensions have surfaced in relation to staff contracting. When the RHAs were established, it was assumed that all MoH staff would automatically transfer or join the RHAs, and incentives for staff transfers were defined. But concerns over differential rates of pay, working conditions, benefits, and pension plans have led senior professionals to remain under the MoH, and major labor disputes have also occurred. Though doctors and nurses have tried their best to ensure that health services in Trinidad and Tobago continue to function, these tensions have compromised the performance of the system as a whole. *“The parallel systems have led to the establishment of parallel administrative systems to deal with the two classes of staff. A duplication, in many cases, of administrative staff now*

exists. The RHAs went overboard in setting up their administrative structure. Managerial posts were created everywhere and anywhere. Managers with little or no experience in health care systems were hired on an ad-hoc basis. Thus while the IDB has been pushing for a Primary Health Care slant to the health reform the RHAs have been left with little to channel to the community". (Ahmed, 2004).

Overall, the least positive experience of health reform appears to be that of Surinam. The report emphasizes the administrative shifts and the lack of government commitment to health as factors that quite easily lead observers to consider that the recent HSR process may just be yet another example of empty rhetoric: "Noting the fact that over the last years, the share of Total Government Expenditure (TGE) going to healthcare was only 3%,²⁶ it comes as no surprise that this medical infrastructure has been severely hollowed out. Polyclinics are in a bad state, understaffed, and have a continuous lack of medicine and equipment. On top of the serious lack of quality service, service also tends to become more expensive. Even if services are supposed to be provided for free, in reality patients have to pay. The whole medical infrastructure is suffering greatly from the fact that the government fails to fulfill their financial obligations... Health institutions and the State Health Insurance Fund were time and again faced with the government as defaulter. As a consequence patients are often confronted with the "no pay, no cure" treatment. More and more individuals and companies who can afford it made a shift to private health insurance, therewith eroding the basis for general health insurance further, and widening the gap between those who have access to quality health care and those who have not."²⁷

GHANA

Background

The Ghana Health system was drastically affected by the draconian rules introduced under the 1980s structural adjustment program. But from the early 1990s on, the country adopted the "reformed health reform" framework with its various components: decentralization, improved management, financial and cost-effectiveness strategies and creation of a national health council and accountability mechanisms at decentralized levels. On the other hand, Ghana is a good illustration of a health reform implemented through a Sector Wide Approach associated with a Poverty Reduction Strategy Program (PRSP), which implied greater coordination among donor agencies and between them and the MoH. The general guidelines of the reform comprised: decentralization, institutional development (MoH and decentralized levels), strengthening of management and planning functions, the creation of



²⁶ Ministry of Finance. Statistics from the Budget Office, 2001.

²⁷ Seminars on Health Sector Reform, Ministry of Public Health/ PAHO.



platforms for dialogue among partners and stakeholders, and the establishment of permanent accountability mechanisms. The following main steps in the reform process can be identified since the early 1990s:

- 1991: Decentralization initiated with the launching of the district health system.
- 1992: The MoH was restructured.
- 1993: Countrywide decentralization of authority occurred. The 110 District Assemblies became Budget Management Centers (BMC) that have as their mandate the control of financial resources, planning and provision of all social services (including health) to their communities. The basic idea behind the first steps of decentralization was that Ministries would work with District Assemblies to ensure that specific sectors – health, education etc – are addressed and adequately resourced.
- 1996: As a result of in-depth reviews and wide consultations (beginning in 1993) with all stakeholders – private, public and external – in the health sector, a Medium Term Health Strategy was developed (MTHS), which formed part of the national development strategy called “Vision 2020”.
- 1999: The Ghana Health Service Bill was approved by Parliament. This created the Ghana Health Services, which would become a main source of service delivery (contracted by the MoH), and most importantly clarified the functions of the MoH as distinct from those of the Ghana Health Council (GHC) and Ghana Health Services (GHS): the MoH is responsible for policy formulation, while the GHS is the main contractor of service delivery and institutional care and has oversight responsibilities, and the GHC is the high level instance of coordination between the two. The Head of the GHS is the Director-General of Health (with several Directors under him, one of whom is the Director of the Family Care Division, responsible for maternal care, family planning, child care and reproductive health). The Law has also clarified the role of regional and district teams with regard to the Budget Management Centers. Implementation of the law began in the year 2000.
- Early 21st century: The MTHS adopted in 1996 would become the operational framework for the SWAP adopted as part of the PRSP, in which measures were defined to ensure greater donor coordination. This step was very important because historically in Ghana health programs funded by specific donor agencies were very fragmented (a problem that was particularly acute in the case of S&R health).

Outcomes

The country report mentions various positives outcomes of the reform, such as: the expansion of coverage and access to health facilities, the

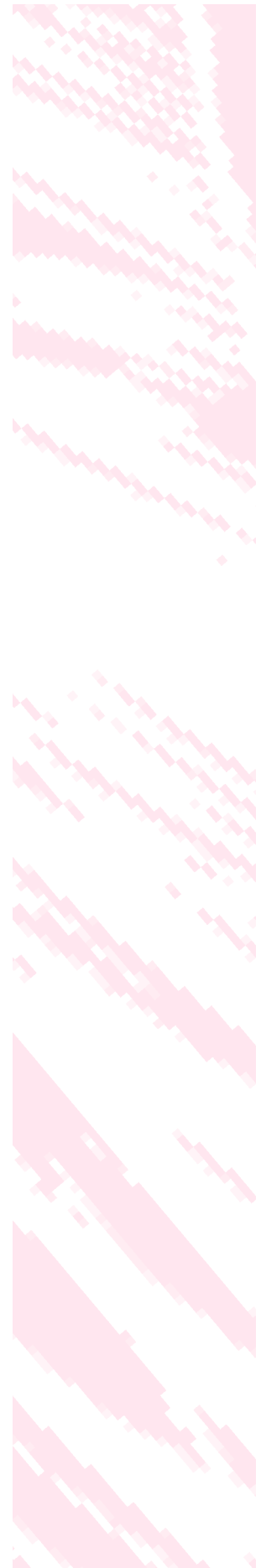
construction of three new regional hospitals and additional district hospitals, and the upgrading of district health centers. Evaluated as particularly positive is the community-based approach to health services and planning (Community Health Prevention Services, CHPS), which relies on the placement of a health nurse within communities who works with the village health committee to improve levels of health care. The report also mentions improvements in terms of the integration of vertical programs in service delivery and a better pattern of resource distribution between the central government, regional hospitals and health districts.

On the other hand, the report also points out that, to a large extent, the reform results are clearer in terms of planning, financing and the construction and equipping of new health facilities, than with regard to programming or capacity-building and retention of human resources. This gap is particularly relevant given the high levels of brain drain observed in Ghana in the case of skilled health professionals.

Mayhew (2003), analyzing the impact of decentralization on S&R health programming, calls attention to the fact that, as elsewhere, the first moment of devolution (1993) led to confusion over the respective functions of the different institutions, and most importantly, to competition between social sectors for financial resources at decentralized levels. The 1999 Health Services Bill, which aimed to resolve these distortions, did so by reaffirming the role of the MoH in policy definition and monitoring.

The same author also mentions as one important element of the reform the creation of regional and district level health management teams whose function is to mediate communication between national and local level authorities, but points out that until very recently this role was not very clear. This seems to be related to the confusion regarding finance and resource allocation, signaled in the country report: *“Considerable progress has been made in deconcentrating health budgets. Financial allocation now goes directly to districts ... improving disbursement times. The budget process, however, remains cumbersome, requiring all district and regional budget plans to be drawn according to national guidelines and approved against national ceilings and priorities. This approach can delay disbursements...”*

A related problem concerns the budget process and resource composition. In theory, regional and district health teams have the authority to define local health priorities, but when the final budget returns to the decentralized levels there is no room for financial modifications with respect to the resources transferred from the MoH. However, probably the most significant financial aspect of the reform is that 20 per cent of MoH spending at district levels is supposed to come from user fees, which in the poorer districts mainly go to revolving drug funds and equipment. Lastly, Mayhew observes that – as is also the case in other countries – it is very hard to make a proper assessment of the reform impacts in terms of the main health indicators.



NIGERIA

Box 11: Characteristics of the Nigerian Health Reform

As already mentioned, the Nigeria study differs from the other country studies in that it does not have a national focus, but rather analyzes the state of maternal health services in Cross River State. But information collected in early 2006 on the Government of Nigeria website provides general information about the health reform process underway. The main objectives of the reform are:

- Ensuring the development of National Health Policy and its implementation through supervision monitoring and inspection;
- Issuing, and promoting adherence to, norms and standards, and providing guidelines on health matters, and any other matter that affects the health status of people, promoting adherence to norms and standards for the training of human resources for health;
- Conducting and facilitating health systems research in the planning, evaluation and management of health services;
- Facilitating and promoting the provision of health services for the management, prevention and control of communicable and non-communicable diseases;
- Ensuring the provision of tertiary and specialized hospital services;
- Coordinating health services rendered by the Federal Ministry of Health, states, local government wards, private health care providers and development partners and providing such additional health services as may be necessary to establish a comprehensive national health system;
- Determining the minimum indicators required to monitor the status and use of resources and services;
- Organizing the National Council on Health to create a forum for integrating all health plans of the Federal and state Ministries of Health and building consensus on national health issues;
- Providing assistance to state Ministries of Health in the development of state health plans, technical materials, including methodologies, policies and standards and other technical assistance as may be necessary in order for the State Ministries to properly perform their functions.

Source: Government of Nigeria website.

Outcomes

The same source reports that since September 2004 the following goals had been achieved with respect to HSR:

- The federal government released the sum of N 7.9 billion for the payment of the shortfalls in the 2004 Personnel Budget for workers in health institutions. The funds were paid to the health workers, and the workers went back to work, thus ending a three month-long doctors' strike.
- Three documents have been adopted to guide the reform: (a) the National Health Policy; (b) the National Health Bill; and (c) the Health

Sector Reform Program, which is to work with the 7 Thrusts of the Health Sector Reform Agenda in order to achieve: (a) the NEEDS and MDGs targets; (b) revitalization of the eight Teaching Hospitals in order to turn them into centers of excellence.

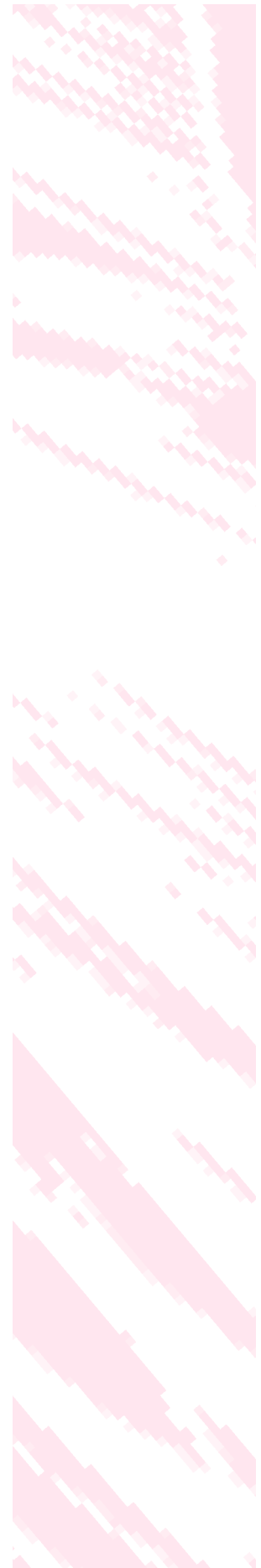
- Through the National Primary Health Care Development Agency (NPHCDA) over 200 Model Health Care Centers have been established throughout the country.
- The government successfully worked out the public-private partnership collaboration of all stakeholders in the health sector, both public and private.
- The Federal Ministry of Health has initiated a review of the Malaria Treatment Drug Policy.
- The Federal Ministry of Health, with assistance from the World Bank, is actively implementing the six Millennium Development health-related Goals, with particular reference to improved maternal health and reduction of child mortality.

Conditions in Cross River State health system (2004- 2005)

In Cross River State (CRS), the total number of government health facilities is 483, while there are 91 registered private facilities. The number of government health facilities ranges from 10 in Bakassi LGA to 43 in Yala LGA. The private health facilities are concentrated in urban areas like Calabar Municipality, Calabar South LGA, Ikom, Obubra and Ogoja LGAs. The Medical Directorate in the state Ministry of Health registers and monitors private practices in the state. In 2004, the state government's annual budget was estimated at N30,980,513,600. Out of this, only 1.6 per cent was allocated to the health sector as a whole and there was no specific allocation for reproductive health.

A major health reform process underway in CRS includes the Drug Revolving Loan Scheme of the Essential Drugs Program, which was resuscitated in late 2003 after a period in which it ceased to function. Essential drugs are supplied by an officially recognized drug manufacturing company that is registered at the National Agency for Food and Drug Administration Control (NAFDAC). The drugs are stored and distributed to all health facilities at the primary, secondary and tertiary levels in the state. The CRS government has signed a preliminary three-year contract with a private company based in Abuja, the capital of Nigeria (Worldwide Health Care Limited, WHL), which is responsible for inspecting the drugs in all health care facilities, in order to check both quantity and quality of stock, as well as to ensure proper utilization of the drugs.

The profit-sharing ratio between the CRS government and WHL Ltd. is 52% to 48% respectively. WHL is required to advance its share of funding and supply trucks to deliver the drugs to their respective destinations – storage areas or health facilities. There are also designated banks in all the LGAs



where the proceeds from the sale of the drugs are promptly deposited. The banks are required to transfer all the money deposited to Zenith Bank, Calabar, from where money is then withdrawn to purchase more essential drugs. In this way the essential drug scheme revolves.

THE PHILIPPINES

Background and Current trends

Since 1991 the Philippine health sector has undergone major changes. The first of them was the decision to decentralize, a policy measure that did not apply exclusively to the health sector, but was part of a general political push towards devolution of responsibilities from the central government to the provinces and LGUs. The next stages in the health reform process, however, were defined and implemented within the guidelines of the global HSR agenda, following recommendations from multilateral donors, particularly the World Bank. They included: a) the establishment of a National Basic Health Insurance Scheme and measures aimed at improving management and financial efficiency, and the definition of priority areas for public health intervention (1995); b) new guidelines to resolve conflicts of authority and responsibility between the different levels of management (that is, to resolve distortions resulting from the first wave of decentralization) (1999-2004).

Decentralization

The Local Government Code or RA 7160 passed in 1991 transferred “all structures, personnel and budgetary allocations from the provincial health level down to the “barangays” (community level units or districts) were devolved to the local government units to facilitate health service delivery” (DoH 1999). The devolution was extremely relevant for the health sector because health expenditures accounted for roughly 65 per cent of the total cost of national government functions transferred to the LGUs (Lakshminarayanan 2003). The same author signals the fact that the decentralization process has also meant the “marginalization” of the Department of Health: “Even though devolution received strong support at the legislative level, there was considerable resistance from the Department of Health, which had not participated in the discussions until very late in the process. The resistance stemmed both from a fear of losing control over the health sector and the likely reductions in employment contracts of central health workers.”

The policy guidelines themselves lacked clarity and contained important gaps with respect to the functioning and financing of health care. The distortions resulting from the decentralization process would lead to the adoption in 1999 of Executive Order 102 “Redirecting the Functions and Operations of the Department of Health”, which aimed to clarify and strengthen the role of the Department of Health with respect to general policy

Box 12: Characteristics of the Philippine Health System

Since the early 1990s the Philippine Health System has been undergoing a series of reforms, mostly characterized by “devolution” or decentralization. In 1999, the Health Sector Reform Agenda (HSRA) outlined the following priorities: expansion of primary health care, improvement of local health systems, the setting of health standards, corporatization of some government health institutions including tertiary hospitals and social insurance (NHIP).

The health system comprises the following structures:

The Department of Health (DoH) – The DoH, which was formerly the main health agency for health care and service delivery nationwide, has since devolution in 1991 transferred administrative control over service delivery and health care to local government units (LGUs). The current DoH role is to: a) formulate national policies and standards for health; b) prevent and control leading causes of death and disability; c) develop disease surveillance and health information systems; d) maintain national health facilities and hospitals; and e) promote health and well-being through public information. The DoH has published National Objectives for Health to synchronize national and local efforts for public health.

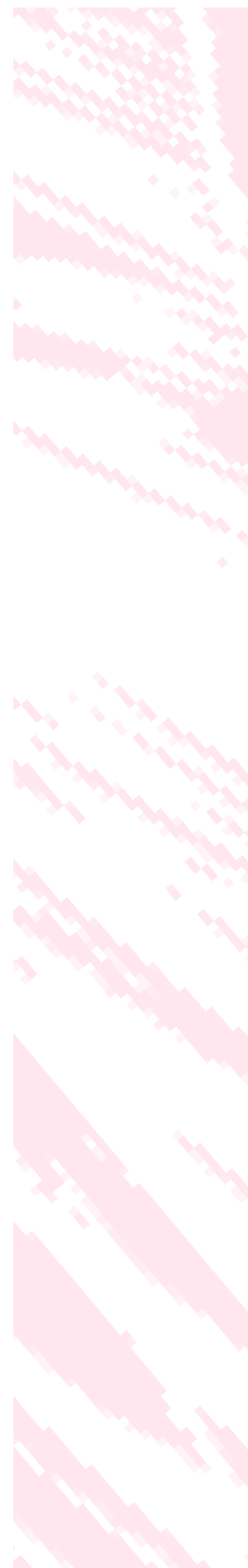
The National Health Insurance Program (NHIP) – Created in 1995, the NHIP is managed by the Philippine Health Insurance Corporation (Philhealth) and has as its goals the provision of basic health coverage to 85 per cent of Filipinos. In mid 2002, NHIP members represented 49.1 per cent of the total population with only a 2 per cent total benefit utilization rate. 16.4 per cent of the “indigent population” are covered by NHIP and 33.76 per cent of the “population below the poverty threshold” are NHIP members.

Local Government Units (LGUs) are accorded by Local Government Code RA7160 autonomy and powers to administer local health systems, facilities and service delivery. Six levels of service delivery operate: (1) *Barangay* health units – managed by *barangay* (community level districts) and municipal governments; (2) rural health units – managed by municipal government; (3) city health offices – managed by city governments; (4) municipal or “district” hospitals – managed by the Provincial government; (5) provincial hospitals – managed by the provincial government; and (6) regional hospitals and medical centers – managed by the DoH. In 1998, some of these health units were reclassified and renationalized.

Private sector – For the most part the private sector absorbs what the government health system cannot afford to provide. Public health institutions, both regional and national, mostly tertiary hospitals and curative facilities, are being “corporatized” with target totals of five by 2002 and more than 10 by 2004. Health Maintenance Organizations (HMOs) have been significant mostly to the paying public.

FINANCING - From 1992-2001, health expenditure rose from 2.9 to 3.2 per cent of GNP with real per capita health expenditure increasing from PhP332 to PhP435 in 2001. In 2001, government spending totaled only 38 per cent, with the private sector funding at least half of total health expenditure. Local government’s share was up from 4.4 per cent at the start of devolution in 1992 to 21 per cent in 2001. Social insurance (mainly NHIP and Philhealth) registered only 8 per cent of the 2001 expenditure. Out of pocket health spending by families for personal health care constitute the bulk of health expenditure. Spending related to the Philippine Population Management Programme (PPMP) totaled PhP16.9 million in 2000, up from P13.8 million in 1998. This represents about 15 per cent of total health spending in both 1998 and 2000 (Herrin 2003). 84 per cent of the PPMP expenditure was for reproductive health/family planning; the bulk of this was spent on RH services and counseling, while 8.3 per cent was spent on family planning. Households are the main source of PPMP financing, although the 37 per cent share in 1998 declined to 32 per cent in 2000. During this period, the national government’s share increased from 21 to 25 per cent. Foreign assisted projects (FAPs) meanwhile were decreasing. Local governments’ share also increased slightly to 21 per cent in 2000, from 20 per cent in 1998.

Source: Viado (2005) based on Grundy J, Healy V, Gorgolon L, Sandig E. Overview of devolution of health services in the Philippines. Rural and Remote Health 3(2), 2003: 220. Available online at: <http://rrh.deakin.edu.au> and National Statistical Coordination Board (2003). Philippine National Health Accounts 1991-2001. Makati City: NSCB.



formulation as well as in relation to decentralized levels of management. These directions would be reaffirmed by a new policy document adopted in late 2001: the DoH Engineering for the Reforms.

As a result of these various policy definitions, the DoH, while retaining its role as a direct service provider for specific programs such as tuberculosis, malaria, schistosomiasis, HIV-AIDS, is expected to become the lead agency in:

- Articulating national objectives for health to guide local health systems, programs and services;
- Health emergency preparedness, including referral and networking systems for trauma, injuries and catastrophic events;
- Ensuring equity, access, and quality of care through policy formulation, standards development and regulations;
- Protecting standards in the training and education of health care providers at all levels of the health care system.

At the same time, National Objectives for Health (NOH) were defined for the 1999-2004 period, as follows: a) Disease Prevention and Control (infectious and degenerative and other non-communicable diseases); b) Health Promotion and Prevention (Family Health and Health of Special Populations); c) Health Related Behaviors and Practices; d) Monitoring the Health of the Filipino People; and, e) Sharing Responsibilities for Health. The strategies defined to attain these objectives include: increasing investments for primary health care particularly at decentralized levels; the development of national health standards; stronger regulation of facilities and services; technical and financial support for local health systems and frontline health workers.

The National Health Insurance Program (NHIP)

As in other Southern countries, the strategy adopted to resolve the financial aspects of health sector reform was the establishment of a National Health Insurance Program (NHIP), which was approved by Congress in 1995 (RA 7875). The NHIP was intended to reduce out-of-pocket health expenditure, which constitutes the bulk of health spending, and to provide universal access to a basic package of health care. It is financed through a mix of public funding, employer and employee contributions, and pre-paid insurance quotas paid by individuals. One main financial strategy of the NHIP is to expand the number of paying contributors in order to create a basis of cross subsidies that will allow the system to cover the health costs of the poorer sectors of the population.

Outcomes

The Health Reform Program in its various policy documents recognizes the many flaws and problems of the health system as it existed at the beginning of the 1990s: the lack of treatment facilities, the imbalance between hospital-

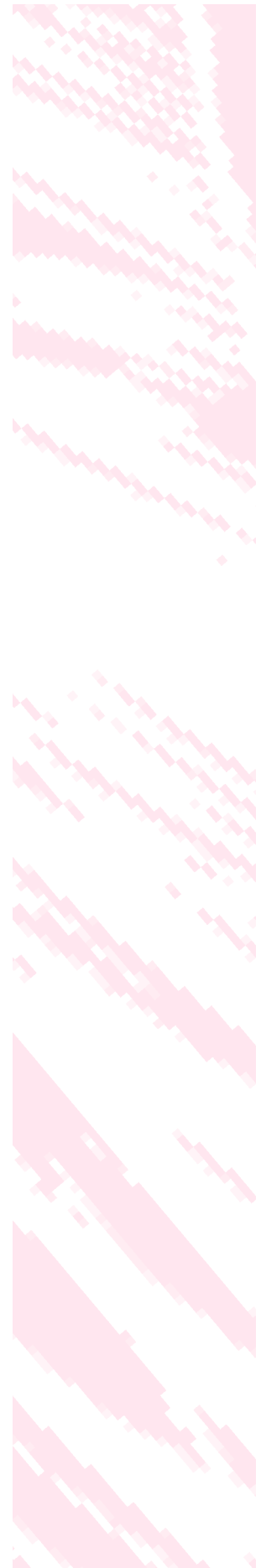
based and primary health care, inadequate and inappropriate capacities and skills, and major funding and management problems. However, its overall conception and implementation have not received such positive evaluations. In general, social movements and women's organizations have criticized the health reform for its neo-liberal privatizing assumptions. In fact, public protests have taken place against the last phases of the reform pushed by the Estrada and Arroyo administrations.


Women's organizations, in particular, have raised concerns about the absence of reproductive health priorities, as defined by ICPD, in the health reform agenda. However, as Francisco pointed out in the previous DAWN policy research effort (Corrêa, 2000), this is not exactly a surprise. Since Cairo reproductive rights advocates have mainly focused on the policy process taking place at the level of the Population Commission, without paying the necessary attention to the processes affecting the Department of Health.

But even from a more strictly technical point of view the Philippine health reform outcomes are doubtful. The country report strongly indicates that, despite the ambitious and intensive production of analytical documents and strategic guidelines since 1991, a major gap remains between the reform policy intentions and the realities of access to and quality of health care. Particularly with respect to decentralization it underlines that: *"Notwithstanding the backlog from pre-devolution where primary health care facilities and even hospitals were already dilapidated and needing maintenance, decentralization negatively affected health care and service delivery within local jurisdictions and caused the overload of regional facilities"* (Viado 2005). Similarly, with regard to the NHIP, Lakshminarayanan (2003) states that even by the year 2000 insurance for the poor and indigent population remained extremely low. These gaps and flaws can be attributed to the instability that marked the Philippines' political and institutional scene in the late 1990s and early 21st century. But the existing literature suggests that, in addition to systemic political and economic factors, one main factor behind the problems observed in the Filipino health reform was the way devolution was implemented in the early 1990s.

Lakshminarayanan's (2003) close examination of the impacts of decentralization on reproductive health programs provides a full assessment of the negative impacts of decentralization on the organization, financing and quality of the country health system, which can be summarized as follows:

Organization of the health system – *"...the public health system was dramatically affected by decentralization. Prior to devolution, the multi-tiered public health system was funded and managed by the DOH, and tertiary health care facilities were located at the national and regional/provincial levels. The primary health care system comprised rural health units...which were responsible for 3–4 barangay health stations set up to serve surrounding villages, and each barangay health station was staffed by a trained midwife and several locally recruited volunteer health workers... In less than two years (after devolution)*





approximately 95% of its facilities, 60% of its personnel and 45% of its budget were transferred from the DOH to local government. ... A major unintended consequence of devolution was the disruption of the technical linkages between the rural health units at the municipal level and the primary and secondary referral facilities at the district and provincial levels."

Technical capacities at decentralized levels – *"A major obstacle to the successful implementation of devolution was the limited institutional capacity at both the local and central levels to fulfill their obligations following devolution. The rapid rate and scope of devolution in the Philippines exacerbated this situation. Also, all local governments were not uniformly situated in terms of their technical and managerial capacity both to effectively deliver services and manage the funding of health care in their jurisdictions."*

Financing – *"Devolution resulted in distortions of public financing at the local level because the resource allocation formula only considered the population size and land area of local government units. As a result, poorer local governments were disadvantaged due to their limited ability to generate revenues at the local level. Also, the cost of devolved functions was not taken into account when calculating central allocations to local governments. Such an allocation formula meant that provincial and municipal administrations, to which much larger numbers of facilities and staff were devolved, received lower allocations than cities and barangays, which bore a smaller share of the burden of devolution... In addition, since the central allocations were largely not earmarked, there was considerable discretion in a local government unit's ability to redirect resources, either towards or away from the health sector. Moreover, when approved budgets at the national and local level did not complement each other for services that required co-financing between local and national governments, disruptions in service delivery occurred."*

VII - Sexual and Reproductive Health Policies: a Common Agenda, Distinct Trajectories

This chapter summarizes the evolution of S&R policies in the twelve countries included in the sample. Its contents reflect important differences in the trajectory of these policies. In some cases they have been evolving for many years and therefore require a more extensive description. In most countries S&R policies gained momentum after ICPD, but in several cases they have suffered from considerable discontinuity, which necessarily limits the possibility of carrying out a systematic assessment.

In addition, there was considerable variation in the amount of information and analysis provided by the country reports. In the case of Barbados, Bolivia, Brazil, Ghana, Trinidad, the Philippines and Uruguay the data collected on the evolution of reproductive health policies was quite substantive. In other countries, more attention was paid to general health reform trends and the collection of S&R health data. It should be also borne in mind that the country research teams were given the flexibility to emphasize those specific aspects that they considered most relevant, which led to even greater heterogeneity among the final reports. As a result, the policy profiles presented in this chapter are uneven both in terms of the amount of data compiled and the depth of the analysis. Lastly, in this global report we aimed to achieve some degree of consistency between the country policy profiles and the main research topics (abortion and maternal mortality). Consequently, a wealth of information and analysis found in the country reports on gender equality initiatives, violence-related policies and most particularly HIV/AIDS are not fully reflected in the brief descriptions that follow below.

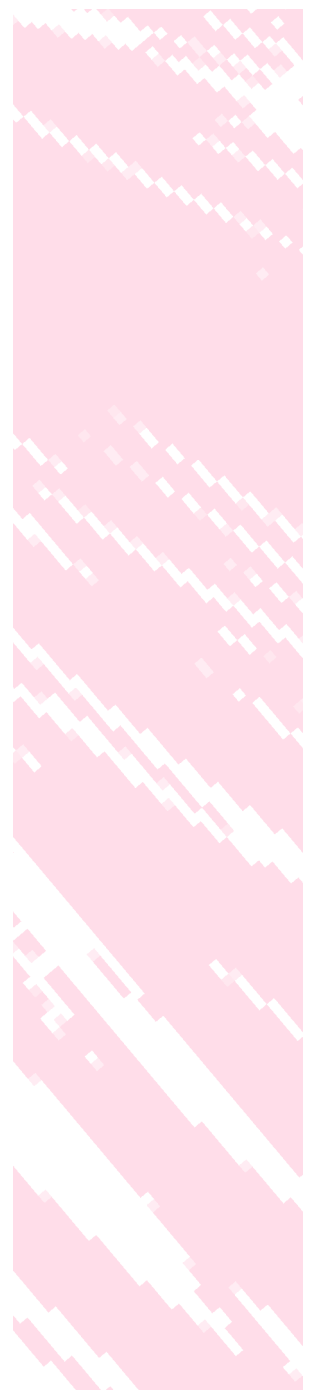


TABLE 3: SEXUAL AND REPRODUCTIVE HEALTH INDICATORS

Country	Total fertility rate, 2000-2005	Contraceptive prevalence rate, ^a		Contraceptive prevalence (modern methods) ^b		Births attended by skilled health personnel		HIV prevalence (% ages 15-49), 2005	
		%	Year	%	Year	%	Year	% [Lower estimate upper estimate]	
Argentina	2.4	...	...	...	...	98.7	2004	0.6	[0.3-1.9]
Bolivia	4.0	58.4	2003-04	34.9	2003-04	60.8	2004	0.1	[0.1-0.3]
Brazil	2.4	76.7	##	70.3	1996	87.6	1996	0.5	[0.3-1.6]
Mexico	2.4	68.4	##	59.5	1997	85.5	1997	0.3	[0.2-0.7]
Uruguay	2.3	...	...	...	...	99.4	2002	0.5	[0.2-6.1]
Barbados	1.5	55.0	##	53.2	1988	100.0	2003	1.6	[0.8-2.5]
Jamaica	2.4	65.9	##	62.6	1997	94.6	1997	1.5	[0.8-2.4]
Surinam	2.6	42.1	##	40.6	2000	84.5	2000	1.9	[1.1-3.1]
Trinidad & Tobago	1.6	38.2	##	33.2	2000	96.0	2000	2.6	[1.4-4.2]
Ghana	4.4	25.2	##	18.7	2003	47.1	2003	2.3	[1.9-2.6]
Nigeria	5.8	12.6	##	8.2	2003	35.2	2003	3.9	[2.3-5.6]
Philippines	3.2	48.9	##	33.4	2003	59.8	2003	< 0.1	[< 0.2]

a Percentage of women of reproductive age (15-49) who are using (or whose partner is using) a contraceptive method.

b Include female and male sterilisation, injectable and oral hormones, intrauterine devices, diaphragms, hormonal implants, spermicides, and condoms.

SOURCE: WHO *Reproductive Health Indicators Database*, <http://www9.who.int/familyhealth/reproductiveindicators/>.

ARGENTINA

In 1974 the government issued a decree prohibiting family planning services and the supply of contraceptives, a measure later ratified by another decree passed by the military regime in 1977. In the early 1980s, in the context of democratization, a debate was initiated around women's reproductive self-determination. From then on, while feminists advocated the right to use contraceptive methods within a broader human rights framework, conservative sectors defended the notion of "responsible paternity" and systematically influenced high-level policy-making to limit (and prohibit) the provision and use of contraception. In general, therefore, the debate on public funding for and access to all contraceptive methods has until very recently been the central focus of the S&R health debate in Argentina.

Following the ratification of CEDAW, in 1986, a Decree was issued lifting the prohibition against contraception. In the same year a first bill on reproductive health was presented in the lower House of the National Congress and in 1988 a bill was presented in the Senate proposing the creation of a national family planning program (which, however, excluded access to sterilization). Concurrently, conservative senators presented a bill aimed at prohibiting the use of contraceptive methods considered to be

abortive in nature. In 1989, despite stringent public resource constraints, the family planning program began being implemented in public clinics, particularly in the metropolitan area of Buenos Aires.

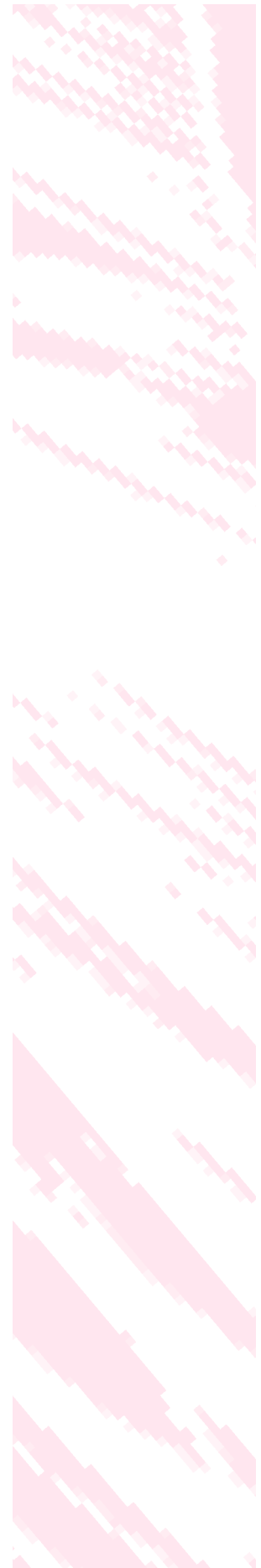
This was the same year that Menem came to power, and the new federal government almost immediately convened an expert commission to discuss the expansion of the program and to propose a new family planning legislative framework. Nevertheless, the legislative proposal would never be debated or voted upon, because of the alliance between Menem and the Catholic Church that developed in subsequent years. In 1995 Menem supported a law creating the Day of the Unborn Child (1995), inaugurating a trend that would gradually affect the majority of countries in the region. This means that although at the time of the Cairo and Beijing conferences a national policy on contraceptive provision was in place in the MoH, all initiatives aimed at effectively implementing this policy were under sustained attack by conservative sectors.

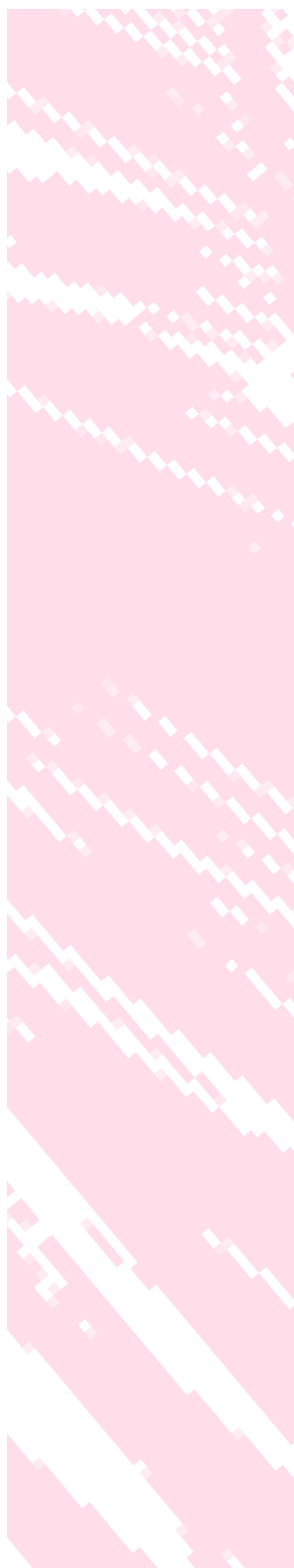
In 1995, under the impact of both conferences, a new bill was presented to Congress that aimed to expand the policy towards a S&R health framework. Even if the bill did not include female and male sterilization – as demanded by women’s organizations – it was a breakthrough, particularly in the political climate created by the Menem administration. But when the bill was sent to the Senate to be ratified, no consensus was reached and eventually it was shelved. Despite this failure, the national public debate generated by the bill promoted the adoption of progressive legislative initiatives at provincial and municipal levels. By the year 2000, 14 provincial or municipal legislative bodies had approved specific S&R health provisions: Buenos Aires (City), Cordoba, Chaco, Chabot, La Pampas, Rio Negro, Jujú, Santa Fé, Tierra del Forego and La Rioja. In 2001 the lower House adopted a newly drafted S&R health policy provision, and in October 2002 – in the midst of the political and economic crisis – Law No. 25,673, providing the legal framework for the National Program on Sexual Health and Responsible Procreation, was finally approved by Congress. In 2003, a specific provincial legal framework was finally sanctioned in the Province of Buenos Aires, home to one third of the Argentinean population.

Between 2002 and 2004, despite the severe economic crisis, major budgetary constraints and attacks from conservative sectors, sustained advocacy efforts have been directed at provincial and municipal governments to press for implementation of the new policy, which is also supported by UNFPA and the World Bank as far as the purchase and dissemination of contraceptive methods are concerned.

Outcomes and Obstacles

By early 2003, 377 hospitals and clinics were already offering contraceptive assistance to 125,000 users, of which 13 per cent were under twenty. By late 2004, roughly 13 million contraceptives (condoms, IUDs, pills and injectables) had been distributed by the public health system to 1.5 million users through 5,076 hospitals and clinics offering both contraceptive services and STI





prevention (web magazine *Página 12*, 28 April 2005). However, the DAWN country report evaluation concluded that the performance of the national, provincial and municipal programs remained uneven. Local S&R policies had not been properly integrated with social security health schemes, which cover an important part of the female population. Furthermore, the effectiveness and quality of services varied widely according to specific conditions prevailing in each province or municipality. The exclusion of sterilization from the package was signaled as another key limitation and, as will be seen further on, as late as June 2006 this question had not yet been resolved.

With regard to financial aspects, in the case of nine provinces (Chaco, Chubut, Mendoza, Neuquén, Rio Negro, Misiones, La Rioja and Tierra del Fuego) and in the City of Buenos Aires the legislation passed explicitly defines specific public funding allocations to support the policies laid out by the new laws. In three cases (Chubut, Misiones and Tierra del Fuego) the laws also state that additional funds from national and international sources will be used to ensure implementation. Article 12 of the national legislation also states clearly that the MoH and the federal budget will cover S&R policy expenditure. Despite these positive provisions, at all levels policies were being negatively affected by fiscal stringency and the distortions generated by the HSR model, in particular imbalances with respect to responsibilities and financial resources following decentralization.²⁸

In addition to the negative impacts of the HSR, S&R policies have been systematically contested both politically and in court by conservative sectors, particularly after the approval of the national legislation in late 2002. The argument used is that they infringe the constitutional article defending the right to life. In 2003, however, the attempt to overturn the Buenos Aires City law (Law 418) was thrown out by the Supreme Court, a decision creating a positive legal precedent to defend other legislations.

The country report also mentions limitations deriving from the wider socio-economic situation, important gaps in terms of policy integration and problems with implementation on the ground. One main limitation mentioned is the increased level of economic deprivation affecting the Argentinean population, and in particular women, whose access to health services has therefore been restricted both because of the costs and time constraints involved. Although poverty alleviation programs have been created since 2002 that widely involve poor women, linkages between these emergency initiatives and the newly created S&R programs have not always been established.

Discrimination, or the absence of a clear rights-based approach, is another area considered problematic, in particular in the case of adolescent pregnancy, which is more frequent amongst the poorer sectors. Adolescent pregnancy prevention programs are very weak and when the girls become mothers no public support programs exist, rather this type of work is mainly done by volunteer and philanthropic organizations. Young people's access to contraception is therefore considered to be a critical area. The protocol

28 It is possible that this situation may have taken a turn for the better as the Argentinean economy improved after 2004 and the Kirchner administration increased public spending on social areas.

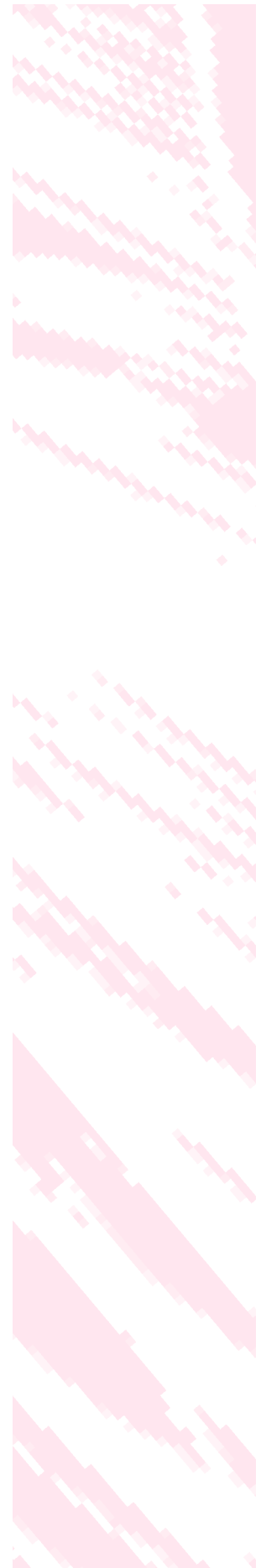
deriving from the national law clearly stipulates that adolescents have the right to information and services along the lines defined by ICPD. In the case of teenagers under fourteen a responsible adult must participate in the consultation. However, the report calls attention to the fact that health providers often resist these stipulations and the guidelines quickly became a major target of conservative sectors.

Another observation regards sexuality. Though the term “sexual” appears in the title of the laws consistent linkages with existing sexual health programs had not yet been created, neither in the case of HIV-AIDS prevention nor in the case of a previously existing adolescent S&R health program (PROAME – Programa de Atención a Menores en Riesgo). Another caveat mentioned concerns men’s role in S&R health. Though recently adopted laws explicitly refer to male responsibility, no concrete measures have been adopted to engage men in the newly created services. What still prevails in institutional health settings are conventional conceptions (deriving from old MCH programs) emphasizing women’s roles and responsibilities in the realm of reproduction. Lastly, the national report calls attention to the absence of integration between health and educational policies. The country team considers that integrative cross-sector initiatives are fundamental to overcome the limitations listed above regarding teenage pregnancy, sexual health (particularly HIV-AIDS) and men’s role in sexuality and reproduction.

Box 13: Argentina: Post 2004 Developments

Three important developments occurred after the country report was published in May 2004. The first was the intensification of the debate and advocacy on the legalization of abortion (see Chapter V). The second was a leap forward in the national S&R policy itself. In April 2005, the government announced it would distribute 10 million condoms, 450,000 IUDs, 1.6 million injectable and 5.8 million oral contraceptives (an increase of 36 per cent on what was distributed in 2004). The decision was accompanied by a mass media campaign to promote access to and use of these methods. The slogan used was “Get informed, consult, make your decision. This is the law, this is your right”, and male participation was emphasized. The fact that the campaign started when the echoes of the conflict between the Argentinean government and the Vatican had not yet died down (see Chapter I) is of considerable significance since, as previously mentioned, conservative sectors and the Catholic Church had systematically attacked the policy since its adoption in October 2002. The policy director Inés Martínez explained that the campaign was a strategy to inform the population and to overcome gaps and distortions identified in the implementation of the policy, such as resistance by doctors to effectively distributing contraceptive methods (in San Juan province) and the charging of users fees for IUDs that were supposed to be free of charge. She also mentioned that in some settings doctors resisted the policy by disseminating false information about IUDs. In the same year, law 26130 was adopted, which regulates tubal ligations, ensuring that adult women and men can have access to these procedures in both public and private hospitals. Lastly, in October 2006 a new law on Sexual Education was approved creating the National Program on Sexual Education and establishing that in all public and private schools, sexual education is provided from pre - school to university levels.

SOURCE: Pagina 12, 28 April 2005 and Alejandra Domiguez



Bolivia

The 1994-2000 DAWN policy assessments described a rather favorable post-Cairo policy scenario in Bolivia. Progress had been made in the adoption of a gender perspective in the most diverse policy areas: health, education, gender justice, and population dynamics. In addition, a comprehensive policy approach to women's S&R health was adopted and integrated in the national health structure as well as in the health reform agenda.

Three main policy components adopted in this period were seen as extremely positive by both the 2000 and 2003 country reports. The first was the Basic Health Insurance Scheme (SBS) that constituted the backbone of the HSR and included a comprehensive package of free reproductive services: antenatal delivery and post-natal care, treatment of first semester hemorrhages (mostly related to unsafe abortion), contraceptives, STIs, cancer screening and adolescent services. Second, and related to this, was the great priority given to maternal mortality, which included official national guidelines for post-abortion care (the first adopted in South America) and the establishment of maternal mortality committees and community networks engaged in the identification of at risk pregnancies and cases of maternal death. Third, the fact that at that point in time programs were designed to respond to gender-based violence.

Both reports strongly emphasize the positive impact of ICPD and Beijing in creating an enabling environment for these changes to happen, as well as the role played by women's organizations as the main pressure group behind them. Advocacy efforts were facilitated by the existence of accountability mechanisms such as the Cross-Sector Council for Safe Motherhood (created in 1996 and involving public officials, academics, advocates and donors) and the Sexual and Reproductive Health Forum. Not surprisingly, in 2000 the budget for S&R health policy was increased by 30 per cent.

But even in 2002 obstacles were already identified, principally among them the extreme dependency on external funding. The reports point out, for instance, that immediately following Cairo some donor agencies were exerting excessive (and inappropriate) pressure on government agencies to achieve rapid outcomes in reproductive health, without paying enough attention to the complexities of the policy process, nor to the negative impacts this haste could have on quality of care. The 1998-2000 (see Corrêa, 2000) also mentioned that although HSR had given local authorities greater managerial power over services, no priority was given to S&R health or to quality of care, as would have been expected.

Outcomes and obstacles

Between 1998 and 2003 several assessments have been carried out of the performance of the Bolivian Sexual and Reproductive Health Program. The 1998 Demographic and Health Survey (DHS) identified improvements in access to and coverage of antenatal and obstetric care: while between 1991 and 1994 just 50 per cent of pregnant women received formal antenatal care, in 1998 the percentage rose to 63 per cent. But great disparities remained between

urban and rural areas – in the latter just six per cent of deliveries received adequate care provided by nurses or nursing assistants (even though coverage had doubled since 1994). In 2002, the National Health Information System (SNIS) reported that in that year a total of 754,000 antenatal consultations were performed, of which 70 per cent were on the public health system, and 44 per cent took place before the fifth month. Finally, an evaluation was carried of the National Program of Sexual and Reproductive Health for the 1999–2002 period, the results of which are summarized in Box 14 below.

Box 14: Assessing Bolivian Reproductive Health Policy

Achievements	OBSTACLES
The SBS helped overcome barriers to S&R health services.	Insufficient dissemination and implementation of new norms. Turnover in health personnel.
Creation of norms and routine protocols.	Lack of information among health providers about the scope of the policy.
Improvement in quality of care.	Lack of monitoring and evaluation. Insufficient equipment and infrastructure.
Favorable public perception regarding the need to reduce fertility and maternal mortality rates.	Management bottlenecks at headquarters. Lack of coordination between national, provincial and municipal levels. Lack of flexibility in adapting to political and policy changes.

Source: *Castro, Salinas and Machicao (2004).*

The 2003 DAWN report went further in identifying steps forward and obstacles not fully addressed by the above-mentioned official policy evaluations. On the one hand, the report recognized that Bolivia had made progress at legal and normative levels with respect to gender equality, gender violence, and S&R health (with the exception of abortion). It also regarded as particularly relevant policy evolution with respect to maternal mortality and post-abortion care, especially because until 2002 initiatives in these two areas were articulated within a broader reproductive health framework. On the other hand, the report also mentioned that a huge gap still existed between existing laws and norms and their practical application to transform the daily lives of the majority of women. In short, the report concluded that the commitments to Cairo and Beijing had to a large extent been achieved solely at the formal level.

Most importantly, as mentioned in Chapter IV, the period under analysis was marked by persistent social, economic and political crises that led to a policy stalemate in most areas, including the health sector. This permanent institutional instability was, from 2001 onwards, a major factor affecting the continuity and consolidation of the breakthroughs achieved immediately following Cairo and Beijing. Moreover, this feature of the Bolivian reality should be analyzed not solely as an institutional question, but rather as reflecting the structural inequalities plaguing Bolivian society and the failure of dominant political structures and forces to respond to them.



29 *One example was the move by some sectors to get a sexual and reproductive health bill passed in early 2004. Although the bill was passed by the lower house, in the midst of a critical moment in the political crisis and under pressure from the Catholic Church, interim president Carlos Mesa declared that he would veto it. Leading S&R H&R advocates did not support the initiative because their appraisal was that political conditions were not favorable (information provided by Ximena Machicao in the DAWN Global Research Meeting, Cape Town, October 2004).*

Transnational trends were also analyzed as having had negative impacts, since after 2001, USAID policy shifted under the Bush administration, and the climate with regard to S&R health became extremely closed, given the relative weight of US development cooperation to this policy area. A number of NGOs, including women's organizations, could not avoid accepting the Gag Rule because of their financial dependency on US funding. The focus of USAID funded MoH programs was also reframed towards abstinence and maternal health in detriment of contraception and post-abortion care, which had been emphasized previously.

In addition, as the social and political crisis expanded, the Catholic Church gained leverage as a mediator between the popular and indigenous movements and the State, and at the same time achieved greater influence at the policy level. One example was the designation as Minister of Health of a doctor with links to Opus Dei. At the same time a series of other institutional changes occurred that would further erode the basis of the policies being implemented since 1997: the Vice-Ministry for Women's Affairs lost policy status and the National Sexual and Reproductive Health Program lost its leadership and its capacity to build links to other government sectors and civil society actors.

However, the main policy shift in the period resulted from the passing in 2002 of a new law renaming and reducing the scope of the SBS to a Maternal and Child Insurance Scheme (SUMI). This change greatly limited the comprehensive framework that had oriented the policy until then. The SBS package covered 90 health procedures in the areas of antenatal care, delivery, post-natal care, post-abortion care, contraception, STIs, and cervical cancer; moreover, coverage included not just women and children up to the age of five, but also men and adolescents. SUMI expanded the number of free procedures to 400, but on the other hand only covers women during pregnancy and for the first six months after delivery, and children up to the age of five. In other words, it meant a step backwards towards a more conventional MCH frame, a development the country report sees as consistent with the increasingly conservative climate and the unexpected revival of a pro-natalist stance, which supposedly was a thing of the past in Bolivia.

At the same time women's organizations and citizenship or civil society initiatives lost mobilization and advocacy capacity. Already by 2001, the National Forum for Sexual and Reproductive Health had disbanded. Partially this can be seen as an unanticipated effect of the HSR, as the decision to dissolve it was taken on the basis of the argument that what should be prioritised was the strengthening of activities at provincial and municipal levels. But it meant that women's organizations and other actors within society committed to the S&R health agenda were not capable of adequately contesting these multiple policy changes. As the political crisis progressed, the action of these groups became increasingly fragmented and this further undermined their capacity to sustain a common agenda.²⁹

In its conclusions the country report (2003) lists other problems and obstacles, such as: the lack of clarity with respect to sexual health (which is

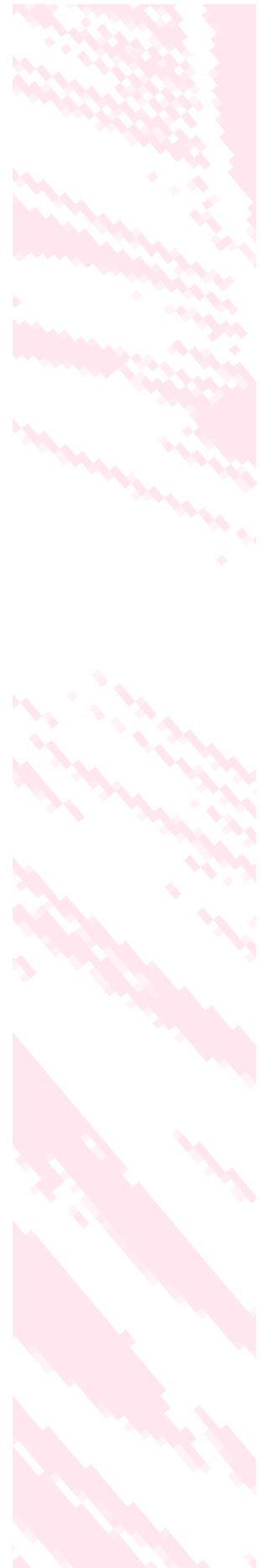
subsumed under reproductive health); the non-implementation of measures to involve adult and young men; extreme imbalances in access to services between different regions in the country and particularly between rural and urban areas; a lack of consistent training and motivation for human resources to provide good reproductive health care and the constant turnover of personnel at both technical and service levels; and the fact that municipal authorities did not always meet their financial commitments.

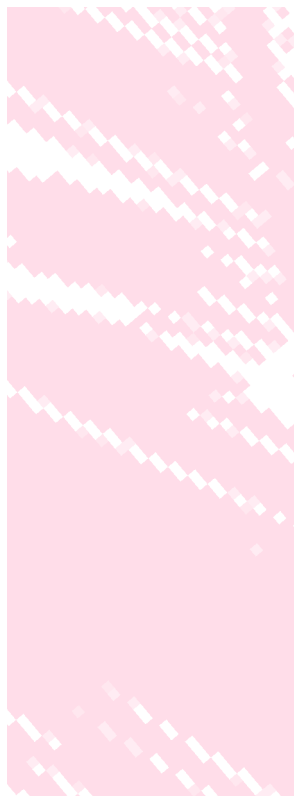
In April, 2004 the Bolivian Parliament unanimously approved the Reproductive and Sexual Rights law provision No 810. The text contained core principles to guide the national sexual and reproductive policy, such as: The right to decide free and responsibly the number of children and spacing between births (art 3); the recognition of reproductive and sexual rights must guarantee the integral care to reproductive and sexual health, including: services of prevention and processing of the ITS, HIV/SIA, Hepatitis B and C; prevention and treatment of cervical and breast cancer as well as of prostate cancer; prevention of unwanted pregnancies; qualified post abortion care and post abortion contraceptive services; infertility services and adequate menopause care (art 5).

The law was sent to sanction by the interim president Carlos Mesa, who indicated it would veto it because the text was not achieved by a full consensus of all interested the sectors of Bolivian society. Beneath this affirmation strong pressures made by Catholic Church hierarchy were in fact at play. The text approved was prompted by an initiative sponsored by UNFPA through the Commission of Human Rights of the National Parliament. This occurred exactly when Bolivia was experiencing the dramatic political and social crisis that would culminated with the renunciation of the interim president.

The rapid evolution of the political crisis implied the law to never be vetoed. But its processing was paralyzed in the Parliament. Since then the proposition to adopt legal principles to guide a comprehensive Sexual and Reproductive policies in the country lost political ground. Today its contents are not anymore visible in the political agendas of neither of the government nor of broader social movements. Even some sectors of the women's movement consider that the political conditions are not favorable to advance an agenda that addresses abortion. These experience tells of how well intended proposals may be easily and negatively caught and eroded by political and social instabilities. Some analysts consider that many years will go by before a similar proposition can be once again presented to the Parliament.

In late 2004, when the country report was discussed in the DAWN global research meeting, it was not possible to predict what would come next either in terms of internal political dynamics, policy evolution or even the position and contribution of international donor agencies, as at that point several agencies were revising their priority focuses and their involvement with the Bolivian health system. As is common knowledge, the political situation remained unstable, leading to the deposition of the provisional government





30 *In the 1980s, in addition to the struggles around the Constitutional reform, the Church hierarchy attacked the contraceptive component of the program, most particularly the inclusion of IUDs (1986). At the beginning of the transition process (1993-1994) a female doctor with close links to the Church became program coordinator. In 1995, when a partial economic constitutional reform was initiated, conservative forces used the opportunity to try once again to get the principle of the right to life from the moment of conception included in the text. Then in early 1996, when the Family Planning Law was sent to the President for ratification, an insidious inside operation led President Cardoso to veto the articles on sterilization included in the bill. Three days later he publicly announced that this had been a mistake and requested that Congress vote to lift his veto. This delayed the final sanctioning of the law until August 1997.*

and the presidential elections of 2005, when Evo Morales became the first indigenous Bolivian president. As already mentioned, it is not clear what direction reproductive health policies will take in the coming years.

BRAZIL

The Brazilian national S&R health policy launched in 1984 – named Comprehensive Women’s Health Program (Programa de Assistência Integral à Saúde da Mulher, PAISM) – included antenatal, birth, and post-natal care, cervical cancer and STD prevention, adolescent and menopausal care, and contraceptive assistance. PAISM therefore preceded Cairo by ten years and, most importantly, was always closely associated with the health reform process (which in the Brazilian case resulted in a progressive model). In 1984 Brazil was in transition from almost 20 years of dictatorship and what explains the presence of these two positive policy agendas was the vitality of the democratization process. This climate was also reflected in the Constitutional Reform (1986-1988) that established principles of reproductive self-determination and – despite much pressure from the Catholic Church – did not include the defence of the right to life from the moment of conception.

Since its inception, PAISM has gone through four distinctive phases. Between 1984 and 1988 the program was quite strong and mostly invested in the training of human resources and in efforts to supply reversible contraceptive methods through the public health system (at the time contraception was provided by UNFPA). From 1988 to 1993 at the federal level the program was negatively affected by the continuing financial and political crises that would culminate in the impeachment of Collor in 1992. But even so, creative and positive experiences evolved at decentralized levels. After 1993 the main challenge was the reactivation of PAISM at the federal level, a process favored by the Cairo and Beijing agendas, which provided advocates with forceful arguments to press the government to implement its international commitments, and the approval (won in 1997) of a family planning law to develop in full the principles enshrined in the 1988 Constitution. From 1998 onwards, women’s health would once again be prioritized in the national public health policy agenda.

The findings of the previous DAWN research effort (Corrêa, 2000) and other sources (Corrêa et alli, 1998, CNPD, 1999) emphasize as positive aspects relating to reproductive health policy in Brazil the sustained advocacy by women’s organizations and the role of accountability mechanisms – which in the case of SUS are fairly effective. On the other hand, it signaled as obstacles the gradual dissociation between PAISM policy and new SUS managing structures that had been built after 1993 (vertical bias), and, most importantly, the continuing negative influence of the Catholic Church.³⁰

In 1998 a four-year plan was devised to reconstruct the national women’s health policy. It included strategies to overcome the “vertical bias” of PAISM through coordination with other relevant MoH programs and, most

significantly, new operational and financial structures. The plan defined the following priorities:

- Improvement of antenatal, childbirth and post-natal care to achieve a reduction in maternal mortality rates through: (a) reduction of hospital-based maternal mortality and of the number of Cesarean sections performed; (b) promotion of natural childbirth; (c) improvement of antenatal and post-natal care;
- Implementation of the Family Planning Law with respect to male and female sterilization and the sustained provision of reversible methods;
- Improvement of post-abortion care;
- Prevention and treatment of cervical and breast cancer;
- Prevention and treatment of STIs and HIV-AIDS among women
- Expansion of health services to respond to gender-based and sexual violence, including access to pregnancy termination in cases of rape;

It is also important to highlight that during the same period, racial and ethnic differentials in health gained visibility, particularly under the impact of the Durban Conference (2001). Data on race-based inequalities in S&R health became available, a national program was established to provide early detection and treatment of sickle-cell disease, and race was included as a variable in the HIV-AIDS epidemiological surveillance system.

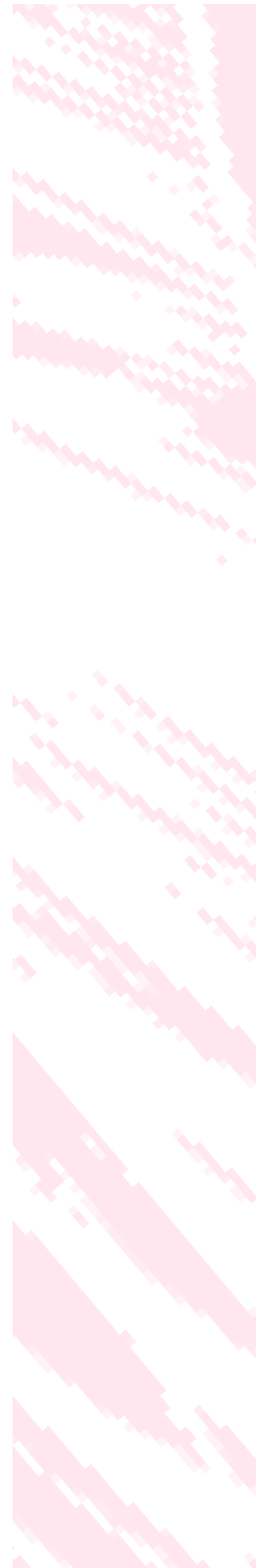
1998-2002: Outcomes


In 2002 an evaluation was conducted to assess policy performance. Its preliminary findings were discussed and improved in a seminar involving state and municipal level managers, health professionals as well as civil society representatives. The main results of the evaluation can be summarized as follows:

Antenatal, obstetric and post-natal care

Measures adopted – Payment for anesthesia in natural childbirth; a protocol allowing deliveries to be attended by obstetric nurses; a ceiling on payment for Cesarean section in SUS hospitals; improvement of obstetric care more broadly prioritized through the provision of equipment and infrastructure to maternity wards (GAR Program); creation of state-level systems of hospital referral for high-risk pregnancies; a new program (Humanizing Childbirth) that included financial incentives to improve care at municipal levels; programs to retrain obstetric nurses, other professionals involved in obstetric care, Family Health Programs teams and traditional midwives in the North and Northeast regions.

Positive outcomes – Antenatal coverage expanded from 5.4 million women in 1997 to 10.1 million in 2001, and the average number of consultations per woman increased from 2.0 to 4.2. Both the “Humanizing Childbirth Program” and the training of obstetric nurses and traditional midwives were positively evaluated.





Problems and obstacles – The GAR Program (infrastructure/equipment) and the training of professionals involved in obstetric care lacked financial transparency and did not have the expected results. State-level systems of referral for high-risk pregnancies were not implemented as scheduled. The incentive for obstetric nurses to perform deliveries provoked strong reactions from doctors. And above all the performance of the “Humanizing Childbirth Program” was considered disappointing. By September 2002 only 12 per cent of all pregnant women included in the program attended six antenatal consultations; 5 per cent of those who attended six consultations had all the basic examinations; and just 0.1 per cent of those who attended six consultations and had all basic examinations, were vaccinated and attended a post-natal consultation. These poor indicators suggest that financial incentives do not automatically translate into commitment to quality of care at local levels.

Maternal mortality epidemiological surveillance

Measures – Creation, expansion and strengthening of maternal mortality committees; retraining of committee members; inclusion of maternal death in the MoH list of compulsory notification events. In addition, the MoH sponsored new research on the magnitude of mortality among women of reproductive age (10–49 years old) in order to overcome problems deriving from under-notification.

Positive outcomes – The number of state-level maternal mortality committees increased from 20 to 24 and in capital cities from 6 to 20. By the end of 2002, 387 municipal and 50 hospital-based maternal mortality committees were functioning. The research identified as the main causes of death among women of reproductive age: brain vascular accidents and HIV-AIDS and, most importantly, it provided reliable data to define the national maternal mortality rate at 80 per 100,000 live births.

Problems and obstacles – Maternal mortality committees fully complied with their defined mandates in just four states and five municipalities, and gaps existed between the committees and SUS managerial structures. Most significantly, the 2002 epidemiological research suggested that health interventions must urgently address other causes of mortality among women of reproductive age, most particularly circulatory diseases and HIV-AIDS.

Contraception

Measures adopted – Historically this has been one of the most difficult policy areas to be tackled because since the late 1970s, the main source of access to reversible contraception and most particularly sterilization was the “market”, through drug stores and fees paid to medical doctors for tubal ligations (often in association with Cesarean sections and in public health services). From 1998 onwards the MoH invested in expanding the number of public hospitals providing tubal ligation and vasectomies, as defined in the Family Planning Law. An agreement was made with the National HIV-AIDS

program to resolve the gap between demand for and provision of condoms. Incentives were also put in place to ensure that reversible methods were included in the Basic Drugs Program implemented by states and larger municipalities. But when it was clear that this strategy was not working properly, MoH recentralized the purchase and distribution of contraceptive methods. In 2000, 6.2 million low dosage pill packets, 582,300 quarterly injectables (Depo-Provera), 58,000 IUDs and 30,000 diaphragms were distributed. But later an audit performed in ten states identified a variety of distortions and distribution was suspended. The decision was taken to send the contraception directly to municipal health departments that fulfilled certain criteria. In 2002, contraceptive kits were delivered to more than 4,568 small municipalities and 398 cities (with over 50,000 inhabitants). To establish a baseline for monitoring, research was conducted in 2002 to assess the outcomes of the new strategy.

Positive outcomes – Between 1998 and 2002 the number of tubal ligations performed in line with legal guidelines increased from 293 to 11,480, while the number of vasectomies increased from 497 to 3,970. The MoH estimated that potentially 2.8 million women per year would benefit from the new strategy adopted for the logistics of reversible contraceptive distribution.

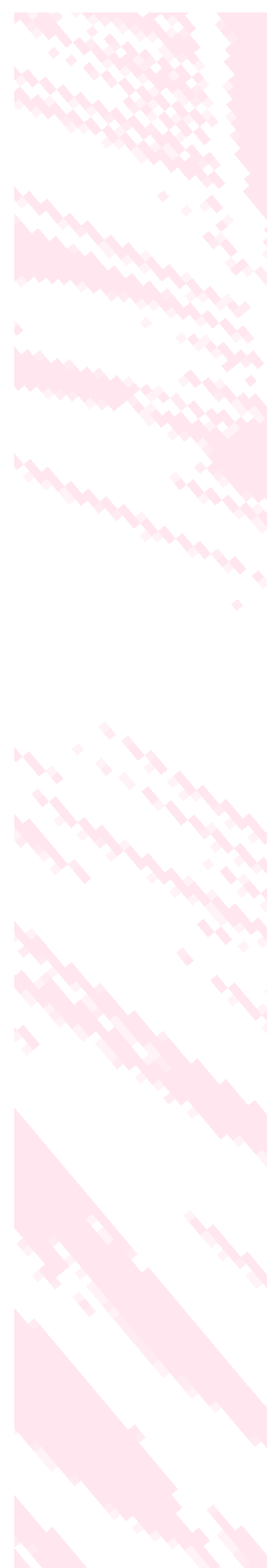
Problems and obstacles – Implementation of the law drags far behind the thousands of female sterilizations performed each year in public hospitals. Research carried out in 2002 indicated that access to free procedures consistent with the law remained rather problematic and that doctors “resisted” the criteria established by the new legislation. Regarding reversible methods, the preliminary findings of the research indicated that the new distribution logistics guaranteed delivery of contraception to municipal health departments. But even so, the goods did not always actually reach the clinics or users. An important limitation in terms of assessing policy results in this area is that the last national DHS dates from 1996.³¹

Post-abortion care

Measures adopted – Although the inclusion of post-abortion care in the strategic plan was an important step forward, the only policy measure adopted was, in fact, the inclusion of Manual Intrauterine Aspiration (MIA) on the list of SUS medical procedures.

Positive outcomes – There was a rise in the number of post-abortion clinical procedures using MIA from 7,000 in 1997 to 33,000 in 2002 (which is very positive from women’s perspectives).

Problems and obstacles – The investment was far from ideal given the scale of post-abortion care in SUS (roughly 230,000 procedures in 2002) and because post-abortion wards are usually sites of institutional violence and abuse. The 2002 evaluation recognized that at least three other key measures should have been adopted: (a) adoption of a specific protocol to improve post-abortion care; (b) the raising of SUS payment for post-abortion care; and, most



³¹ A new DHS is finally underway (2006). The first results are scheduled for 2007.

principally the establishment of clearer connections between post-abortion care and contraceptive assistance.

Cervical and breast cancer

Measures adopted – In 1998 a national cervical cancer screening campaign was launched targeting women in the at-risk age group (35–60 years old) in the poorest and most remote areas of the country. In early 2002 efforts to prevent cervical cancer were again intensified. The new program implied increasing the levels of SUS reimbursement for Pap smears and lab procedures, improvement of quality control of exams, involvement of women's organizations and professional associations, media strategies and training. It also expanded the use of High Frequency Equipment to simplify surgical procedures. In the case of breast cancer, a key investment was the expansion of diagnosis technologies (mammography) in addition to treatment (chemotherapy, radiotherapy and reconstruction surgery).

Positive outcomes – In 1998, the cervical cancer prevention campaign covered 98 per cent of municipalities and performed roughly 3 million Pap smears: 38.6 per cent of the women were screened for the first time in their lives and 3.1 per cent of results presented alterations. In 2002, 2.9 million examinations were performed. By late 2002, there were 6,980 Pap smear services in 2,807 municipalities, and 308 services providing High Frequency Surgical Procedures (HFSP), with the number of HFSP increasing to 21,153 from 413 in 1998. Regarding breast cancer, one positive indicator is that the number of surgeries decreased while the use of less invasive procedures expanded. The number of reconstructive surgeries also increased.

Problems and obstacles – Despite these positive figures, the cervical cancer program was highly controversial. The 1998 campaign format was strongly criticized. Some observers said it disorganized the health network, hampering routine pap smears and follow-up. Others criticized the contracting of private labs in the process. Above all, there was strong criticism of the fact 22.7 per cent of the women screened were not properly tracked by the health system after the end of the Campaign. This meant that those women in whose Pap smears anomalies had been detected would not receive proper follow-up and treatment. The assessment made by the Cross-Sectoral Women's Health Commission suggests that many of this distortions were corrected in the second round of the campaign in 2002. But by that time the poor image of the program was established. Despite these harsh critiques, in the 2002 policy evaluation the Women's Health Technical Team and other voices considered the cost-benefit balance of the program to be as follows: (a) the campaigns included women who would otherwise have never had a Pap smear; (b) the initiative disclosed obstacles to cervical cancer prevention that were not easily visible in the daily routine of the health services. With respect to breast cancer, specifically, the evaluation report expressed great regret that little had been done in relation to prevention and early detection.

Women and HIV/AIDS

Measures adopted – Until the mid-1990s, there was little connection between the HIV/AIDS and women's health policy areas. The main investment made in the 1998-2002 period was therefore to improve articulation between the two areas with regard to: STIs/HIV transmission among women, HIV/AIDS-related female morbidity and mortality; vertical transmission; quality of life of women living with HIV/AIDS and the protection of their human rights. The two main actions undertaken in this period were the expansion of (male and female) condom distribution and efforts to contain mother-child transmission, with incentives adopted to ensure voluntary testing and treatment of pregnant women in antenatal care. But as the system did not have a good response, a new intervention (Projeto Nascir) was devised to ensure testing and treatment at the time of delivery.

Positive outcomes – The Brazilian program distributes millions of male condoms each year and by late 2002 Brazil consumed 75 per cent of global Femidom production. Feminization of AIDS achieved greater visibility and female mortality rates have decreased, though more slowly than male mortality.

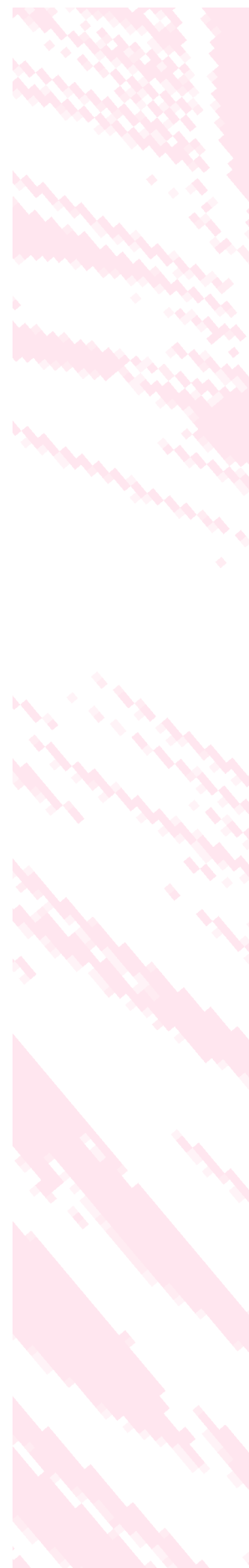
Problems and obstacles – HIV/AIDS prevention and treatment among women were regarded as the Achilles heel of an otherwise extremely successful program. The main reason for this was that, despite better integration at federal level, the HIV/AIDS and women's health programs remain highly fragmented at the local level.

Gender-based and sexual violence

Measures adopted – This was the main new area of the Brazilian Women's Health Program. Its first step was the approval in 1998 of a SUS Protocol on Gender-based violence (Norma Técnica de Atenção às Mulheres Vítimas de Violência) to guide related services, including access to emergency contraception and abortion procedures in cases of rape, and HIV prophylaxis. In 2002 another protocol was adopted that made it compulsory to notify all gender-based violence cases reaching the public health system. Investments were made to expand the number of specialized services and to ensure quality of care. Integration between health services and local level public security networks was also promoted.

Positive outcomes – By late 2002, 245 gender violence services (82 hospitals and 163 clinics) were in operation, of which 73 services provided abortion procedures in the two cases permitted by law.

Problems and obstacles – This specific component was systematically attacked by conservative sectors (see Chapter X). It also faced great resistance from health professionals themselves. In the light of this, the progress made was quite substantial. On the other hand, considerable challenges remained to be tackled, such as the consolidation of local referral systems, effective protection of women victims, greater clarity regarding how to treat aggressors, and the proper design of strategies to prevent gender-based and sexual violence.





32 *The Minister's declaration was strongly criticized by feminists, progressive demographers and other sectors. It did not have a concrete effect on policy, but got support from a variety of quarters, including some key op-ed writers. This neo-Malthusian revival may seem unusual given how the population debate has evolved in Brazil at policy levels since the 1980s. But it may be explained by the persistence of poverty combined with increased levels of violence.*

On a positive note, this "neo-Malthusian" revival puts pressure on the MoH to resolve public provision of contraception. But, it also indicates that the rights-based approach of PAISM, ICPD and Beijing has not been consistently incorporated by society at large or even by certain relevant policy actors.

33 *Dr Maria José Araújo is a leading reproductive health and rights advocate. She coordinated the Municipal Women's Health Program in Sao Paulo, when the first legal abortion service was established.*

34 *Even so the policy and operational pace got slower and eventually discontinuities occurred. The effects of the transition were more evident in the case of the HIV/AIDS policy, since it implied discontinuity in the provision of condoms and ARVs, and by mid-2004 the HIV/AIDS social movement was protesting on the streets. Similar problems appear to have also occurred in the case of contraceptive provision, even though they never became widely publicized. Also, during practically the whole of 2003, the MoH organigram and contracting rules were being revised and this necessarily affected the restructuring of teams and program implementation in all areas.*

Other Gaps

The evaluation also identified other critical issues that had not received adequate attention, such as infertility, gynecological care, mental health, labor related health problems and, above all, chronic diseases. In addition, it underlined the fact that much still needed to be done with respect to gender and race differentials in access to services, quality of care and epidemiological outcomes, in relation to which policy measures were considered to be insufficient. Lastly, the report emphasized that no investment was being made to ensure that private health services comply with existing SUS S&R health standards and protocols.

2003-2004: Policy Review and New Challenges

As mentioned in Chapter IV, the policy environment in Brazil from 2003 to 2005 was rather contradictory. The overall health budget was affected by fiscal constraints and the influence of conservative forces on policy deepened. It is also important to mention that, since the end of 2002 when the recently elected Lula administration announced that poverty reduction would be one of its main priorities, the country experienced an unexpected revival of neo-Malthusianism. Voices within society started calling for measures to control the fertility of poor women, particularly teenagers. In early 2004, the Minister of Women's Affairs publicly declared that "family planning" should become a conditionality of poverty reduction schemes. The statement caused an uproar and the Minister left shortly afterwards. Nonetheless, the population control agenda did not vanish, but rather kept resurfacing at each "social crisis".³²

However, in contrast to previous political administrative transitions, the 2002 changeover did not mean drastic discontinuity in terms of S&R health policies. A well-known feminist was nominated as the new coordinator of the women's health policy unit and the new team had a solid baseline from which to move forward.³³ The overall framework of the HIV/AIDS policy was also preserved. The general direction of the Women's Health Policy was not altered, but rather it would be positively amplified.³⁴

In 2003 policy guidelines were revised in discussion with state and municipal level managers and women's health teams. Publicly presented in early 2004, the new Work Plan defined gender equality, women's human rights, and the integrality of health care and services as its guiding principles. Within this framework the plan prioritized access to services and responses to the health needs of rural laborers, black and indigenous women, women in prison, women during the menopause, disabled and elderly women and lesbians (the most excluded groups). A large number of sector-specific working groups were created involving women's health and other MoH areas as to make sure that this wider focus would be translated into concrete policy measures.

With respect to reproductive health goals and targets, the new policy frame in general reaffirmed and expanded the main elements of the previous strategy, as follows:

General guidelines – Elaboration and regular adjustment of the National Women’s Health Policy; support for and supervision of state and municipal health programs; production and updating of norms and protocols; training programs; technological investments to improve quality of care; elaboration of managing tools to enhance implementation at state and municipal levels; capacity building to ensure that women’s organizations could effectively influence accountability mechanisms.

Family planning – Expand the provision of reversible methods to 60 per cent of the target population in all municipalities with Family Health Programs (PSF) and included in the “Humanizing Childbirth Program” (PHPN); increase by 30 per cent the number of hospitals providing female and male sterilization; create 27 referral centers for infertility treatment; reduce by 15 per cent the number of post-abortion complications.

Antenatal, obstetric and post-abortion care: (a) reduce maternal mortality rates by 25 per cent in capital towns; (b) reduce the national Cesarean-section rate by 25 per cent compared to 2002 levels; (c) expand the PHPN to all municipalities in which PSF is being implemented and that had adhered to the PHPN; (d) ensure that all pregnant women registered in the PHPN are regularly screened (all lab tests); (e) double the number of health professionals and traditional midwives trained in high quality and humanized obstetric care; (f) create maternal mortality committees in all states and cities with over 50,000 inhabitants.

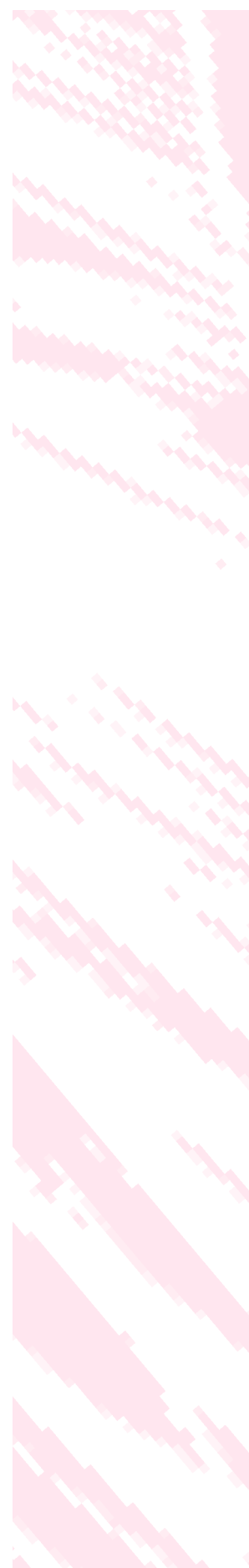
Gender-based and sexual violence – Increase by 30 per cent the number of services providing specialized care (including access to abortion in the case of rape) in municipalities that constitute micro-regional hubs of SUS.

STIs and HIV/AIDS – Expand measures aimed at reducing HIV-related female morbidity and mortality, including systematic engagement with a Special Committee on Vertical Transmission. Greater investment in gynecological care and creation of a specific working group to discuss epidemiological aspects of congenital syphilis.

In addition the new strategic plan explicitly defined goals to fill key gaps identified in 2002, as was the case with infertility, the menopause, gynecological care and post-abortion care. It also included specific goals to address mental and occupational health and chronic diseases, in particular high blood pressure (the principal cause of vascular accidents, which were identified as the main cause of death among women of reproductive age. (Leocádio, 2004, Rede Feminista de Saúde, 2005).

2003-2004: Outcomes

Information on the overall evolution of policy was collected up until May 2004, when the research focus shifted more directly to the debates and



institutional processes concerning the legalization of abortion. By that date the main actions and outcomes identified were as follows:

- Elaboration of the 2004-2007 Work Plan.
- Training programs to improve obstetric care (midwives and health professionals), antenatal care, family planning, gender-based and sexual violence (specifically in the area of HIV prophylaxis), and research on maternal mortality.
- Technical and logistical support for states and municipalities, which mainly meant the distribution of one million “SUS pregnant women cards” (to ensure follow-up and referral) and 24,000 contraceptive kits and emergency contraception to 432 municipalities.
- In relation to gender-based and sexual violence, new financial investments were made to create and sustain local referral networks, involving the health system and other institutional actors, in particular the public security system. An important advance was the approval by Congress in November 2003 of a new law making it compulsory to notify gender violence cases identified by SUS services (Lei 0.778/03).
- Elaboration of technical manuals to guide health care in the areas of Gender and Mental Health and Menopause.
- Investment in international linkages across reproductive health programs in Latin America, particularly within Mercosur. This included sponsoring a seminar in May 2004 as well as strengthening the Mercosur Working Group on Reproductive Health.

From the point of view of the elements prioritized by the DAWN research effort, three aspects of the 2003-2004 policy developments are worth highlighting. The first was the creation in 2003 of a working group to elaborate a Protocol on Post-Abortion Care, in which obstetric-gynecological professionals and feminists were involved. The protocol became public in late 2004 and was immediately attacked by conservative sectors (see Chapter IX). The second was the strategic participation and contribution of the MoH Women’s Health Technical Team in the policy process regarding abortion legal reform (see Chapter X). Finally, on 8 March 2004 a Compact to Reduce Maternal Mortality was launched, involving MoH, state and municipal health managers and with a specific budget allocation. Each of these policy initiatives will be more closely analyzed in the relevant chapters below.

In assessing progress made from 2003 to 2004 one of the background papers informing the country assessment makes two observations that are worth emphasizing. The first is that the expansion of the National Women’s Policy Agenda, though very positive, would require greater refinement of policy steps and improvement of monitoring tools to ensure implementation. Second, it calls attention to new challenges deriving from decentralization. Although at this new stage of SUS it is important that regional and local diversities be respected, past experience suggests that it is unwise to limit the MoH’s leading

role too much, among other reasons, because many deficits still exist at local level in terms of installed capacity to manage in a consistent and coherent manner all dimensions of the women's health agenda (Leocádio, 2004)

MEXICO

Mexico is the only country in our sample (and in Latin America as a whole) where in the 1970s a solid family planning program was established, which included contraceptive prevalence targets coupled with fertility reduction goals. Since the First World Conference on Women in 1975 (which took place in Mexico City) this policy has been systematically criticized by the feminist movement and other progressive sectors: as in other countries the response to women's reproductive health needs took the form of isolated family planning programs on the one hand, and MCH on the other.

Women's organizations mobilized strongly for both Cairo and Beijing, and Mexico would become a major player in pushing through the new 1994 and 1995 consensus on population and development. Immediately after 1994, an ICPD follow-up Commission was established, involving governmental agencies, the academic sector and feminist NGOs, and a variety of advocacy and policy initiatives were taken designed to implement the two Programs of Action. As a result, Cairo and Beijing language and premises have been widely disseminated through feminist networks and much academic investment has been made in relation to gender, sexuality and reproductive health.³⁵

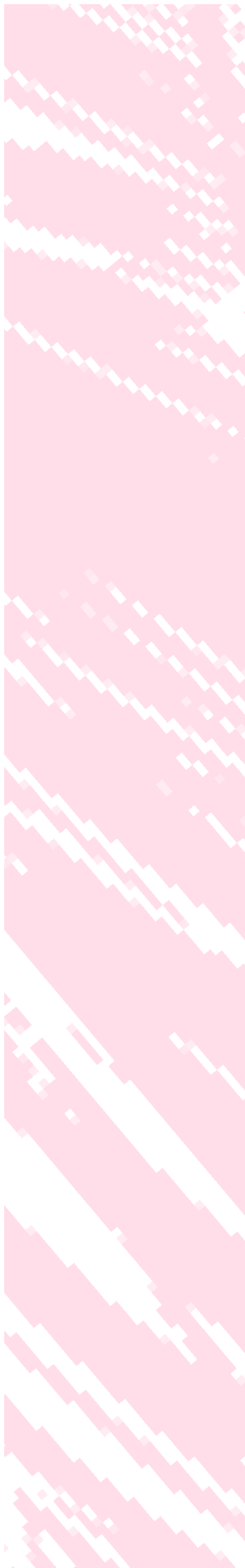
At the policy level, investments have been made in gender and reproductive health training within the sub-system managed by the Health Secretariat, which covers the "general population". The existing family planning program was also carefully reviewed in order to overcome existing problems, such as post-partum and post-abortion sterilization and IUD insertion, which were often denounced as coercive. The National Council on Population (CONAPO), established in the 1970s to undertake demographic research and to monitor population policy, also reframed its research agenda in order to measure more than just contraceptive prevalence – gender empowerment, gender-based violence and the quality of family planning services, with particular emphasis on informed consent.

The policy framework adopted immediately following ICPD prioritized the following elements:

- Expansion and improvement of antenatal, obstetric and post-natal care to overcome gaps in coverage. Between 1994 and 1997, 88 per cent of women had access to antenatal consultations; Cesarean sections represented 25 per cent of deliveries; just 6 per cent of women received proper post-natal care; in four states roughly 40 per cent of deliveries occurred at home.
- Strengthening and greater visibility of a high level commission on maternal mortality.
- Correction of distortions observed in the family planning program



³⁵ Among the top academic institutions involved in these efforts are the Mexican College (Colégio de México), the Gender Program (Programa Universitario de Estudios de Género, PUEG) of the National Autonomous University of Mexico (Universidad Nacional Autónoma de México, UNAM) and the (Universidad Autónoma Metropolitana, UAM) at Xochimilco.



through the implementation of informed consent and the expansion of services to rural areas, poorer urban sectors and among the indigenous population (in municipalities where more than 40 per cent of the population is indigenous the contraceptive prevalence rate is roughly 10 per cent).

- In relation to post-abortion care, since the 1970s abortion is recognized as a major public health problem. As mentioned above, the problems with post-abortion provision of contraceptives (including sterilization) received much attention post-ICPD and since then measures have been taken to correct them. In addition, training programs (mainly provided by IPAS) to improve quality of care have greatly expanded.
- Expansion of cervical cancer screening programs and more attention to HIV/AIDS transmission among young people.
- Normative measures have also been developed to enable the public health system to respond to gender-based violence, including the adoption a specific protocol on the health implications of intra-household violence.
- Training of health managers and professionals at all levels. Programs sponsored by the Health Secretariat started to include a gender and rights-based approach to S&R health and a number of feminist organizations and progressive academics were directly involved. This would gradually evolve toward the Women and Health Program (Programa Mujer y Salud, PROMSA) that is currently responsible for gender and health training across the health system.
- Specifically in relation to safe and legal abortion, no immediate policy measures were adopted. But since the mid-1990s there has been more widespread and visible public debate on the issue, leading to legal reform in Mexico City and several major controversies, as it will be described below (see Chapter X).

2000-2004: Outcomes

A mixed picture is probably the best way to characterize the reproductive health policy scenario in Mexico at the beginning of the 21st century. On the one hand, ICPD and Beijing still shaped the public debate and research agendas. The policy orientation adopted in the 1990s regarding contraceptive provision, post-abortion care and gender training were also maintained. On the other hand, as already mentioned, the health reform agenda somehow weakened the rights dimension in Mexican social policies in general and narrowed the 1990s agendas down to cost-effective basic health care interventions. At the same time, the moral climate became increasingly unfavorable, particularly as far as abortion and related issues were concerned.

The country report highlights two recent developments that illustrate this ambivalent situation. In the year 2000, the Federal Health Department adopted a specific protocol governing the provision of Emergency Contraception (EC).

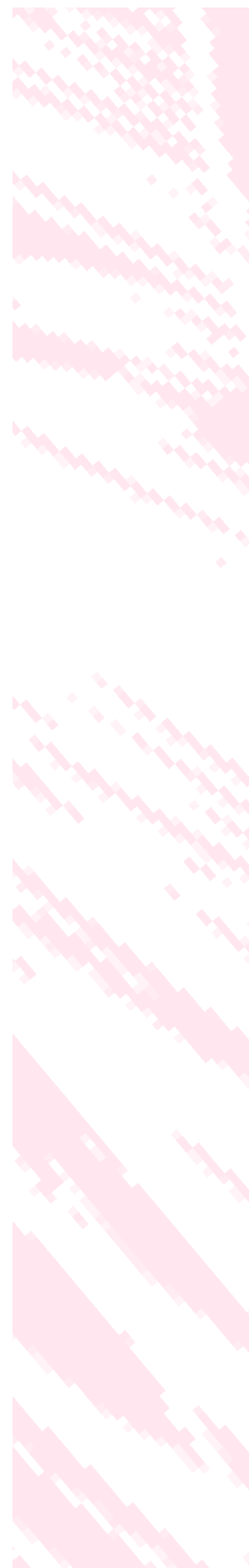
This policy decision was considered very relevant because in Mexico, as in other Latin American countries, after ICPD EC became a main target of the Catholic Church campaign against the legalization of abortion. On the other hand, the report sees the more recent federal initiative in reproductive health – the “Fair Start in Life” Program – as a clear step backwards in relation to previous policy agendas. The main objective of the program is the reduction of maternal and infant mortality and it will therefore be more fully described in Chapter IX below. But it seems relevant to mention here that, although the overall reproductive health policy framework remained more or less in place, the “Fair Start in Life” Program signaled the revival of a rather conventional MCH policy approach that in the long run may further dilute the relevance of other key components of the ICPD agenda.


URUGUAY

The history of S&R policies in Uruguay can be traced back to the 1940s and the beginning of the demographic transition in the country, which led to relatively low fertility rates in the 1970s, when population growth was becoming an issue in the region. Also, until the late 1990s the relatively good performance of the health system ensured that the majority of the population had access to MCH services. Lastly, Uruguay has a remarkable liberal and secular political tradition, which includes an episode when abortion was legalized in the late 1930s, for a brief four-year period. These characteristics do not completely prevent the Catholic Church from having an influence on policy, which at times is greater than at others.

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

Therefore with respect to maternal health care, maternal mortality and contraceptive prevalence by the late 1980s the country indicators were fairly good by Latin American standards. But a comprehensive women’s health policy was not yet in place, female sterilization was not permitted, articulation among programs was poor and there was still great moral resistance with respect to abortion. In the early 1990s discussion started on a comprehensive women’s health program to be implemented by the recently elected left-wing administration in the Municipal Government of Montevideo (Intendencia Municipal de Montevideo, IMM). This was then followed by Cairo and Beijing, which would give a further boost to the drive towards a broader S&R rights perspective. From then on feminist advocacy systematically emphasized





the commitment to the ICPD comprehensive policy perspective, which in addition to maternal care and contraception identified abortion as a major public health problem, and placed emphasis on adolescent health and sex education within a human rights framework.

Under the impact of ICPD and with UNFPA support two reproductive health programs would be launched, which included access to contraceptive methods: in 1996 the Women's Comprehensive Health Program (Programa de Atención Integral a la Mujer, PAIM), implemented as part of the primary health program of the IMM; and the Chosen Maternity and Paternity Program (Programa Maternidad-Paternidad Elegida), which in 1999 was defined as a policy priority by the MoH. Subsequently, a new law (N°158/97) was passed in 1997 on the testing of pregnant women and free treatment for those identified as being HIV-positive.

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

RECENT POLICY DEVELOPMENTS

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

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

health care. Finally, in 2003 the MoH began drafting S&R health norms and protocols and in 2004 a National Commission on Sexual and Reproductive Health was created, which, among other functions, liaises with the Mercosur Commission on Sexual and Reproductive Health.

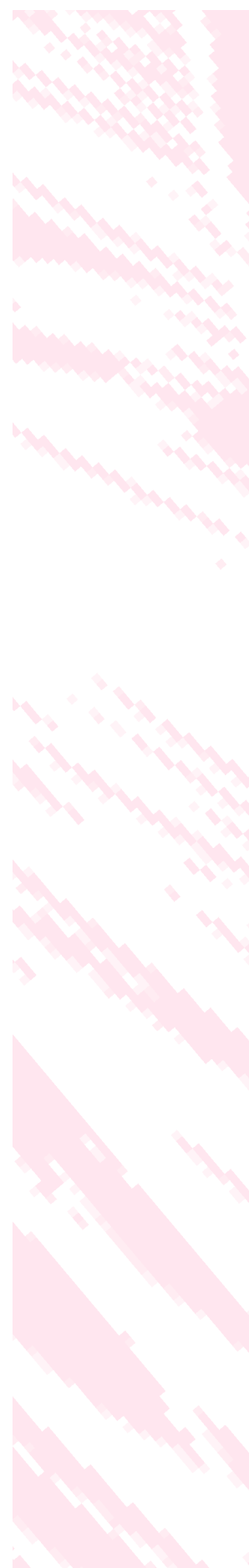
In addition, in 2003 a Program for Children, Adolescents and the Family, which includes an Adolescent Sexual and Reproductive Health component, was negotiated directly between the Uruguayan Presidency and the IDB, as part of a wider poverty reduction strategy. In fact, one interesting insight provided by the country report is that in practically all reproductive health policy documents debated or adopted after 1999 the connection is made with poverty reduction strategies.

OUTCOMES

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

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

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



CARIBBEAN COUNTRIES

The evolution of S&R policies as defined by ICPD and Beijing differs somewhat in the four Caribbean countries from what is observed elsewhere. There is substantial variation in both the pace and content of the policy processes across these national settings and, with the exception of Trinidad and Tobago, it is difficult to identify a turning point at which the ICPD agenda started to be implemented nationally. This different panorama appears to relate to historical precedents since, as described above in Chapter V, in all these countries apart from Surinam post-independence health policies were consistent with PAHO guidelines concerning primary and MCH care and had had conventional family planning programs (provided by non-governmental associations). In addition, in the early 1980s groundbreaking abortion reform was passed in Barbados and even if in Jamaica abortion remained illegal, access to safe procedures is available through closed-door decisions between women and doctors.

The positive public health outcomes of the 1970s would be negatively affected in most countries by the 1980s structural adjustment programs, though non-governmental family planning programs generally remained in place. But overall, the positive past record in some ways created the false idea that women's S&R health demands were being adequately responded to. On the other hand, the 1980s and 1990s witnessed an expansion of feminist initiatives and of a vibrant women's empowerment agenda across the region (even when these initiatives did not always emphasize S&R health issues).

This vitality was a major factor behind the Caribbean countries' commitment to and impact on the ICPD and Beijing processes. Regional support for ICPD and Beijing has come from various groups including women's and feminist organizations such as ASPIRE, CAFRA and DAWN, youth groups such as the YMCA and Advocates for Youth Sexual and Reproductive Rights (AYSHR) in Trinidad and Tobago, and implementing organizations such as Family Planning Associations (for example, Sticking Lobi in Surinam), and UN bodies such as UNFPA and UNIFEM, which encouraged the participation of governments and activists in the ICPD+10 review process.

In line with this performance in the international arena, ICPD recommendations were included in Caricom population and development plans, as well in country policy papers. However, the regional report also notes that, despite the efforts made by these vocal groups, ICPD has not generated a great deal of activism round S&R women's health issues. This was to a certain extent reflected in the Plus Five Review processes where the Caribbean presence was not as strong as in 1994 and 1995. In the post-ICPD scenario two new trends deeply affected the policy context relating to S&R health issues: the rapid expansion of HIV/AIDS and the gradual adoption of "reformed health reform" frameworks. The DAWN mapping of the policy landscape between 2003 and 2005 identified a quite uneven, not to say contradictory, landscape both within and across countries.

Recent Trends

In the early years of the 21st century in the Caribbean long-standing reproductive health structures were still in place, and, at least in the case of Barbados and Trinidad and Tobago, seemed to be working quite well. But when a comprehensive S&R lens is used to assess what was being done, fragmentation and a lack of consistency are what characterize the scenario. It is true that a reproductive health agenda had been revived by ICPD and, more recently, reproductive health issues were included in health reform packages. But this was not a homogeneous trend across countries and did not overcome the lack of consistency.

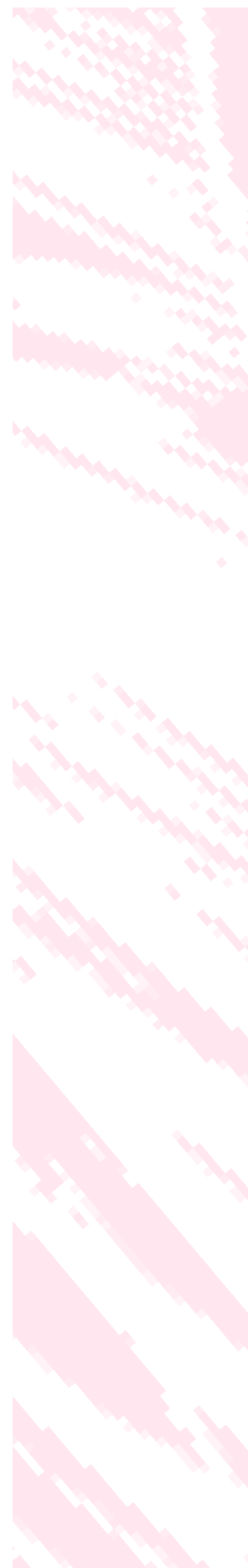
In Surinam preliminary debates on health reform potentially opened up space for S&R health issues to be raised, but implementation had not yet started. In Jamaica, where since the 1970s considerable investment had been made in MCH and family planning, the late 1990s reform mainly focused on improving the overall functioning of the health system, and no great visibility was given to S&R health issues. In Barbados, maternal health, cervical cancer and HIV/AIDS were all mentioned in the health reform policy guidelines, but these did not contain a comprehensive framework in line with Cairo and Beijing. In fact, the reform agenda was explicitly framed in terms of Family Health, along the lines recently developed by PAHO, which tends to subsume S&R health in a conventional, if not outright conservative, perspective. This is quite disturbing in the light of the progressive country record regarding abortion. Trinidad and Tobago is the only country in which S&R health issues are consistently addressed by both the health reform and the poverty alleviation policy packages.

As already mentioned, these new trends coincided with the increasing relevance of HIV/AIDS policy frameworks that are seen as positive given the rapid expansion of the epidemic. However, practically everywhere HIV/AIDS policies and programs are being designed as something completely separate from the comprehensive S&R health agenda envisaged by ICPD. Overall it would not be an exaggeration to say that in the four countries the S&R policy frameworks lack consistency with ICPD and in several ways reflect two layers of dissociation: the past dissociation between MCH and family planning, and the contemporary lack of connection between reproductive health interventions aimed at women and the expanding HIV/AIDS initiatives targeting different sectors of the population, especially youth.

National Policy Frames

Contrasting Barbados and Trinidad & Tobago

As previously mentioned, in Barbados Family Health provides the overall framework for the health reform. Its main aim is to improve health and quality of life for the population through interventions in reproductive health, women's health, men's health, health of adolescents and the elderly, oral health, and rehabilitation. The main reproductive health issues to be



addressed are: inadequate antenatal, obstetric, post-natal and neonatal care, inadequate breastfeeding programs and inadequate family planning services. Women's health is defined in relation to breast and cervical cancers, and obesity and gender violence are also mentioned as priorities. Men's health is defined in terms of prostate cancer, the percentage of men at the psychiatric hospital, obesity and men's lack of access to health services. Cancer and a list of causes of death among young people define adolescent health. In addition, the National Strategy on HIV/AIDS for Barbados defines reproductive health as a function of population growth, total fertility rate, and maternal mortality. The quantitative indicators defined for reproductive health, adolescent health and HIV/AIDS are shown in the chart below:

Box 16: Barbados: Quantitative Targets for reproductive health, adolescent health and HIV/AIDS

REPRODUCTIVE HEALTH	ADOLESCENT HEALTH	HIV/AIDS
<ul style="list-style-type: none"> •Reduce the infant mortality rate to fewer than 10 per 1000 live births. •Maintain the maternal mortality rate at zero. •Decrease the incidence of low birth weight and babies. •Reduce morbidity and mortality associated with cancers and STIs in men and women by 20percent. 	<ul style="list-style-type: none"> •Between 2003-2012 80percent of adolescents participating in community and school health programs. •Between 2003-2007 increase health-seeking behavior among adolescents by 10percent. •By 2012 reduce by 30percent the rate of adolescent obesity as identified in the 1999 Adolescent Health and Fitness Study Survey. •By 2012 reduce by 10percent the number of reported cases of adolescents suffering from depression and wanting to harm others, as identified in the 1999 Adolescent Health Survey. •Reduce injuries due to accidents and violence by 2percent per annum. •By 2012 reduce substance abuse among adolescents by 30percent. 	<ul style="list-style-type: none"> •Implement a national multi-sectoral program to reduce the incidence and impact of HIV/AIDS. •Key Health Indicator. •Between 2002-2012 achieve a 50percent reduction in morbidity and mortality rates and a 50percent reduction in the HIV incidence rate.

This policy framework is, to a certain extent, in line with ICPD language. However, the way components and targets have been defined and the indicators chosen suggest that the thinking behind the policy is not fully consistent with the Cairo and Beijing frameworks. In addition there are clear gaps between priorities and quantitative targets. For instance, the linkages between men's and women's S&R health has been lost. The inadequacy of family planning is a priority, but no quantitative indicator for that target has been set and there is no mention of current legislation, which restricts

adolescent access to contraceptives.³⁶ Particularly striking is the total absence of S&R health indicators to measure progress in terms of adolescent health and HIV/AIDS. And, most significantly, no reference is made to abortion, despite the fact that it is legal there, nor to reproductive rights as a guiding concept for the implementation of S&R health policies.

In contrast, in Trinidad and Tobago S&R health policy is evolving along combined tracks. The first relates to the initiatives under the responsibility of the Population Unit Program. This body was established in 1969 to facilitate fertility management and in 1989 it was reconstituted as the National Population Council. In 1997, under the impact of ICPD, Trinidad and Tobago adopted a National Population Policy as part of the HSR program. Under this policy, the Population Program Unit was reorganized to assume responsibility for Sexual and Reproductive Health Services in Primary Health Care. The government also provides gynecological care and screening for breast and cervical cancers for women, and prostate cancer for men, as well as HIV/AIDS-related services (screening, diagnosis, treatment).

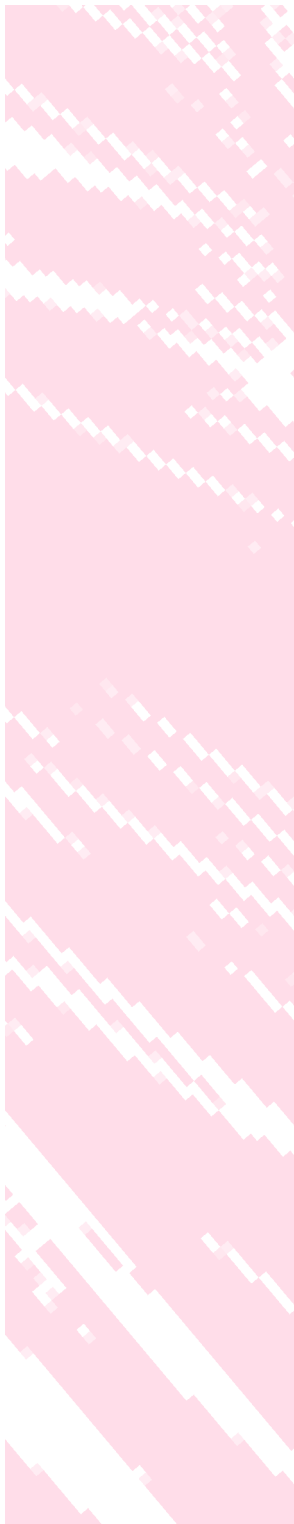
As far as family planning is concerned, with the decentralization of the national health system, 100 government health centers now offer contraceptive methods as a part of their MCH care program. The Family Planning Association of Trinidad and Tobago (FPATT) operates three clinics in San Fernando, Port of Spain and Tobago, as well as a mobile clinic that covers mainly rural and marginalized areas. In addition to providing a contraceptive delivery service (including emergency contraception), FPATT also offers other S&R health care services such as pregnancy tests, pap smears, urine tests for diabetes, breast examinations, and general gynecological services, counseling, as well as prostate screening. In 1996 FPATT launched its “For Men Only Clinics” in Port of Spain and San Fernando, and in 2001 opened the “Living Room”, a multipurpose youth center in Port of Spain that focuses specifically on young people’s reproductive and sexual health care needs. The private sector also promotes the use of contraceptives.

As part of the drive to improve sustainability and performance in reproductive health service delivery, the only women’s hospital in the country – the Mount Hope Women’s Hospital (MWH) was integrated into the Eric Williams Medical Sciences Complex (EWMSC), a vast health services complex that is largely under-occupied and under-utilized. One of the many advantages of this move would be the availability of a greater number of hospital beds for women seeking medical attention. In 2003, the Population Program Unit of the MoH completed a nation-wide training program for nurses to improve the quality of reproductive health care. In September 2005, the government teamed with PAHO to develop a five-year strategic plan for the implementation of its Sexual and Reproductive Health (SRH) policy.

The National Poverty Reduction Strategy includes a well-defined S&R health program for adolescent mothers. The Ministry of Social Development,



³⁶ Currently, young people in Barbados have no access to family planning without the consent of their parents (interview with Eleanor Smealy, Barbados Family Planning Association).



in collaboration with the Child Welfare League of Trinidad and Tobago, hosts a community-based project that targets pregnant adolescents, teenage mothers and their children. It provides counseling, remedial/continuing education, day care services for the children, and training in ante- and post-natal childcare at established centers. The Program is intended to decrease the number of repeat pregnancies among young women and to break the cycle of inter-generational poverty which may emerge among the target groups due to early pregnancy.

Lastly, it should be noted that though HIV/AIDS infection in Trinidad & Tobago is quite high (17,000 infected person of which 32 per cent are women) the country report does not provide detailed information on the policy response to the epidemic. Some of the initiatives reported above evidently overlap with HIV prevention. Given the lack of information it is not possible to assess, as was done in the case of Barbados, to what extent HIV/AIDS and S&R policies are being articulated.

Jamaica and Surinam: Unclear Policy Trends

The country reports do not provide much information about the design and implementation of HIV/AIDS policies. This is an unfortunate limitation, as infection rates are quite high in both contexts (18,000 people in Jamaica, of which 40 per cent are women; 3,500 people in Surinam, of which 50 per cent are women).

Specifically with regard to reproductive health, in the case of Jamaica, although there was official global Health Sector Reform Program until 1997, there were other reform initiatives prior to that date. The information collected by the MoH to review policy initiatives over the years shows that family planning and MCH have been central features of all of them. The MoH has taken several steps to reduce maternal mortality. The report prepared by Jamaica to assess policy progress since 1994 lists the following achievements:³⁷

- Special high risk antenatal clinics in each parish;
- Special adolescent antenatal clinics at the largest maternity facility;
- Access to emergency obstetric care in each parish, including special facilities for transportation and referral to higher levels of care;
- High risk antenatal registers in each parish to identify women for home visiting to ensure compliance with care;
- In-clinic education for all antenatal clinic attendees regarding warning signs in pregnancy and appropriate courses of action to take;

It is necessary, however, to underline that this report does not explicitly mention any high level health policy guideline spelling out and prioritizing a comprehensive S&R health policy framework, which would consistently articulate maternal health, family planning and HIV/AIDS within a rights based approach.

In the case of Surinam, the 1999-2003 Multi-annual Development Plan announced a structural reform of the health sector designed to: increase and

³⁷ Questionnaire responded to provide information for the document prepared by UNFPA and ECLAC for the ICPD+10 Review: "Review and Appraisal of the Implementation of the Cairo Programme of Action in the Caribbean". 17 November 2003

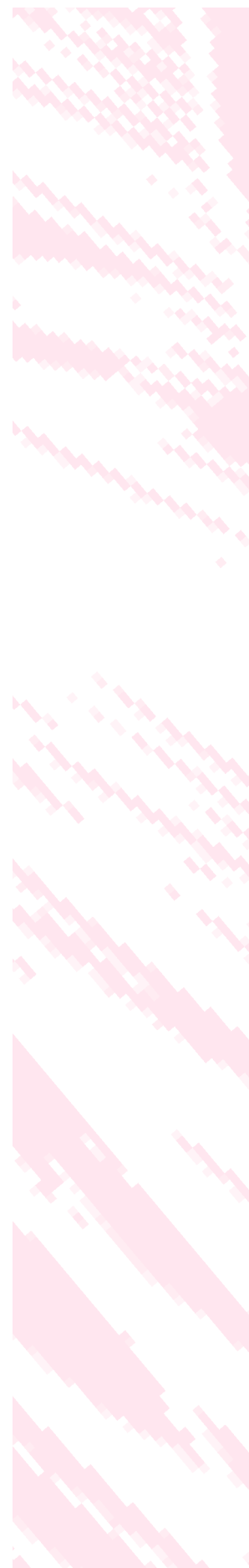
improve the quality of coverage in the health sector; improve access to general healthcare; adjust public health legislation where necessary. Immediately after the announcement, the MoH with support from the IDB initiated a series of studies to guide the reform. These were discussed at seminars to which stakeholders and key institutions and organizations were invited, among them women's organizations and family planning NGOs. In the meantime, bilateral assistance from the Netherlands shifted from a broad development cooperation framework towards a sector-based approach. The health sector was included as a priority in this new approach. But by the time the collection of data for the country report was finalized in Surinam no information was yet available on what the Health Sector Plan would include in respect to S&R health. The country report does however mention that the HIV/AIDS crisis is opening a strategic window of opportunity to revisit and promote the ICPD agenda.

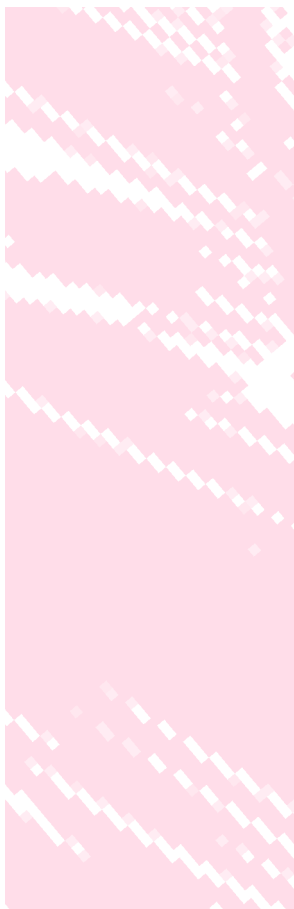
Overall Outcomes

The regional report identified the following gaps and distortions in the policies being implemented:

- Stigma and discrimination faced by women seeking S&R health services, particularly abortion-related services.
- Limitations that persist in access to contraception, exemplified by the case of Surinam, where in the year 2000 just 41 per cent of women living in union reported using some form of contraception, or by the restrictions on sterilization that remain in place in Trinidad and Tobago.
- Lack of integration of S&R rights into traditional reproductive health rights programs.
- Lack of integration of prevention of mother to child transmission programs (PMTCT) and MCH initiatives.
- Lack of integration of HIV/AIDS and reproductive health programs.
- No thorough integration of gender analysis and programmatic considerations into programs and planning.
- Lack of programs focusing on male health needs around reproduction and including men in the reproductive process.

More substantively, the analysis emphasizes the absence of a clear gender and health policy framework. With increased funding dedicated to HIV/AIDS, women's health issues are increasingly dichotomized into two streams: MCH or HIV/AIDS. Despite the intrinsic connections between HIV/AIDS and S&R H&R, programs and policies addressing the two areas are often planned and implemented in isolation. The continued neglect of women's health in the Caribbean, particularly women's S&R health rights, is reflected in the continued valuation of women's lives based on their reproductive capacities, as seen in the MCH programs that have historically focused on women of reproductive age. Women's health issues, in particular issues around sexual health and sexual rights, are marginalized.





GHANA

In Ghana the policy debate on reproductive health issues preceded ICPD by many years. This concern is what explains the fact that as early as 1985 the country adopted progressive legislation on abortion and the National Advisory Commission on AIDS (NACA) was established to advise the government on HIV/AIDS issues. In 1987, the National AIDS Control Program (NACP) was established as the structure within the MoH responsible for both implementation and co-ordination of the program. In 1993, a Medium Term Health Strategy (MTHS) was initiated as part of the national development strategy called “Vision 2020”, which would later become the MoH’s Five Year Program of Work. All these high level policy documents included a reproductive health framework and the revised National Population Policy already emphasized the harmful effects of STIs/HIV/AIDS, which was an important sign of policy integration.³⁸ Another key feature of Ghanaian policy is the high priority given to adolescent health.

Current Policies

Since these beginnings, the frameworks have been progressively broadened, refined and articulated resulting in a comprehensive S&R health policy model, the main characteristics of which are summarized below:

The Reproductive Health Framework

In 2004 the Reproductive Health (RH) program included the following elements:

- Safe motherhood including antenatal care, safe delivery and post-natal care in order to reduce maternal mortality. In 1997, when the maternal mortality rate stood at 214 per 100,000 live births, a target was defined to reduce this figure to 100 maternal deaths per 100,000 live births by 2001.³⁹
- Expansion of family planning in order to increase birth intervals to an average of 3 years by 2001. In this area great emphasis is given to training to ensure technical proficiency as well as to improve quality of care.
- Prevention and management of unsafe abortion and post-abortion care.
- Prevention and treatment of reproductive tract infection (RTI) including STIs and HIV/AIDS.
- Prevention and treatment of infertility.
- Prevention and management of cancers of the reproductive tract including breast, cervical, testicular and prostate.
- Issues of the menopause.
- Discouraging harmful traditional practices affecting the reproductive health of men and women, including female genital mutilation.
- Information, education and counseling on human sexuality, responsible sexual behavior, responsible parenthood, pre-conception care and sexual health, targeting adolescents and young people in particular.

³⁸ Before the drafting of the national policy concerns with HIV/AIDS were included in: the National Youth Policy, which identifies the provision of services to people living with HIV/AIDS as a priority; a draft Adolescent Reproductive Health Policy that has as one of its objectives the implementation of programmes aimed at reducing or eliminating STI/HIV/AIDS; the draft policies on Ageing and Gender; as well as the Affirmative Action Policy Guidelines designed to promote gender equality and women’s empowerment in all areas of life.

³⁹ The country report does not mention whether this target has been updated or not.

HIV/AIDS

The goal of the Strategic Framework is to prevent and mitigate the socio-economic impact of HIV/AIDS through efforts aimed at:

- Reducing new HIV infections by 30 per cent by the year 2005 among the 15-49 age group and other vulnerable groups, especially youth.
- Improving service delivery and mitigating the impact of HIV/AIDS on individuals, the family and communities by the year 2005.
- Reducing individual social vulnerability and susceptibility to HIV/AIDS through the creation of an enabling environment for the implementation of the national response.
- Establishing a well-managed multi-sectoral and multi-disciplinary institutional framework for coordinating and implementing HIV/AIDS programs in the country.

The framework also includes a research component and emphasizes decentralized implementation of key health interventions to curtail new HIV transmission and to provide care for people living with HIV/AIDS through:

- Promotion of safer sex particularly among the most vulnerable groups in the country.
- Effective management of STIs.
- Minimizing the risk of transmission through blood and blood products.
- Reducing mother-to-child transmission.
- Promotion of voluntary counseling and testing.
- Provision of cost-effective institutional care and home-based care.

Adolescent Sexual and Reproductive Health

Adolescent health has been identified as a priority program area for the Ghana Health Service (GHS) for the period 2002 to 2006 and the main policy document is fully consistent with ICPD definitions.⁴⁰ Adolescents are entitled to a full range of health services, including reproductive health. The GHS Adolescent Program, while promoting abstinence as much as possible, also provides a full range of reproductive health services including contraceptives for sexually active adolescents. One main strategy of the Adolescent Program is the training of health professionals in topics such as: counseling, adolescent development, early and unplanned pregnancy, safe motherhood, family planning, STI/HIV/AIDS, abortion, harmful practices, reproductive health disorders, nutrition, substance abuse, mental health and immunization.

In parallel, civil society initiatives have also emerged to address young people's S&R health. One example is the Young and Wise Program spearheaded by the Planned Parenthood Association of Ghana (PPAG) and the Ghana Social Marketing Foundation (GSMF) to effect positive behavior change among young people in order to reduce HIV/AIDS, STIs and teenage pregnancy (among people aged 10-24).



⁴⁰ Reproductive health is 'a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes'. Sexual health is 'the integration of the physical, emotional, intellectual and social aspects of a sexual being in ways that are positively enriching and that enhance personality, communication and love'. Adolescent Sexual and Reproductive Health refers to the physical and emotional well-being of adolescents and includes their ability to remain free from unwanted pregnancy, unsafe abortion, sexually transmitted infections and all forms of sexual violence and coercion and able to make responsible choices.

Policy strategies and structures

In terms of implementation strategies the policy guidelines emphasize primary health care (PHC), outreach and community-based activities, health education, promotion of appropriate technology and collaboration with non-state partners. The Head of the GHS is the Director-General with several Directors under him. One of these Directors is the Director of the Family Care Division, responsible for maternal care, family planning, childcare and reproductive health. It represents only a fraction of the total MoH budget, which under the current government increased to 13 percent of current spending. The budget of this directorate is mainly for policy development and training, safe motherhood, Emergency Obstetric Care (EMOC), training of Traditional Birth Attendants (TBAs). Norms for qualified post-abortion care services were only recently adopted after the scope of RH was reviewed and broadened. The division has been working closely with UNFPA, private midwives as well as private practitioners.

Since 1987 the National AIDS Control Program (NACP) is the main body responsible for HIV/AIDS policy. In 2000 two other relevant bodies were created: the Ghana AIDS committee at MoH level and the Ghana AIDS Commission (GAC), which is a multidisciplinary, cross-sectoral body chaired by the Vice-President of the country. The country strategies to address the epidemic are defined by the National HIV/AIDS and STI Policy Guidelines.⁴¹

The National Adolescent Health and Development Program was established in 1996, but due to cultural resistances it was not until October 2000 that the Adolescent Reproductive Health policy was adopted, which intersects with broader reproductive health initiatives, the HIV/AIDS program and National Youth Policy, which involves other sectors beyond health.

Outcomes

The Ghana country report recognizes that since the mid-1990s important advances have been made in terms of policy guidelines, intersections across programs and positive linkages with the health reform process, and these are reflected in some quantitative indicators. For instance, antenatal services' coverage has roughly doubled, the percentage of supervised deliveries rose to 52 percent in the year 2000 and there are also signs that post-natal care has expanded.

In relation to family planning, investments have been made in expanding the choice of methods and capacity building and training. In 2004 the following reversible methods were offered at service delivery points: condoms (male and female); spermicides; pills; combined monthly injectables (Norigynon); IUDs; three monthly injectables (DEPO); Norplant; and behavioral methods (including Lactation Amenorrhea Method (LAM)). Vasectomies and female sterilization (mini laparotomy or C-sections) were also available. In the same year a series of trainings have taken place on topics such as: mini-laparotomy technique for medical doctors; insertion and removal of Norplant for doctors, nurses and midwives; counseling skills for midwives;

⁴¹ In addition to the policy documents detailed in footnote 37 above, these include the Reproductive Health Standards and Protocols, the Labour Bill and the Work Place HIV/AIDS Policy.

infection prevention and client satisfaction for a whole range of health professionals. The prevalence of reversible contraception reached 18.7 percent in 2003 (in 1988 it was just 5.2 per cent).⁴²

In relation to HIV/AIDS, state and non-state stakeholders have been trained and are implementing a number of programs and projects in different areas of the country. Training programs have also expanded in the area of Adolescent Health, with 273 resource people trained in 2005. Adolescent-friendly health services in the Greater Accra region – Ada Foah Health Centre, La Polyclinic, Teshie Community Health Centre and Ridge Hospital – were visited during the research and all of them met standards with respect to sensitizing all categories of health workers, training frontline personnel and peer educators, and ensuring appropriate counseling rooms.

Problems and Obstacles

Despite progress made, the report underlines that several gaps remain between policy guidelines and realities at ground level. It also mentions unresolved problems between the center and decentralized levels. In terms of indicators one main concern is that, despite the improvements in antenatal and obstetric care, maternal mortality rates have not been reduced. In relation to family planning unmet needs for family planning remain high, even in the case of married women (34 per cent), while the needs of unmarried women and adolescents have not even been measured.

This results in high rates of unwanted pregnancy (16 per cent unwanted and 24 per cent mistimed pregnancies, according to the 2003 Ghana DHS). This is coupled with the non-use of services even where they are available, due to socio-cultural, economic or religious reasons, or legal restrictions deriving from a lack of clarity around the law on abortion in Ghana, which is one aspect that will be looked at more closely in Chapter X. In addition, though the policy states that information and services will be provided to young people, the legal age limit for administration of contraceptives to adolescents is 18 years, although the age of consent is 16. Consequently, contraceptives cannot be legally administered to sexually active adolescents below that age.

With respect to HIV/AIDS, the report considers the overall co-ordination of the HIV/AIDS program to be weak at all levels (national, regional and district). Reference is also made to the inadequacy of funding for HIV/AIDS activities. In assessing the policy as a whole the Ghana research team identified the following key policy challenges:

- Reproductive health had not yet been fully accepted as a priority area within the districts. Unfortunately the 2004 annual review of the health sector did not place any emphasis on it.
- There had not been adequate investment in human resource development, which in the case of Ghana is aggravated by a considerable “brain drain”.
- Much still remains to be done to ensure that national policies consistently address and respond to the core S&R H&R challenges and needs identified in the Ghanaian context.



42 WHO data for overall contraceptive prevalence in Ghana informs that in 1998-1999 22 percent of women used some method of contraception.

NIGERIA

The population debate in Nigeria started more than twenty years ago. In 1988 a National Population Policy for Development, Unity, Progress and Self Reliance was adopted which is still mentioned in official documents. However, its implementation came up against cultural resistance and was hindered by the continuing political and institutional instability affecting the country throughout the 1990s. Despite the difficult political environment, the pre- and post-ICPD and Beijing debates provided an impetus for the population debate to be reopened, and enhanced the adoption of a series of new policy strategies, such as:

- Breastfeeding Policy (1994)
- Maternal and Child Health Policy (1994)
- National Adolescent Health Policy (1995)
- National Food and Nutrition Policy (1995)
- National Policy on HIV/AIDS/STIs Control (1995)
- The National Health Policy and Strategy (1988, 1998)
- National Policy on the Elimination of Female Genital Mutilation (1998)
- Plan of Action for Control of Non-Communicable Diseases in Nigeria (1999)
- National Policy on Women
- National Reproductive Health Policy and Strategy (2001)

These various guidelines provided the grounds for the review of the 1988 Population Policy. Since 1997, a great deal of advocacy efforts have been directed at ensuring that that happens. Though the draft of this review has been ready for some time, as late as 2005, a high level policy dispute was still at play over whose imprint should be on it: the Department of Population Activities in the Federal MoH, which initiated the review process, or the National Population Commission.

Recent policy processes

All the previously mentioned documents are relevant for mapping the national policy framework, but the 2001 National Reproductive Health Policy and Strategy remains the main reference for the issues examined in the DAWN research. In general terms the document is consistent with the ICPD and Beijing agendas. One main gap, however, relates to abortion, as it makes no reference to paragraph 8.25 of the ICPD Program of Action and no mention of paragraph 106k of the Beijing Platform for Action, a question that will be dealt with below.

In section 1.2.2 entitled “The State of Reproductive and Sexual Health of the Population” the policy document admits: *“Available statistics show that the reproductive health situation in Nigeria is poor... the situation deteriorated further in recent times. Among others, Nigeria’s maternal mortality has remained one of the highest in the world, neonatal mortality is on the increase, and the*

nation has one of the largest population of people living with HIV/AIDS globally. Moreover, there is wide geographical disparity in the reproductive health situation in the country”.

Section 1.2.2 addresses “Maternal Morbidity and Mortality” and estimates maternal mortality ratio as 704 deaths per 100,000 live births, while recognizing that these rates vary widely across regions.

Under the paragraph on “Family Planning”, the document recognizes that *“The level of contraception among sexually active adolescents is particularly low, contributing to the high level of teenage pregnancy, unsafe abortions and maternal mortality, among others”*. Though a clear policy action on abortion is not mentioned, the section dealing with Adolescent Reproductive Health states that *“... about 2/5 of teenage pregnancies in Nigeria are believed to end up in induced abortion, with the majority being carried out by quacks and in unsafe environments. On the whole, about 600,000 induced abortions are believed to take place in Nigeria annually”*.

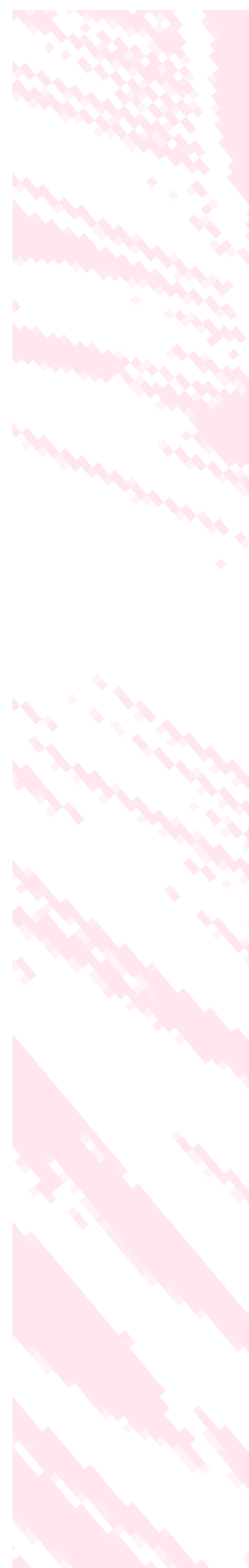
The 2001 policy guidelines define as its main objectives:

- To address and reduce “the unacceptable high levels of maternal and neonatal morbidity and mortality”;
- To address the “increasing high-risk behavior of adolescents leading to premarital sexual encounters, early marriage, unintended pregnancies, unsafe abortions and other social consequences...”
- To correct the “low level of male involvement in reproductive health...”

Outcomes

On the whole, the data shows that the availability and accessibility of quality health care services in Nigeria remain extremely poor, despite the existence of a whole range of good policy guidelines. This can be illustrated with reference to family planning, which is one of the better known and more prominently advocated components of the ICPD agenda. The results of the 1999 DHS indicated that although knowledge about contraception was increasing – 65 per cent of all women and 82 per cent of all men had heard of at least one method – prevalence rates remained quite low. Currently 15 per cent of married women and 32 per cent of married men use some method of family planning, but these figures are much lower in the case of so-called modern methods, used by just 9 per cent of married women and 14 per cent of married men. These figures certainly reflect cultural resistance to contraception. But it is fair to say that if there had been integration between reproductive health services and family planning strategies as mandated by ICPD and Beijing since 1994-1995, these figures would most likely have been different.

When the analysis shifts toward antenatal and obstetric care the picture is not promising either. Low levels of access to and utilization of quality reproductive health services play a significant role in Nigeria’s high maternal mortality rate. For example, data from the 1999 NDHS shows that only 31 percent of deliveries took place within health facilities. This aspect will be



analyzed more closely in the chapter on maternal mortality, in respect of which in the case of Nigeria, access to and quality of MCH care in Cross River State was subject to direct empirical assessment.

The country report recognizes that there is a high level of awareness among key MoH officials and that many attempts have been made to address S&R health issues, such as: the Emergency Obstetric Care survey conducted by the MoH in collaboration with UNFPA, the National Reproductive Health and HIV/AIDS survey (NARHS) in collaboration with the Society for Family Health (SFH), and the National Reproductive Health Consultative Summit in collaboration with the Planned Parenthood Federation of Nigeria (PPFN). On the other hand, the findings of a study carried out by Engender Health examining the current situation of maternal health services indicate that conditions remain very precarious at service levels:

- Health information forms are not available in many facilities and health information systems are poorly utilized for monitoring;
- Only two-thirds of clients have easy access to health facilities;
- Long waiting times in a high proportion of cases;
- Drugs are not regularly available in about half of facilities;
- Poor client-provider interaction; no proper information provided to clients and lack of privacy;
- Poor adherence to infection control guidelines;
- Re-use of needles and blades;
- Low use of gloves for relevant procedures;
- Low use of appropriate sterilization procedures;
- Delays in seeking care in high proportion of maternal complications;
- Delays in receiving proper care for pregnancy complications;
- Poor infrastructure, inadequate equipment, poor storage facilities and operation of logistic management system.

The Engender report also raises a few questions about the ways in which the 2001 policy is being implemented, such as: To what extent are girls and women, who are the victims of deplorable health system and gender based sexual violations as well as sexual/reproductive rights denials, have or not been consulted? What budgetary allocations are consistent with the commitments of ICPD, of Beijing, of ICPD +5, of Beijing +5, and the MDGS in respect to the target of reducing maternal mortality?"

THE PHILIPPINES

As is the case with most Latin American countries in the sample, in the Philippines the development of S&R health policies can be traced back to the 1980s. During the struggles against the dictatorship, women's organizations had pursued two main agendas: an end to the population control framework implemented by the Marcos regime and a concerted effort to influence the redrafting of the Constitution. The struggle for legal abortion was lost when,

under the powerful influence of the Catholic Church, the right to life from the moment of conception was included in the new constitutional text, a defeat that would deeply affect the policy context until the present time, something that will be analyzed below in Chapter X.

From the 1980s onwards the population and health policy landscapes would be transformed. A complex two-way process evolved, involving two main governmental bodies – the Population Commission and the MoH – and interacting with the impacts of the HSR. At the same time, underlying conservative trends would remain a feature of the landscape. The main actors in this ongoing process were and continue to be different strands of feminist advocacy, external donors (in particular USAID) and the Catholic Church.

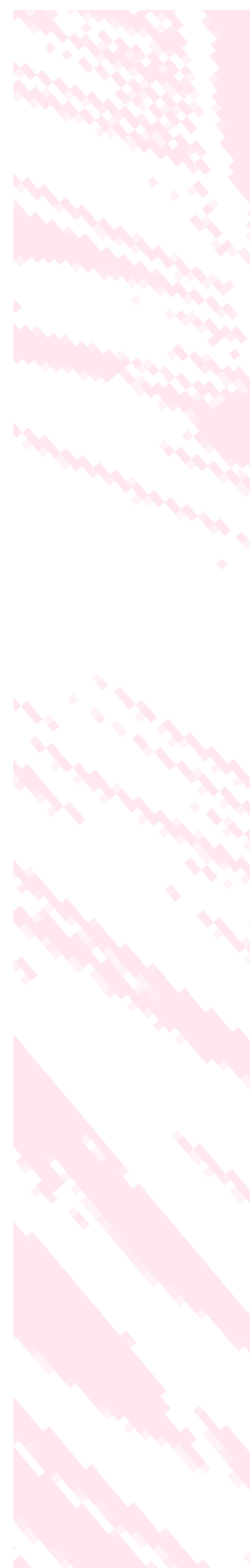
The scope and content of reproductive policy frameworks would be constantly affected by the repeated political and administrative transitions that – as described above in Chapter IV – have taken place since the 1980s. The four-year timeline of the country study actually covered two Philippine administrations since Estrada was forced to leave office in January 2001 and was succeeded by his vice-president, Gloria Macapagal Arroyo. But it is interesting to revisit briefly prior policy developments.


The shift from the Marcos regime to Corazon Aquino's presidency meant the abandoning of population control, but the influence of the Church increased. However, the subsequent election of protestant President Ramos opened up possibilities for a more progressive reproductive policy. It was during his time in office that the 1990s UN conferences relevant to women were held, creating a momentum that would match the vibrancy of the women's movement at that point. But these positive trends, as previously analyzed, were coupled with the first negative impacts of health reform privatization and decentralization.

This pattern would remain largely in place during the brief Estrada administration. The subsequent Arroyo administration was marked by two main trends: on the one hand, the privatizing health reform model was consolidated, and on the other, the growing influence of both the Catholic Church and the Bush administration implied a drastic step backwards, as natural family planning would become the core element of the reproductive policy framework.

The ICPD aftermath

The Philippine Population Program Plan (PPPP, 1993-1998) and the Directional Plan of the Philippine Population Management Program (PPMP, 1998-2003) were crafted by the Population Commission (POPCOM) under a new administrator. Coherence within the institutional environment for population, health and development was completed with the adoption by the DoH of the new Philippine Family Planning Program (PFPP) that focused on “providing clients with high quality care by enhancing the efficiency and effectiveness of health service delivery including family planning” (Herrin 2002).





In January 1998 the DoH, under the leadership of a liberal Catholic, launched the Philippine Reproductive Health Program that included the following elements: (a) family planning; (b) MCH and nutrition; (c) prevention and treatment of RTIs, including HIV/AIDS; (d) prevention and management of abortion and its complications; (e) breast and reproductive tract cancers; (f) education and counseling on sexuality and sexual health; (g) adolescent health; (h) violence against women and children (VAWC); (i) men's reproductive health, and (j) infertility prevention and treatment.

Three years later, however, POPCOM admitted that of the ten priority areas, only three were being successfully addressed. These were MCH and nutrition, RTIs/HIV/AIDS, and breast and reproductive tract cancers. Critics also argued that the DoH had adopted a strictly medical approach, leaving the non-medical, behavioral aspects of the program unattended. Last but not least, as signaled by the previous DAWN research, as far as contraceptive provision was concerned, the program was fully dependent on USAID funds.

The Arroyo Administration

In 2002 the DoH issued Administrative Order 125 laying out the Natural Family Planning Strategic Plan (2002-2006) that defines natural family planning as the only acceptable method of birth control. This represents a reversal of the population policy pursued in the previous Ramos and Estrada administrations. The institutionalization of natural family planning methods as the only possible option for women is not just a rhetorical ploy by the President – Congress itself has allocated 50 million pesos for its first year of implementation. The argument used to justify this policy shift is that a balance needs to be achieved with other population control methods, which purportedly had been overemphasized by previous governments. In October 2003, 1.5 million dollars originally allocated by the Estrada Administration to contraceptives were diverted to natural family planning methods instead. At the same time the government directed the DoH to stop its purchase of contraceptives.

In addition to promoting exclusively natural family planning, the government actively denied access to other contraceptive methods. In 2001, the Bureau of Food and Drugs (BFAD), using its strengthened regulatory powers, delisted Postinor, the emergency contraception pill. While the former Estrada administration health secretary had once asserted that Postinor was not an abortifacient, the position of the current head of the DoH – a Catholic conservative – was that Postinor should be delisted because of its “abortifacient effect”. He also asked BFAD to check on the abortifacient effects of IUDs. Given the new policy-making status acquired by the DoH, the department has now greater power to regulate and ban contraceptives available on the market.

Local government units (LGUs) have also passed legislation impeding access to artificial contraceptive methods within their territory. Metro Manila Mayor Jose L. Atienza Jr explicitly supports natural family planning as the sole

means to reproductive health. In early 2000 he declared that national family planning should be “*a way of self-awareness in promoting the culture of life while banning the use of artificial methods of contraception*” .(Viado, 2004) In December 2001, the mayor of Puerto Princesa, Palawan, issued a resolution banning condoms, birth control pills and other artificial methods of family planning will be banned.

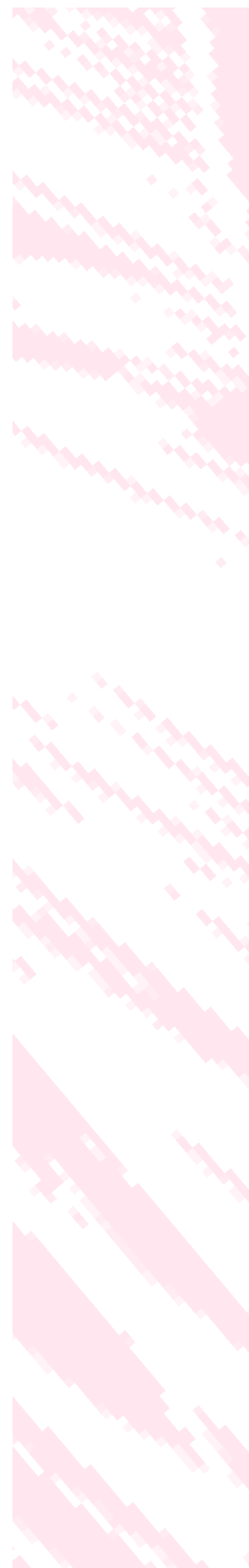
Disquieting trends are also surfacing in the area of youth health. Given a large population base of under 15 year-olds, adolescents are a major focus of the Arroyo Administration’s development plan, which aims at “ensuring that adolescents are provided with appropriate information, knowledge, education, and counseling services on population and reproductive health”, especially those from poorer sectors. The fundamental premise of the program is the limited notion that adolescents will in the future marry and become parents themselves. Sex education services are therefore designed “within the context of family life”, and promote abstinence, delayed marriage, responsible parenthood and sexuality, and a small family model.


The Catholic Church, for its part, is implementing its own initiatives. Family life values are being promoted through its Teen Health Quarters program, which is based on the idea that young people should be provided with “age-appropriate” information on reproductive health and responsible sexual behavior during childhood, adolescence, and adulthood. The strategy provides information geared towards inculcating “responsible” sexual behavior. In 2003 women from Malitbog (in Bukidnon), for example, were threatened with excommunication if they did not remove their IUDs. A medical doctor from the Serve Life Ministry in Malitbog tricked women into allowing her to remove their IUDs by saying she was giving them a thorough medical check-up. Other women submitted voluntarily out of fear of excommunication.

Last but not least, the Bush administration’s Gag Rule has also had a direct impact in the Philippines. USAID, the country’s top supplier of contraceptives, announced in 2002 its plans to stop contraceptive supply by 2004. The policy shift and the neo-conservative rhetoric that accompanied it were consistent with the national policy discourse around natural birth control. USAID is actively promoting the Standard Days Method (SDM) (Jennings, Rivera and Arevalo 2001)

Outcomes and Dissent

Despite the continuing struggle for reproductive health and rights and the legitimacy gained by gender equality principles, since 1986 policy outcomes in the Philippines are poor and preoccupying. Over time these new ideas were constantly reshaped to accommodate within them the dominant assumption that women are embedded in a traditional Catholic model of the family – heterosexual, with no possibility of divorce, and unchanging over time. The best illustration of this is the current administration’s policy that seeks to assist, not individuals, but couples to achieve their desired family size within





the context of responsible parenthood and using natural family planning. In the light of this, the country report concludes that “Notwithstanding the many years of feminist engagement with the state and the wealth of rhetoric on reproductive health, the Philippines has not consistently and progressively pursued a comprehensive national reproductive health policy... This situation is a result of a protracted contest between liberal and conservative perspectives on women’s rights and empowerment from within the politically influential Catholic Church.”

On the other hand, despite this regressive climate, dissenting voices exist that are pushing for a progressive and comprehensive S&R health agenda. The Population Commission itself, which is headed by a non-political appointee who is a liberal Catholic, is determined to offer services and information regarding a wide range of contraceptive methods in partnership with women’s health organizations. Surprising as it may seem, in March 2004 Muslim religious leaders declared a national ‘fatwah’, or religious decree, on family planning that recognizes it as a part of Islam, approved by the Qur’an.⁴³ Within the business community, the Employers Confederation of the Philippines (ECOP) has undertaken comprehensive family planning initiatives that are a striking contrast to the government’s weak and conservative stance. Many of ECOP’s associated business firms provide family planning and contraceptive services to its employees as mandated by the labor law.

Women’s health organizations are also key actors in sustaining a progressive S&R agenda. Even if funding has been reduced in recent years, they still fill the void left by the state by providing much-needed services at the grassroots level. Most importantly, they are the main advocates of a new legal reform initiative currently underway, which will be described in detail in Chapter X below.

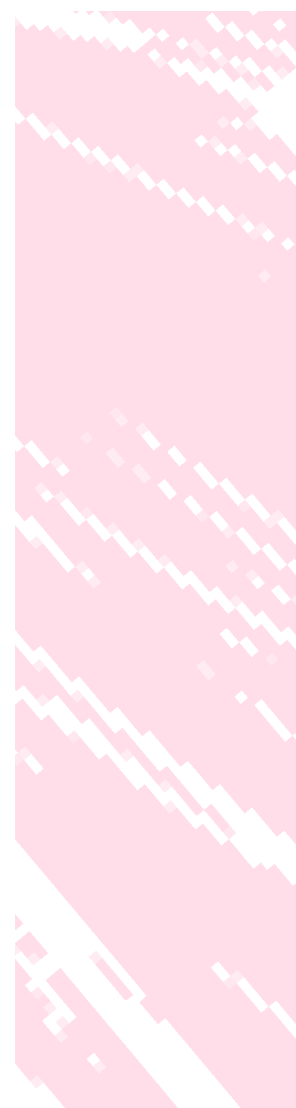
⁴³ Muslim law in fact supports abortion until the 120th day of pregnancy, in contrast to the prevailing views of the Catholic Church.

VIII. Health Sector Reform and Sexual and Reproductive Health: Linkages and Disconnections

In general the data collected in the twelve countries confirmed what had already been known for some time: in most cases the HSR and reproductive health agendas remain largely dissociated, if not openly in conflict. But, there are differences among the countries, which present a more nuanced panorama, marked both by virtuous connections and negative gaps and contradictions. At one end of the spectrum we find Brazil, where since the 1980s productive linkages have existed between the two agendas. At the other end we find Nigeria, where reform has barely started and practically no connection has been made between the two agendas, or Surinam, where health reform stalled in 2003. The other countries fit in between these two extremes.

However, even those cases where more positive connections can be identified are not free from problems and challenges, as the Brazilian case itself shows. Though great progress has been made since the late 1990s in terms of connecting the women's health agenda and SUS mechanisms, the new emphasis on basic health care through PSF, and above all decentralization, require new strategies to translate effectively a comprehensive S&R health agenda to programs on the ground at local levels. In the case of decentralization these challenges were clearly identified by the Coordinator of the Women's Health Policy in late 2004:⁴⁴

- Decentralization per se does not improve the quality of care;
- There are difficulties relating to “local cultures”;
- In the absence of an active and empowered civil society the transfer of power and resources may favor clientelist practices;
- There is a tendency for municipal health expenditures to increase in relation to the level of federal funding; although this is desirable, it is not always valued by mayors and local health managers;
- When services improve in one setting this may create inequalities across different municipalities and increase additional demands on those systems that are working better, which may lead to a loss of quality;
- Follow-up and monitoring tools to assess decentralization are still under-developed.




⁴⁴ Dr Maria José Araújo, in her presentation at the seminar “Sexual and Reproductive Health and the Millennium Development Goals”, Rio de Janeiro, November 2004.

Box 17: Health Sector Reform and Sexual and Reproductive Health: Linkages and/or Disconnections

COUNTRY	MAIN TRENDS MOSTLY POSITIVE
BRAZIL	The health reform and the women's health agenda were part of the same broad agenda of social transformation in the 1980s. The 1984 Women's Health Program was an early experiment with integration of services, prevention and care. The development of the Brazilian HIV-AIDS Program is closely linked to the nature of SUS as a publicly funded universal health system. From 1998 onwards women's health policy items have been increasingly incorporated into SUS global strategic guidelines. However, this does not automatically resolve the problems deriving from decentralization or the integration of S&R health issues in primary health programs that have recently expanded.
URUGUAY	Given the nature of the HSR process - silent and gradual - the advocacy work performed by the S&R H&R community was critical for increasing visibility of S&R health policies, not as a technocratic agenda, but as a citizenship rights issue. In 2002-2004, the impacts of the economic crisis in terms of higher fertility rates among adolescents and abortion-related maternal mortality became increasingly visible. In other words reproductive health issues appeared linked to poverty and economic issues. This would open new windows of opportunity to link the two agendas more consistently.
BOLIVIA	ICPD and Beijing coincided with the beginning of a "reformed" HSR process. This initially favored positive synergy between the two policy processes. Given the high levels of maternal mortality and the precarious nature of the health system, the adoption of a basic health insurance package had positive impacts in terms of coverage and mortality reductions. These virtuous connections would be weakened in 2001. Given the SWAp framework of the HSR, donor positions are critical in terms of whether these linkages are favored or not, and from 2001 USAID clearly moved against the ICPD agenda.
TRINIDAD AND TOBAGO	This is the only country in the Caribbean where consistent and potentially positive connections could be identified between HSR, S&R health initiatives and poverty reduction. Though users fees have been adopted for tertiary levels of care, public financing remains high. Information suggests, however, that ICPD and Beijing rights-based approaches are not given high priority in the HSR agenda. The country report does not provide indicators that would allow for a fuller assessment of these connections.
MEXICO	ICPD and Beijing coincided with the beginning of the second phase of HSR. This favored some dialogue across the two processes and got communities involved. The reform retained the constitutional definition of health as a right, which is consistent with the ICPD rights-based approach. Other common conceptual links between the two agendas are equity principles, the need for a better integration of services and the emphasis on primary care. However, limitations are noted in respect to the basic package model, as it abandons the universal comprehensive rights-based approach to health. Moreover, the positive synergy between the two agendas diminished from 2000 on under the Fox administration, when a narrower maternal mortality reduction strategy was adopted, based on a more traditional MCH approach.

- GHANA** Many elements of the ICPD and Beijing agendas were incorporated into the HSR policy agenda: maternal mortality, cervical cancer, family planning, HIV/AIDS and post-abortion care. This is mainly due to the positive stance taken by the government with respect to the S&R H&R agenda as well as to favorable donor positions, which are quite relevant given the SWAp nature of the Ghanaian reform process. However problems and distortions are observed in terms of priority setting and most principally decentralization, as not always district levels properly follow national guidelines.
- BARBADOS** The health reform agenda uses ICPD language and includes relevant reproductive rights interventions, such as the improvement of family planning, cervical and breast cancer screening, and HIV/AIDS. But abortion and post-abortion care is not mentioned even though abortion is legal. The overarching HSR conceptual framework is Family Health, along the lines recently developed by PAHO, which tends to dilute or even eliminate ICPD definitions and priorities.
- ARGENTINA** Though coinciding in time, the S&R H&R agenda and the HSR process have run parallel tracks until very recently. While the first was mainly “political” - centered on the struggle for support for reproductive health legislation in Parliament and within society - the second has been silent, technocratic and top-down. The privatizing nature of the reform had clearly detrimental effects on women's reproductive health. However, following the 2001-2003 crisis new possibilities began to open up for greater dialogue and connections between the two policy agendas.
- PHILIPPINES** ICPD and Beijing coincided with the push for health reform under an administration that was favorable to the reproductive health agenda. But within society itself a consistent dialogue has not been established between the two fields/communities. Philippine advocates and external observers coincide in the view that as HSR progresses, the negative effects of privatization and decentralization will appear. The current administration has sharpened the trend towards privatization and most importantly has adopted an extremely conservative position that, among other aspects, has made natural family planning the core of reproductive health policies.
- JAMAICA** The HSR framework mostly addresses the reconstruction of the public health system in terms of management, infrastructure, and human resources. This will necessarily impact on S&R health care. But the country report does not provide enough information on these potentially positive connections.
- NIGERIA** The country case study did not examine in depth HSR trends at the national level. But information collected directly from a government source indicates that while infant mortality is explicitly mentioned, wider S&R health areas are not prioritized. Several problems were detected in the functioning of maternal health services in Cross River State. At that level, the main health reform initiative underway is a revolving fund for purchasing drugs (including for HIV/AIDS treatment), a project supported by the World Bank, which is the main supporter of health reform at national level.
- SURINAM** A HSR debate started in 2001 that could have potentially opened up space for the ICPD agenda. But this process was stalled as changes occurred at the level of the Dutch development cooperation agency, which is the main donor in the country. By late 2003 it was not clear what would happen with HSR.



These brief profiles suggest that, in addition to a lack of dialogue and understanding between the two fields and communities, important conceptual differences also affect the possibility of building connections between HSR and S&R health. One main distinction is that while the latter is strongly rights-based and aims at expanding the policy agenda beyond maternal health and family planning (abortion, cervical cancer, adolescent health, etc), the HSR agenda tends systematically to draw back the policy agenda towards conventional approaches that are more easily measured in epidemiological terms, such as the DALY indicators. Furthermore, it is important to remember that conventional approaches to women's health are more easily absorbed by public health professionals who have been trained in MCH but have rarely heard of the S&R health framework and who are often the main actors in health reform processes.

Consequently, although in current policy conditions HSR processes may offer a window of opportunity to enhance the S&R H&R agenda, in the realities that DAWN examined from 2002-2005 the construction of positive linkages between the two agendas was not a given. It depended on a wide variety of factors and required much more than semantic convergence between policy documents and the promotion of cross-sector dialogue. Existing literature on the subject provides some insights into other relevant factors.

One key element to be addressed in future debates on how to connect more positively HSR and the ICPD agendas (which was not thoroughly examined in the case studies) is the new financial logic of the "reformed" reform packages. Lakshminarayanan's (2003) analysis of the Philippines' case provides a striking illustration: *"There were several adverse implications for the financing of reproductive health services, which were either exacerbated by devolution or government spending for health has meant under-spending on some priority health services essential to women's health. Second, with the increasing feminization of poverty, greater reliance of the health care system on out-of-pocket payments, which are regressive in nature and reduce access of the poor to health services, disproportionately punishes women. Third, the national health insurance benefits package discriminates against the reproductive health needs of women since it does not cover basic reproductive health care, such as normal deliveries. Furthermore, many women work in the informal sector and do not have access even to this limited form of insurance. All this indicates that devolution was not accompanied by supportive policies, such as legislated cost-sharing schemes between central and local government, development of regulatory and financing policies for moderating reliance on out-of-pocket payments, and development of health benefit schemes protecting the vulnerable through risk-pooling mechanisms"*.

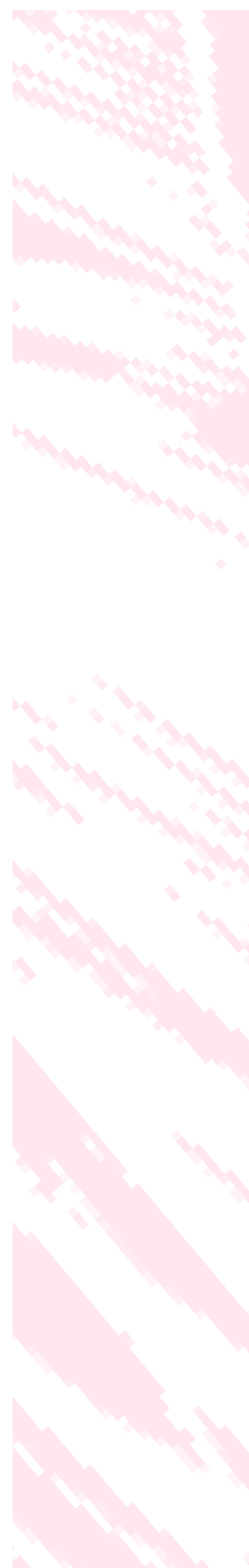
Almeida (2004), who in her studies of Latin America has closely examined the "mother and child basic insurances packages", is also rather skeptical about their potential as a strong basis for expanding comprehensive S&R health policies: *"The mother and child basic health insurance schemes do not*

fulfill minimal requirements to be considered a form of social insurance. They are more precisely subsidies that support a basic health package aimed at mitigating the effects of poverty and the lack of coverage by wider social policies. A basic package of medical interventions can be an efficient programmatic tool in countries experiencing great deficits in terms of health care coverage (such as Bolivia and some Argentinean provinces). However the lack of connections between the basic package funded services and the health system at large, in particular the units providing more complex level of care...make them valid for short term policy intervention but not as an effective form of long term social insurance. Moreover the sources of financing of basic packages are not sustainable in the long run. To summarize, basic packages must necessarily be combined with structural mechanisms that would require additional efforts in terms of both health and macroeconomic policies.]”


These critical observations suggest that in order to create more positive synergy between the two agendas it is necessary that S&R health advocates do more than frame policies in terms of priority areas and present arguments in their favor to health reform promoters. They must start to intervene in high-level policy arenas where structural decisions are being made regarding financing and decentralization. In most settings this requires that advocacy communities' skills be substantively improved in terms of how they understand and intervene in relation to those macro aspects.

Another dimension worth mentioning, albeit briefly, concerns another key component of the 1990s HSR agenda: participation. The emphasis on participatory approaches was already included the 1993 World Bank Report. At present all reform packages include “participatory structures”, though their format varies from case to case. Although it has not been possible to examine in depth the implications of this trend, in practically all the countries studied mention has been made of regional or local-level health councils and, in the case of Africa of “revolving fund schemes”. However, in very few cases are these new participatory structures highlighted as a key platform from which to advance further the S&R H&R agendas. One positive example comes once again from Brazil, which however constitutes an anomalous HSR model. In the cases of Bolivia, Mexico and the Philippines, reference is made in the country reports to participatory structures at central levels that have favored the visibility and relevance of S&R H&R issues.

But overall it appears fair to say that the existence per se of participatory structures does not automatically ensure that a progressive vision of S&R health issues is incorporated in health sector planning and priorities. The DAWN 1998-2000 study of the Brazilian case suggested that for that to happen many other elements must be in place, such as: enough density of women's organizations, sensitization of other actors participating in health councils about gender and SRHR issues and also health managers that are committed to these agendas. These enabling factors are not yet at play in the large majority of the almost 5.000 municipalities.



IX. Maternal Mortality



In almost all the countries studied in the DAWN sample the reduction of maternal mortality appears in official policy documents as one of the main reproductive health problems to be tackled. In Bolivia it has been defined as a policy priority since the mid-1990s. In Mexico it would gain prominence under the Fox administration. In Brazil, major investments to reduce maternal deaths were made after 1998 and particularly from 2004. In Argentina and Uruguay the issue also gained visibility after the year 2000 and in the latter case this linked directly to the debate on unsafe abortion. In Barbados, Trinidad, Ghana and the Philippines the reduction of maternal deaths is also a major component of the national reproductive policies being implemented. Less emphasis on this issue was found in Jamaica, while in Surinam and Nigeria no clear strategy was yet in place while the research was underway (2002-2003 and 2002-2005 respectively).

These findings are not surprising given that almost everywhere MCH programs (in some cases coupled with vertical family planning) prevailed before ICPD. In addition, since the late 1980s safe motherhood programs have been adopted in almost all the countries studied and maternal mortality is the “uncontroversial element” of ICPD and therefore most easily accepted everywhere. Lastly, as the research evolved the Millennium Development Goals framework, which includes the reduction of maternal mortality, gained policy relevance in some of the countries. But even so, as we will see this visibility and legitimacy did not always translate into consistent policy measures and positive outcomes.

Policy Heterogeneity across countries

But cross-country analysis also tells that, although antenatal, obstetric and post-natal care programs were in place long before ICPD and can be said to have been strengthened in all cases, differences exist in terms of implementation time frames, their continuity or discontinuity and outcomes. While some programs have been implemented since the 1950s and 1960s, others started in the late 1980s. Even in the cases where programs have been functioning for more than thirty years variations were found in terms of epidemiological outcomes.

Barbados is the best illustration of an early MCH program that has had a sustained performance. But the same cannot be said of Jamaica and Trinidad. Argentina and Uruguay were also doing pretty well until the late 1990s. But this is not the case of Brazil, where MCH programs became a priority in the early 1970s, but have not yet translated into maternal mortality rates comparable to the levels registered in neighboring countries. In most cases, the poor performance of maternal care can be attributed to the negative impact of 1980s structural adjustment programs. In Surinam, Ghana, Nigeria and the Philippines the low coverage of antenatal care and hospital-based deliveries particularly in rural areas also must be taken into account. In the particular case of the Philippines, in addition, the negative impacts of decentralization must be considered as a potential factor behind the low performance of maternal health care. In Brazil, where the public health system is universal and free of charge – and more than 90 per cent of deliveries are hospital-based – unacceptably high maternal mortality rates can be explained with reference to regional, class and race inequalities and the poor quality of antenatal programs and obstetric care.

Problems of data collection and analysis

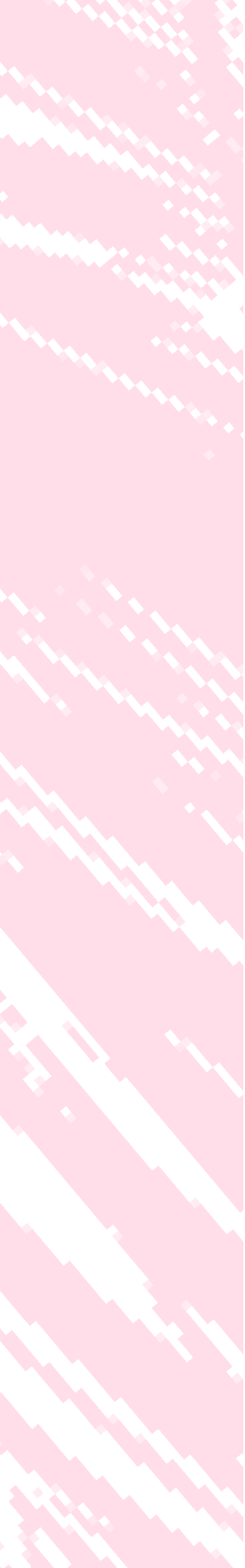
Maternal mortality is a key indicator of coverage and quality of health services and may also reflect economic and gender-based constraints affecting women's lives. But one main problem identified in the DAWN country analyses is the paucity, bad quality and unreliable nature of available data on maternal health. A clear example is provided by the Caribbean databases. It should be remembered that the four Caribbean countries are much smaller than any other included in the DAWN sample, in all cases more than 90 per cent of deliveries are hospital-based – factors that greatly facilitate maternal mortality investigation – and Caribbean data is recognized to be quite reliable as far as other gender-related statistics are concerned. However, the table below shows the discrepancies between data compiled, on the one hand, by the University of the West Indies for a Review of the MDGs and, on the other, by UNFPA and ECLAC for the ICPD+10 Review (2003). In addition to the differences shown in the chart, in Barbados, MoH administrators interviewed for the study stated that, in fact, the maternal mortality rate in Barbados was zero in 2003.

TABLE 5: DISCREPANCIES IN ESTIMATED MATERNAL MORTALITY RATES (PER 100,000 LIVE BIRTHS)

Country	University of West Indies		UNFPA	
	circa 1995	circa 2000	circa 1995	circa 2000
Barbados	81	95	70	20
Jamaica	106	87	120	106
Surinam	153	110	88*	153
Trinidad and Tobago	70	160	NA	70

* 1998.

SOURCE: This table was constructed using data collected by Ahmed (2004)



But in other countries, too, the absence of consistent data is a major obstacle hindering the design of strategies to reduce maternal mortality or to evaluate their outcomes. In Ghana, for instance, maternal mortality estimates have not been reviewed since 1993. In addition, important discrepancies are to be found between domestically collected data and information stored in international databases such as UNDP, World Bank and WHO. In some cases, the maternal mortality rates provided by international sources are lower than the figures used at national levels, while in other cases they are higher. Lastly, it is important to bear in mind that national average rates – even when they exist and are reliable – tend to gloss over regional, class, race and ethnic differentials in maternal death.

The estimation of maternal mortality is not a trivial exercise. It requires good information on maternal death itself, which as a relatively rare epidemiological event is more difficult to detect accurately than other cases of mortality. A proper understanding of the determinants of maternal mortality demands that information about multiple factors be collected and analyzed, such as location, income, context specific gender biases (such as women’s seclusion that impedes their access health care) and traditional health practices. But it is also necessary to look into the quality of care offered by of “modern” health systems, since in many developing country settings – Latin America being one clear example – women die in childbirth in hospital wards after having been attended by qualified health professionals. Lastly, in order to define maternal mortality rates it is also necessary that good epidemiological data be available on live births (against which they are compared). If this information does not exist or if it is of poor quality the estimates cannot be calculated. In other words, the production of consistent data on maternal mortality to feed policy purposes usually demands substantial financial and human resource investments.

The lack of adequate data detected in most countries in the sample can therefore be seen as a sign of inconsistency between the stated prioritization of maternal mortality reduction in official policy documents and the commitments effectively made by governments to address the problem. It is not possible to reduce maternal mortality if the magnitude of the problem is not properly measured and the factors behind it are not understood. Nonetheless, advocacy efforts are often needed for this investment to happen.

Despite the many limitations listed above, in the DAWN sample two country cases positively exemplify the policy relevance of good data on maternal mortality and the role that advocacy can play towards that end: Uruguay and Brazil. In the first case the quick epidemiological assessment made of the growth in maternal mortality rates related to unsafe abortion was a critical tool and argument to push forward a broad-based campaign for legalizing the procedure. In Brazil the updating of the national maternal mortality rate (and reduction target) defined in 1990 was preceded by public campaigns and debates, internal pressure at MoH level and the creation of a parliamentary inquiry commission on maternal mortality. The research on

mortality among women of reproductive age finally performed in 2002 corrected national maternal mortality parameters, providing a much more consistent basis for designing and evaluating the maternal mortality reduction compact launched in 2004.

Interpretation of data

In relation to research and data it is also important to bear in mind that interpretation of maternal mortality figures and their evolution is not a simple matter either, as it greatly depends on the quality of the information. Improvements in databases may create the false impression that mortality rates are increasing and vice-versa – when information quality is lost this may create the impression that mortality rates are decreasing. Few cases included in the DAWN sample exemplify this complexity. In Brazil, in the mid-1990s, hospital-based mortality rates increased slightly in relation to levels measured in previous years, and this predictably created an uproar. But further investigation proved this to be an effect of improvements made in data collection. In Barbados, the information compiled by the West Indies University (Table 4 above) could be interpreted as a rise in maternal mortality between 1990 and 1995, from 33 to 81 deaths per 100,000 live births. But this may well be a positive sign that research methodologies have improved in the period. The information contained in the Trinidad and Tobago country report also suggests that methodological aspects should be more closely examined as the rates varied rather erratically throughout the 1990s.⁴⁵

Variation in the Magnitude of the Problem

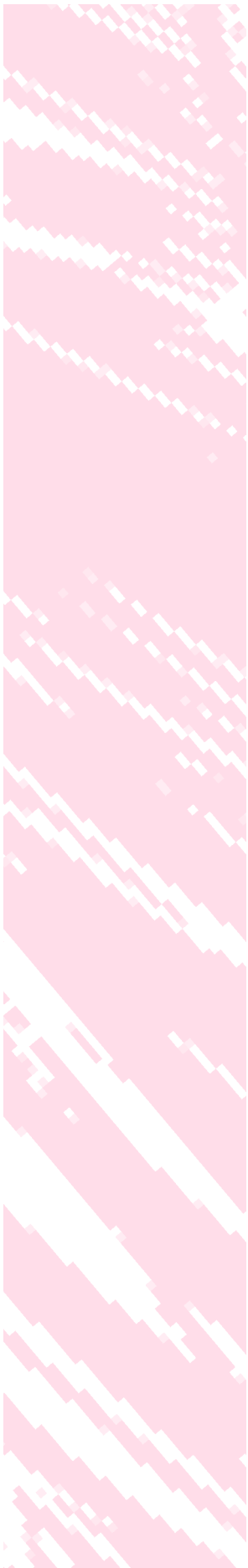
The table below shows that great variation exists with respect to levels of maternal mortality across the twelve countries in the DAWN sample. The rates, calculated in relation to 100,000 live births, range from 800 in Nigeria to 20 in Barbados.*

Table 6: Maternal mortality rates (as informed by country reports)

Country	Source and Year		Rate per 100,000 Live Births	
Argentina	MoH 2002		46	
Bolivia	MoH 1994		235	
Brazil	MoH (based on Laurenti,2004)		76	
Mexico	2001 National Health Dep.		59	
Uruguay	MoH 2001		31	
Barbados	ICPD Review 2004	MDG Review 2000	20	95
Jamaica	ICPD Review 2004	MDG Review 2000	106.2	87
Surinam	ICPD Review 2004	MDG Review 2000	153	110
Trinidad and Tobago	ICPD Review 2004	MDG Review 2000	70.4	160
Ghana	GDHS 2003		214	
Nigeria	Multiple Indicators Cluster Survey 1999	WHO 2.000	704	800
Philippines	National DHS 1998		172	



45 As follows: 49/100,000 live births (1991), 60/100,000 (1992), 66/100,000 (1993), 76/100,000 (1994), 76/100,000 (1995), 67/100,000 (1996), 38/100,000 (1997), 70/100,000 (1998), 44/100,000 (1999), 38/100,000 (2000) and 70/100,000 (2001).



Policy rationality would lead one to suppose that, in the light of these variations, the priority given to the problem as well as the design of strategies to tackle it would vary according to its magnitude. However, this is not exactly the case. In Nigeria, for instance, the 2001 Sexual and Reproductive Health Strategy defines as a target the reduction of maternal mortality rates by 50 per cent by 2006. Since then a series of studies have been performed to assess more precisely the scale of and factors behind the problem. However, up until early 2006, the main national Health Reform Policy, while explicitly mentioning infant mortality as a national priority (75 deaths per 1.000 live births, which is a relatively low infant mortality rate, considering the poverty levels in the country) does not include the goal of reducing maternal deaths. As the Nigerian study shows, awareness of the problem and of existing policy guidelines is practically non-existent at the level of the maternal health services that cope with the problem on a daily basis. In contrast, in Barbados, where the maternal death rate has reached a very low level, health reform guidelines still give great attention to the issue, when policy attention and financial resources might have been expected to have shifted towards other neglected S&R health issues.

Maternal mortality and unsafe abortion

Global research and reliable data collected in country-specific settings have for a long time called attention to the close association between maternal death and unsafe abortion, since in all countries where the procedure is illegal it is one of the four main causes of maternal mortality. However, in not all the countries included in the DAWN sample did policy discourses and frameworks make the necessary linkages to unsafe abortion as one of the principal causes of maternal death, nor did they include specific policy measures to address the implications of clandestine and risky procedures for the termination of pregnancy.

This gap may be partially attributed to the problems signaled with respect to research and data-gathering on maternal mortality, to which we should add the difficulty of doing research on abortion itself, given that in ten of the countries studied abortion remains illegal. Where epidemiological information is poor the possibility of accurately estimating the numbers of maternal deaths resulting from unsafe abortion are very meager and this constrains policy design. However, closer observation of country trends suggests that other factors must also be examined to understand more fully the frequent dissociation between maternal mortality and unsafe abortion.

It is interesting to start with Barbados and Ghana, the two countries where, since the mid-1980s, abortion performed by medical practitioners is legal under certain circumstances (see Chapter X). In both cases recently adopted reproductive health policy guidelines give priority to maternal mortality but no clear connection is made between maternal deaths and abortion. In the case of Barbados, it might be expected that at least some positive correlation would

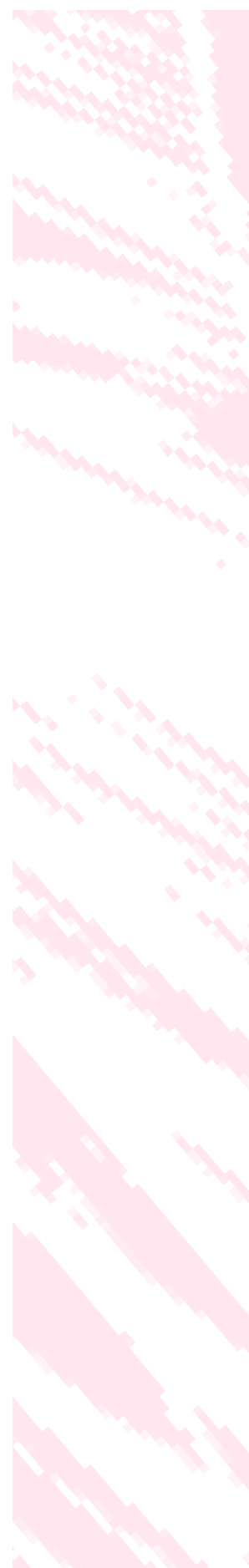
be made between the decrease in maternal deaths and access to safe abortion, but this is not the case.

In Ghana, the country report provides consistent data indicating that despite the fact that medical abortion is legal, women still resort to unsafe procedures, amongst other reasons because women and even doctors do not have adequate information about existing legislation. Current maternal mortality policy guidelines recognize the problem and since 1996 an important investment has been made to improve post-abortion care. But even so, until July 2003, no strong recommendation was made in existing policy documents to ensure access to safe procedures, as defined by the existing law. The country study was already underway when safe abortion services were included in the review of reproductive health policies. Immediately afterwards the Ghana Health Service set up a committee to draw up plans to reduce the high level of unsafe abortions in the country, which would explicitly address the need to expand knowledge about and access to safe procedures.

In Mexico, a different pattern can be observed. The new program launched to address maternal mortality under the Fox administration – Fair Start in Life – is completely silent on the implications of unsafe abortion. This shift is rather surprising since in the early 1990s one strategic platform to raise policy awareness about unsafe abortion was a high-level maternal mortality committee. In addition, Mexico is one of the few countries in the sample that has reliable data on unsafe abortion. As mentioned before, post-abortion family planning has for a long time been a well-established practice in the public health system and in recent years IPAS has invested heavily in post-abortion care. Finally, impressive advocacy efforts for the legalization of abortion have been underway for many years.

In Argentina, Jamaica, Surinam and Trinidad and Tobago – where with some nuances abortion can be said to be illegal – no strong policy articulation was identified, either in terms of policy proposals or even to improve post-abortion care. In Nigeria the association between unsafe abortion and maternal mortality has been recognized for some time now, but once again no consistent policy has been adopted. These cases suggest that religious, cultural and moral constraints may also constitute an obstacle to achieving a clear and rational connection between unsafe abortion and maternal mortality at policy levels, and that systematic advocacy efforts are usually required to ensure that maternal mortality and abortion are articulated in policy – and not just epidemiological – terms.

But the sample also includes the positive experiences of Bolivia, Brazil, Uruguay and the Philippines. Ghana should also be mentioned as an example of progress made as – although for a long time there was a culture of silence around the issue of legal abortion as a strategy to reduce maternal deaths – early investments were made in post-abortion care and finally in 2003 steps were taken to fill the policy gap. Brazilian and Uruguayan policies and advocacy strategies adopted in the early 2000s consistently articulated efforts to reduce maternal deaths rates and the negative health impacts of clandestine



abortion. In the case of Uruguay, recognition of this epidemiological connection was in fact what triggered a near-successful campaign for legalizing the termination of pregnancy. In the Philippines the existence of a well-designed post-abortion care strategy should also be positively evaluated, given the regressive political climate, even though its implementation is not as positive as it should have been.

Maternal mortality : A major challenge worldwide

Lago (2006) did a literature review of Medline, LILACS and of MDG countries' reports and concluded that, since 1990, the decline of the maternal mortality was observed just in eight countries of the world. Three of them are in Latin America: Bolivia, Honduras and Chile. In case of the Bolivia, the decline is related to the introduction of the Mother and Child Health Insurance Scheme (SUMI), even when its precise assessment is difficult since records are not of good quality. In Honduras, maternal mortality declined from 200 deaths to 100 deaths per 100.000 live births between 1990 and 2000 under the impact of a strong vertical program that was made a priority by the government and received substantial financial resources from international donors. In Chile, rates had been declining since the 1950's, when the National Health System was created and midwives were engaged in pre-natal, delivery and post partum care. Given that reduction observed between 1990 and 2000 was really impressive, as rates went down from 40 to 19/100.000 live births. Once again, this resulted from a focused and sustained policy and financial investments.

These experiences indicate that reducing maternal death is not an easy task, particularly when rates have reached a relatively low level (around 50/100.000 live births). On the other hand these focused and vertical approaches and results contrast with the experience of other countries that have opted for the implementation of comprehensive women's health policies. One clear example is Brazil where, since the early 1980's the implementation of PAISM expanded health care beyond pregnancy and birth, to include including responses to sexual health, contraception, cervical cancer, DST/AIDS and gynecological care. Today SUS provides free care to 80 percent of the population. But in the specific case of maternal mortality this expansion has not yet been sufficient to substantially reduce the risks experienced by pregnant women. What is, therefore, lacking in the design and implementation of existing reproductive health policy as to transform this reality?

A Brief Summary

- Maternal mortality is the most widely and easily accepted component of the ICPD agenda and it has been given the status of a global priority, but this does not translate easily, automatically or adequately into national policy frames.
- One clear illustration of this inconsistency is the gaps and discrepancies in the collection and analysis of policy-relevant data.

- Research on maternal mortality requires substantive investment and often depends on systematic advocacy. Even when data exists, its interpretation is highly dependent on the quality of the statistical information.
- Striking contradictions can be identified with respect to the way the problem is prioritized or not in different country contexts. In the sample, the cases of Nigeria and Barbados indicate that maternal mortality is not a priority where it should be, whereas it is given great attention in a context where the rates are very low, to the detriment of other neglected S&R health issues.
- In the majority of the countries no consistent articulation is made in policy strategies between maternal mortality and unsafe abortion.

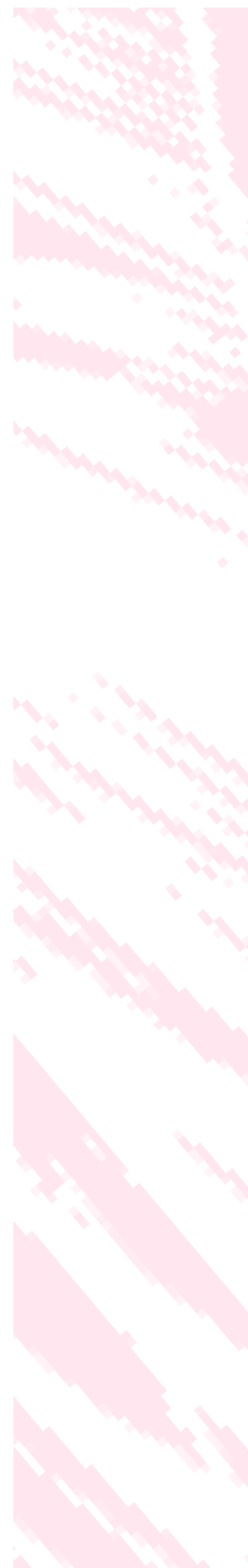
COUNTRY EXPERIENCES

Argentina

The Argentinean public health system has invested in conventional MCH programs since the 1950s. Since the late 1980s greater attention has been paid to maternal mortality and rates have been roughly stabilized between 40 and 50 per 100,000 live births. However, under the impact of the economic crisis evidence emerged pointing to an increase in maternal mortality rates, and this led to a renewed investment in research that may lead to the revision of maternal mortality reduction targets and strategies. Unsafe abortion is still a major cause of maternal mortality and a significant proportion of women who undergo clandestine abortions subsequently search for post-abortion care in the public health network. Calculations performed in the mid-1990s indicated that a quarter of female hospitalizations were due to abortion. Given the difficult political climate surrounding the issue, these women are very often subjected to degrading treatment and discrimination. Until 2004, when the country report was published, no policy measure had been adopted to improve treatment provided to incomplete abortion. But in August 2005 the Minister of Health issued a new protocol to improve post-abortion care. Though in mid 2006 its implementation at local level was still slow and problematic, this is to be considered a major step forward.

Bolivia

Bolivia is the Latin American country in the sample with the highest maternal mortality rates and the lowest rate for hospital-based deliveries. In 2002 a specific survey on the issue calculated the national maternal mortality rate to be 232 per 100,000 live births for the year 2000, suggesting that a decrease in death rates had occurred since 1994, when the estimate stood at 390 per 100,000 live births. However, the 1994 and 2000 results are not comparable because a different methodology was used in each case. Precisely for that reason the MoH decided to retain the 1994 data as the basis for



defining policy reduction targets, and wait for the results of a new DHS scheduled for September 2003. The same 2002 survey identified as major causes of maternal mortality: hemorrhages (38 per cent), infection (8.9 per cent), abortion (7.2 per cent), hypertension in pregnancy (5.1 per cent), obstructed labor (2.1 per cent), and other causes (37.5 per cent). The survey also found that 37.8 per cent of deaths occurred in the health services.

Available data on births attended in hospitals or by health professionals vary depending on the source of the information. While the 1998 DHS found that just 56 per cent of births were attended in hospitals, the *Human Development Report 2002* mentions 59 per cent. MoH data for 2000 refer to 158,000 births of which 87 per cent were performed in institutions. In any case, coverage is recognized as being extremely low, particularly in rural areas. A census performed among indigenous populations in the Llanos in 1998 detected that just 37 per cent of deliveries had taken place in hospitals or clinics. In 2001 10 per cent of all babies were born to young women between 10-19 years of age.

As previously mentioned, the Bolivian basic health insurance package included specific measures aimed at reducing maternal mortality, such as expansion of antenatal, hospital-based obstetric and post-natal care, as well as free and adequate care for first semester hemorrhages (mostly resulting from induced abortion). Between 1994 and 1998, 63 per cent of pregnant women received formal antenatal care, in comparison to just 50 per cent registered in the 1991-1994 period. In 2002, the National Health Information System (SNIS) reported that in that year a total of 754,000 antenatal consultations were performed, of which 70 per cent were provided by the public health system. First consultations before the fifth month constituted 44 per cent of these procedures.

Within the same framework complications resulting from incomplete or unsafe abortion have been prioritized as a national policy issue. Bolivia was the first country in South America to adopt a MoH protocol to guide post-abortion care and the post-abortion program that was developed includes both hospital-based care using curettage and ambulatory care using manual intra-uterine aspiration (MIA). A major institutional player in this area is IPAS, which provides technical assistance to the MoH and NGOs providing health services. IPAS data for the period from August 1999 to February 2002 shows that a total of 76 health services provided these procedures, of which five were tertiary-level hospitals, 25 were secondary-level hospitals and 46 were primary health care services. Through the IPAS program 1,723 providers have been trained for the first time and 238 were retrained. The number of procedures performed is presented in the following table.

TABLE 5: POST-ABORTION CARE IN BOLIVIA: PROCEDURES PERFORMED (2001-2003)

Technique Used	2000	2001	2002	2003 (first trimester)
Curettage	313	1386	2199	168
MIA	NA	623	1115	22
Curettage and MIA	NA	60	107	2

Source: IPAS Bolivia/MoH.

The other key component of policy concerns epidemiological surveillance. As early as 1994 maternal mortality was defined as a compulsory notification event. This was then followed by the creation, expansion and strengthening of maternal mortality committees at all levels and of community networks of people who could identify pregnancy risks and maternal deaths, and refer cases to the public health system.

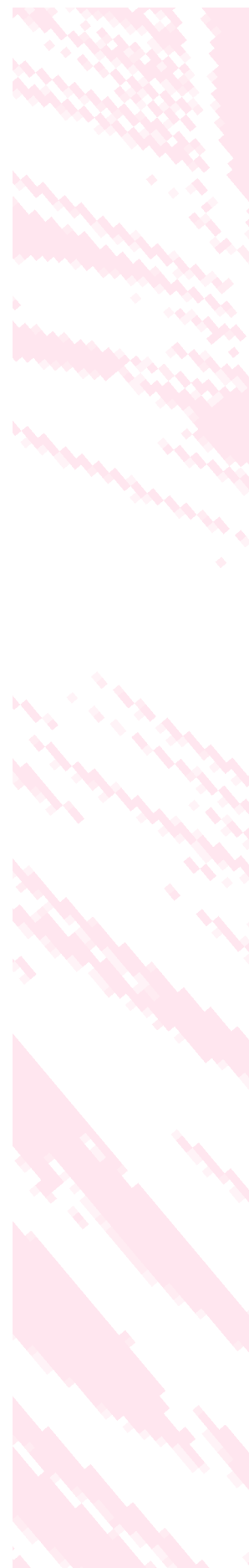
While recognizing the progress made, the country report considers the outcomes to be far from ideal and identifies as the main problems: a lack of regular follow-up of epidemiological data and health interventions; the high rate of turnover in personnel; a lack of coordination between MoH and local levels; the gradual loss of importance and the weakening of the communications strategies that had been vital in raising awareness when the policy was first implemented.

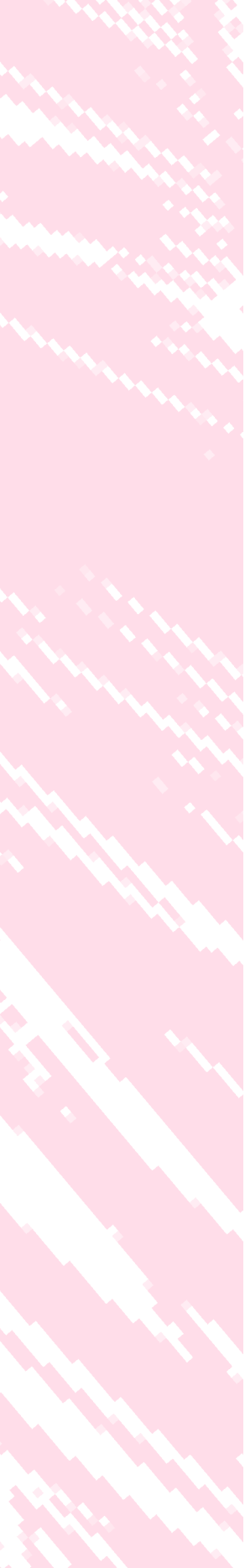
Brazil

In the late 1980s Brazil's maternal mortality rate was estimated at 115 deaths per 100,000 live births, a much higher figure than that registered in other Latin American countries with relatively similar socio-economic conditions. This figure was arrived at by an adjustment made through multiplying the number of maternal deaths registered in 1989 in the national system of mortality records by a factor defined on the basis of specific research into maternal death carried out in São Paulo. This, of course, created distortions because it did not capture regional disparities.

But in any case it was clear that the rate was unacceptably high and most importantly that this was so despite the fact that by that point in time already more than 80 per cent of childbirths took place in hospitals. The conclusions that can be drawn from this evidence are that maternal deaths can be explained mainly in terms of the lack of access to qualified antenatal care and of the poor quality of care during delivery. As in other countries, maternal deaths are also related to unsafe abortions, which is the fourth cause for the country as whole and the first cause in certain settings.

The estimate from the late 1980s would not be revised until 2002. But by the mid-1990s, as the SUS health information systems improved, it became clear that 65 per cent of these deaths occurred in hospital settings. In any case controversies persisted with respect to estimated maternal mortality rates that fluctuated, but showed an overall increase, during the 1990s: 44.6 per 100,000 in 1992; 48.3 in 1994; 44.1 in 1996; 58.5 in 1998; 46.8 in 2000. There has been a constant outcry by feminist and other voices about the "shame of maternal mortality in Brazil". In 2000 a Parliamentary Inquiry Commission on Maternal Death was set up, which would give the problem higher policy visibility. In 2002 the national women's health program funded a nationwide (in all 27 capital cities) project of research of mortality among women of reproductive age. The research outcomes permitted a new estimate of maternal mortality rates as well as the definition of an adjustment factor to correct distortions observed in existing data bases.





The research, performed by Laurenti and Jorge (2004), established as the average Maternal Mortality Rate for all capital towns was established at 54,3 deaths per 100,000 live births and observed a variation from 42/100,000 in the South to 73,2/100,00 in the Northeast. The adjustment factor for the totality of capital towns was of 1,4, which means a final adjusted maternal mortality rate of 76/100,000. Though in Brazil, roughly 90 percent of childbirths take place in hospitals, direct obstetric deaths corresponded to 67,1 percent of all identified events.

The research provided a more accurate picture of rates and trends at national level and in capital towns. But it did not cover smaller municipalities or rural areas, nor did it evaluate differentials in mortality patterns determined by class, ethnicity or race. To illustrate how these differentials are relevant in the Brazilian context, a research project carried out in the state of Paraná that reviewed 986 maternal deaths of women aged between 10 and 49 found that among black women the rate was almost seven times higher than among white women. In 2004 the Women's Health technical team announced that in the medium term new research on the magnitude of female mortality among women of reproductive age would be carried out to complement the 2002 database and to establish more consistent parameters for adjusting policy strategies.

Policy strategies to reduce maternal mortality adopted before 2002 were described in the previous chapter. In early 2003 the national epidemiological surveillance system finally included maternal mortality on its list of compulsory notification events, a policy measure that had been advocated since 1997. But the main post-2002 policy initiative was the Maternal Mortality Reduction Compact, launched on 8 March 2004. This new package set as its target the reduction of the national maternal mortality rate by 15 per cent by the end of 2006. In addition to strengthening PHPN (Humanizing Childbirth Program), it includes:

- centralized purchase and distribution of drugs to control pregnancy-related hypertension;
- emergency care for pregnant women provided by the newly created SUS Emergency Service (SAMU);
- restructuring of 1,000 small hospitals to ensure qualified obstetric care;
- discussion with blood banks about how to ensure adequate provision of the blood supplies needed to treat women experiencing hemorrhages during pregnancy, childbirth and abortion procedures;
- the discussion and adoption of a protocol to ensure high quality post-abortion care.

The compact was negotiated with state and capital city health managers and has been translated into state-level maternal mortality reduction strategies. Follow-up structures were set up at both ends of the policy spectrum: a working group was created at high MoH level and annual state levels reviews have been planned that include the participation and

contribution of health and maternal mortality accountability mechanisms (local and state-level health councils and maternal mortality committees) and women's organizations. In May 2006, when a new MoH campaign was launched – to promote natural childbirth and reduce unnecessary Cesarean sections – the Coordinator of the National Women's Health Policy preliminarily assessed progress made since 2004, in the following terms: *“The 2004 Maternal Mortality Compact has given greater visibility to the problem. The Ministry of Health has promoted training of 1,400 heads of obstetric services at 280 main maternity wards in the country, in order to achieve a change of paradigm in obstetric care. Since 2004, maternal mortality rates have been reduced by 8 per cent. The projection is that by 2007 a reduction of just 10 per cent will have been achieved. This is not what was foreseen, but it must be regarded as a positive outcome, since it is much harder to reduce maternal deaths than to diminish neonatal mortality. Factors behind maternal mortality imply much more than the quality of health services, involving social aspects such as malnutrition of pregnant women.”*⁴⁶

Finally, in relation to post-abortion care, as mentioned above, in 2003 a working group was created to elaborate a draft protocol. The protocol – “Technical Norm to Guide Humanized Care for Unsafe Abortion”⁴⁷ — was made public in December 2004. The main content of the norm is to guarantee that women experiencing post-abortion complications have access to public services and adequate care clearly stating that these women are in a circumstance of life risk and consequently health professionals would not be punished (for complicity with the “crime of abortion”).

The text not just ensure the right of clients and health professionals of confidentiality but also make clear that doctors and nurses should not denounce the woman to the police or judicial authorities.⁴⁸ The norm also defines technical aspects regarding the post-abortion procedure and care, including the referral to contraceptive assistance. The protocol was a major positive breakthrough. However, the text of the protocol also included an update of the 1998 regulations regarding access to abortion in the case of rape, among them a new rule concerning the requirement of documentation to prove the sexual violation. As it will analyzed in the next chapter, this new regulation caused a public controversy that would delay its full implementation at the level of service provision until late 2005.⁴⁹

Mexico

In the early 1990s a Committee on Risk-free Maternity was created, which before ICPD represented a key policy platform from which to advance the reproductive health agenda, and in particular unsafe abortion concerns. After 1994, maternal mortality would be addressed in the context of the broader reproductive health policy framework emerging from ICPD and advocated by the Mexican S&R health community. But, as previously mentioned, the parallel implementation of the second phase of the health reform program




⁴⁶ Translated and adapted from the interview published on the website of the Latin American Center on Sexuality and Human Rights (Centro Latinoamericano de Sexualidad y Derechos Humanos, CLAM). Available at:

www.clam.org.br/publicue/cgi/cgilua.exe/sys/start.htm.

⁴⁷ In Portuguese: *Norma Técnica de Atenção Humanizada ao Abortamento Inseguro*

⁴⁸ The full text reads as follows: “Confidentiality in health practice is a legal and ethical duty, except for the protection of the client and with her informed consent. The non compliance with this rule may imply a criminal, civil or ethical professional suit of the person that disclosed the information because of the harm this can cause to the woman”.

⁴⁹ This process was also affected by the Ministerial change of July 2005, when a new Minister of Health was appointed. A new text was finally adopted in September 2005.



would gradually narrow down the policy agenda along the lines defined by the basic health care package. As in other health reform contexts, this shift would also mean focusing on specific epidemiological problems in relation to which the impact of health investments could be more easily assessed. Not surprisingly, maternal mortality would, under Fox, become the main reproductive health priority.

In 2001, the national maternal mortality rate was estimated at 59 per 100,000 live births, the main causes of deaths being: (1) pregnancy-related hypertension; (2) post-partum complications; (3) hemorrhage; and (4) abortion. But great variations were observed across states, the highest rate being registered in Oaxaca and the lowest in Baja California (85 and 10 deaths per 100,000 live births, respectively). Between 1989 and 1991, 4,409 maternal deaths were registered in the country. Official data for the year 2000 shows that antenatal care covered 80 per cent of pregnant women in that year. Among them, 80 per cent attended more than four consultations. Concerns remain, however, in relation to the quality of care and, in particular, to the fact that coverage is much lower among indigenous and illiterate women.

Abortion-related mortality accounts for 8 per cent of all maternal deaths in Mexico. Post-abortion family-planning services have existed for a long time now. More recently, in order to improve the quality of incomplete abortion care, IPAS has invested in the expansion of manual intra-uterine aspiration (MIA) in public hospitals. The technique can be carried out in primary health care units, it minimizes anesthesia risks, and reduces the hospital stay as well as costs.

In 2001, a new program was launched – Fair Start in Life – aimed at expanding and improving the quality of antenatal, obstetric and post-partum care, and childcare. This new health strategy is closely connected to broader poverty reduction policies. While the emphasis on maternal mortality reduction and poverty alleviation can be seen as positive, the content of the program meant a rupture with the post-Cairo agenda in that it essentially restores the conventional MCH approach, with the addition of the prevention of HIV/AIDS vertical transmission. As a result, Fair Start in Life leaves aside previous efforts aimed at better integrating contraceptive assistance and MCH care, post-abortion care, and cervical and breast cancer prevention and treatment. It also excludes broader and more consistent strategies for HIV prevention among women, beyond the emphasis on abstinence that characterizes the HIV-Youth program led by Cristina Fox (the President's daughter).

The country report highlights these conceptual limitations and biases, and raises concerns with respect to the management of both programs, as they are directly presided over by the First Lady and the President's daughter. This "presidential cabinet" approach departs from the previous institutional framework through which policy change had been developed after 1994-1995. Even if a consultative body, on which civil society organizations have a seat, was created to monitor the maternal mortality reduction program, until 2004

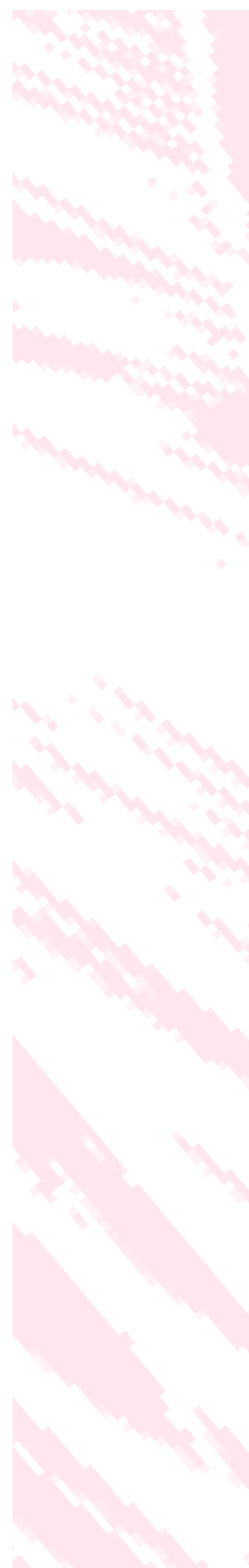
its operation remained highly concentrated in the First Lady's office. Most importantly, funding for the program is not exclusively public, but rather relies heavily on an endowment provided by a private foundation created by the Mexican telecommunications enterprise (Telmex) privatized in the early 1990s.

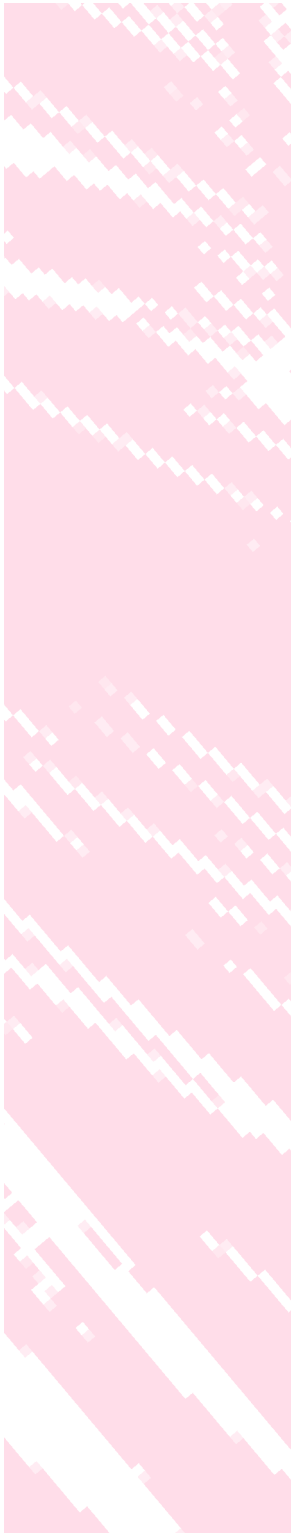
Uruguay

In Uruguay, 99 per cent of births take place in hospitals and are attended by qualified professionals. Antenatal care has steadily expanded its coverage over the last few decades. However, in 1999 roughly 10 per cent of pregnant women did not receive any kind of antenatal care. Although these indicators are very positive in comparison with other countries in the DAWN sample, some distortions may be observed in terms of the prevailing model of antenatal and obstetric care. Between 1977 and 2000, the proportion of deliveries attended by an obstetrician rose from 39 per cent to 64 per cent, which has meant the gradual disappearance of midwives as providers of antenatal and obstetric care. This trend is directly associated with the decrease in the numbers of natural childbirths, and the parallel increase in the proportion of Cesarean sections (from 15 per cent to 23 per cent nationally and reaching 27.6 per cent in Montevideo).

In the early 2000s maternal mortality rates were the lowest in the Southern Cone. Between 1990 and 2002, 173 maternal deaths were registered; as during this period there were 716,671 births, this corresponds to a rate of 2.4 deaths per 100,000 live births. During this period unsafe abortion accounted for 27 per cent of deaths and already appeared as the main independent cause. But in 2001, in the Pereira Rossell Hospital, which is the main tertiary-level referral facility for obstetric care, abortion-related mortality rose to 49 per cent. As mentioned before, this increase coincided with the impact of the social and economic crisis that deepened during the period of financial instability from 1999-2000. This rise in abortion-related maternal mortality differs from the norm in most countries in the world and in Latin America itself, since abortion usually appears as the second or third main cause of maternal deaths.

With respect to post-abortion care, until 2001 incomplete abortions received conventional treatment. One deficiency observed in relation to those services was that no systematic referral was made regarding contraceptive assistance. However, as the issue gained visibility, the group *Iniciativas sanitarias*, involving doctors and feminists, developed new guidelines to orient pre and post-abortion care: "Maternal protection measures in situations of unsafe and risky abortion". In addition to setting criteria and standards for treating incomplete abortions, which include referral to contraceptive services, these guidelines are very innovative in that they also cover pre-abortion counseling. This novel component is based on a damage-reduction framework: if unsafe abortion is a reality that will not





easily disappear and meanwhile abortion remains illegal, the health sector is ethically compelled to take measures to prevent the potential damage caused by clandestine practices.

The protocol provides detailed instructions on how to address a situation in which a woman informs the practitioner that she has decided to resort to an abortion. It develops ethical standards of confidentiality and respect for the woman's decision, and information about existing procedures and risks. It also lists basic prophylactic measures that must be adopted in these circumstances, such as risk assessment and the use of antibiotics to prevent infection. The norms were approved by the Uruguayan Gynecological Society, the Council of the National Medical School and the Executive Committee of the Uruguayan Medical Union. The Ministry of Health adopted the Protocol on August 2004. Until late 2005, its implementation was affected by a combination of factors: the electoral process, the administrative transition and the political climate regarding abortion. But since then investments have been made to ensure access to pre and post abortion care and, more recently (July 2006) it became possible for public health professionals to perform an abortion for economic reasons without being subject to punishment.⁵⁰

Caribbean Countries

Barbados

Antenatal clinics provide care for pregnant patients, monitor progress and initiate early interventions where the risks of complications are evident. The specific aim of the program is to promote early registration of antenatal patients by the 12th week of gestation and regular check-ups thereafter to monitor maternal health and fetal growth as well as to prevent medical complications affecting both the mother and the fetus. Data for 2000-2001 shows that approximately 49.9percent of antenatal clients registered in the first 16 weeks and that teenage pregnancies represent 24percent of total pregnancies.⁵¹ All pregnant women seen in polyclinics are referred to Queen Elizabeth Hospital between 30–36 weeks for continued care and delivery.⁵²

Jamaica

The MoH has taken several measures to reduce maternal mortality, which has led to a decrease. The field questionnaire prepared to inform the ICPD+10 review process in 2004 lists the following efforts:

- Special high risk antenatal clinics function in each parish;
- Special adolescent antenatal clinics at the country's largest maternity facility;
- Access to emergency obstetric care in each parish, including special facilities for transportation and referral to higher levels of care;
- High risk antenatal registers in each parish to identify women who need home visiting to ensure compliance with care;

⁵⁰ *In the exiting abortion law one of the circumstances in which the judge can waive the punishment is economic reasons.*

⁵¹ MoH. *Annual Report of the Chief Medical Officer 2000-2001*. November, 2002

⁵² *Ibid.*

- In-clinic education for all antenatal clinic attendees regarding warning signs in pregnancy and the appropriate courses of action to take.

According to Pate (1997) unsafe abortion complications were among the leading causes of maternal deaths in Jamaica. But no specific policy guidelines are in place regarding the quality or improvement of post-abortion care.

Surinam

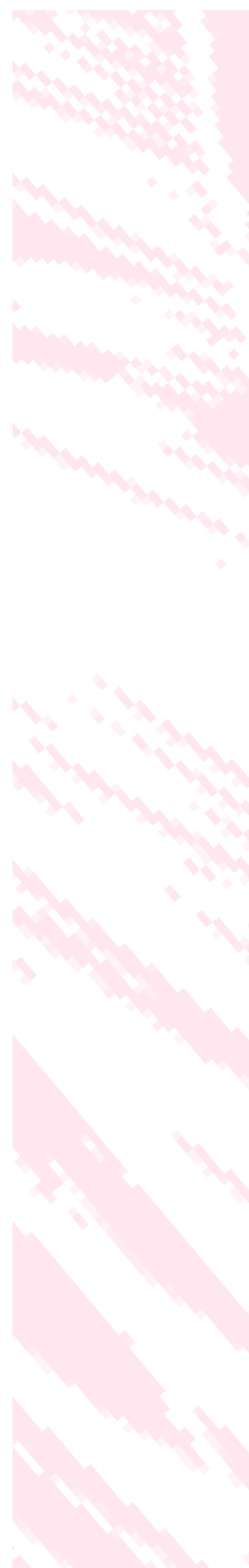
Between 1986 and 1994 maternal mortality was the fifth leading cause of death in women. But the Bureau of Public Health, which collects the data, claims that there are difficulties involved in extrapolating from this information the conventional per 100,000 live births' ratio. In 2003 the General Bureau of Statistics announced that funds were being mobilized to collect the most essential data. There is no policy as yet on maternal mortality, although rates are alarmingly high. A study conducted from 1991-1992 stated that most incidents of maternal mortality were due to post-delivery hemorrhaging and pregnancy-induced hypertension, which accounted for 29 per cent and 19 per cent respectively of such cases. As Ketwaru-Nurmohamed (2001) states, these deaths could have been avoided if there had been timely transportation and blood transfusion available.


It is important to note that health workers in the interior of the country report malnutrition and chronic anemia among women and children. The anemia gets worse when the woman gets pregnant. Women themselves do not regard it as a problem, but are in great danger if the slightest thing goes wrong during delivery. There are also reports that within the Maroon community there is a lot of pressure to have many children starting at an early age. As a result, women in difficult economic conditions exhaust their bodies by having a baby every two or three years. The extra risks involved in teenage pregnancies have caused some doctors in the interior and rural areas to refer all teenagers to the capital for their first delivery (Guicherit 2002).

No post-abortion care is provided: abortion takes place as a polyclinic consultation and the patient is supposed to leave immediately after surgery. Anecdotal evidence suggests that surgeons tend to be more concerned about money than consultation services. When questions were asked these were purely medical, and comments tended to be denigrating. This means an opportunity is missed every time to find out how the unwanted pregnancy came about, and how the client plans to prevent it from happening again in the future. Since abortion that is not by medical recommendation is illegal, no policy or protocol exists, there is no training, and it definitely has no place in the HSR debate.

Trinidad and Tobago

The "Policy for the Reorganization of the Population Program Unit to Establish Sexual and Reproductive Health Services in Primary Health Care"





aims to improve the quality, availability, accessibility, and use of S&R health services, of which maternal health is a part. As one of its broad objectives, this policy proposes to reduce levels of maternal mortality through the improvement of antenatal, delivery and post-natal care. Ahmed (2005) informs that in 1999 a PAHO/WHO identifies Trinidad and Tobago as one of the countries in the region where abortion and its complications were the leading cause of maternal morbidity.

This widespread practice of abortion is clearly a major public health problem. Every year unsafe abortion was among the top ten leading causes of admission, competing with intestinal infections, other injuries, and skin infections. In at least two years, 1991 and 1992, post-abortion complications – including bleeding, fistula, pelvic infection disease and sepsis – were the leading cause of hospital admission. ASPIRE claims that these complications could be avoided if the government decriminalized abortion so that safe services could be provided to all women.

On average, each woman spends approximately four days in the hospital, and requires blood tests, blood transfusions, medication and IV treatments. It is estimated that the government spends approximately \$9 million a year treating women who are suffering complications from unsafe abortions, and that more than a third of gynecological beds are occupied by post-abortion complication cases. According to ASPIRE (2000), 90 per cent of medical practitioners interviewed believed that a civil law would reduce the number of complications, while 65 per cent agreed that a civil law would save the government money. Although they were divided over the extent to which a civil law would improve maternal health, more than half (56 per cent) felt that it would, while only 36 per cent felt that it would not. None of the medical practitioners interviewed thought that the law was either effective or fairly effective. Despite this fact, the law remains unchanged.

Ghana

In Ghana, as elsewhere, accurate statistics on maternal mortality are scarce. In particular not much is known about how unsafe abortion contributes to those rates or about abortion-related deaths. Current data available on maternal mortality varies depending on the source and the method of data collection. In 1993, the Ghana Statistical Service conducted a community-based study using the sisterhood method and documented a national maternity mortality ratio of 214 per 100,000 live births, with a lifetime risk of dying from maternity-related causes of 1 in 71 pregnancies. More recent figures for maternal mortality range from 98 per 100,000 in urban areas in Southern Ghana to 870 per 100,000 in rural areas, with a national average of 214 per 100,000 live births (GDHS 2003). There are also regional variations in the maternal mortality rate: it is highest in the Upper East, Upper West and Northern regions. One of the reasons for the wide variation in data is that maternal death is not yet a compulsory notification event. The other is

that the cause of death is often ambiguous making it difficult after death to identify the precise cause of death.

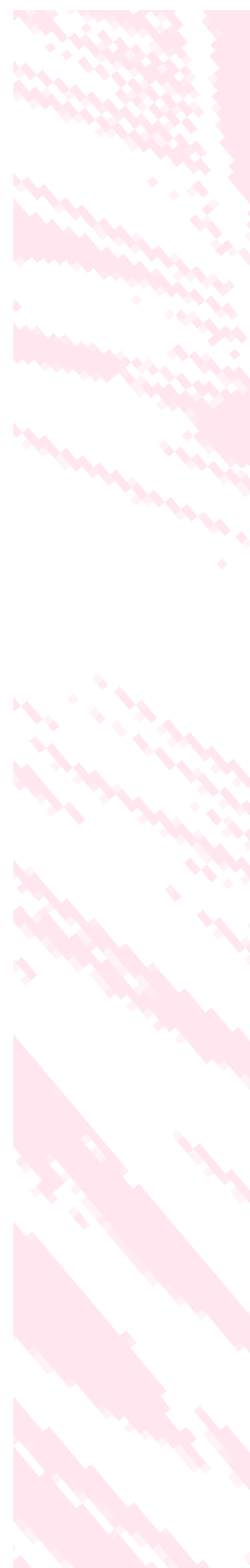
Reduction of maternal deaths was prioritized in the reproductive health policy guidelines adopted in the 1990s, with a target being set to reduce the rate from 214 per 100,000 live births in 1997 to 100 per 100,000 live births by 2001, and to increase birth intervals to an average of 3 years by the same year. These objectives were to be achieved using concepts of primary health care (PHC), outreach and community-based activities, health education, promotion of appropriate technology and collaboration. A civil society initiative also exists that contributes to these efforts: the Prevention of Maternal Mortality Network (PMMN), which has a good database and library.

The main policy investments made since the late 1990s were:

- Three new regional hospitals were built that provide obstetric care;
- Additional district hospitals and health centers were built and upgraded;
- Adoption of the community-based approach to health services and planning (CHPS) through the placement of health nurses within communities, who work with the community health committee to improve the health of the community;
- ^a Integration of vertical programs in service delivery;
- Evidence of resource shift from the centre and tertiary institutions to the districts;
- Improvement in coverage of antenatal services, leading to double the number of antenatal registrants;
- An increase in supervised deliveries to 52percent in 2000;
- An increase in post-natal coverage rates.

Though the 1990s policy documents recognized the impact of unsafe abortion on maternal mortality, abortion issues were exclusively “*dealt with under prevention and management of unsafe abortion and post-abortion care. No specific mention is made of abortion in the safe motherhood indicators*”. Over the last ten years, measures adopted in this area include post-abortion care training for midwives in the use of Manual Vacuum Aspiration (MVA) under local anesthesia as treatment for incomplete abortion, initially spearheaded by IPAS International and later taken up by the MoH. The MoH has also invested in creating public awareness of the dangers of unsafe abortion, prevention of unwanted pregnancies and education of clients on the complications of abortion, and MVA services are being decentralized to district levels.

One limitation that emerges from the country report is that by 2004 the 1993 maternal mortality estimates had still not been reviewed. Since field observation by MDs suggests that these rates are either stagnant or may have even slightly increased, new research and estimates are urgently needed to evaluate and subsequently adjust the policies implemented in recent years.



Box 19: A Survey of Ghanaian health facilities

The Ghana research included a survey of managers and professionals working in six health services providing obstetric care: two teaching hospitals, two district hospitals, and two NGO services. In one teaching hospital the research focused on the legal abortion services provided. The two NGOs do not provide legal abortion services, but offer post-abortion counseling and management of incomplete abortions using manual vacuum aspiration. The main findings relating to post-abortion care and the link between abortion and maternal deaths were:

- The commonest post-abortion complications presented to the institutions surveyed included: bleeding, uterine perforation, sepsis, peritonitis, renal failure, infertility and chronic pelvic pain.
- NGO services did not mention deaths.
- In Nsawam Hospital, a district unit in the Eastern Region, no figures were available specifically for abortion-related deaths until 2002.
- In Juaben Hospital, another district hospital in the Eastern Region, in 2001, 27.5 per cent of complications seen in the obstetrics service were due to abortion. No figures were recorded for maternal mortality until 2002.
- Komfo Anokye is a teaching hospital, which is a tertiary referral centre in the Ashanti region, the second most populous region in the country. In 2001, two maternal deaths were attributable to abortion.
- Two of the surveyed institutions did not see the obvious maternal morbidity and mortality connections with unsafe abortion. Indeed, it was very difficult to identify actual mortality figures attributable to illegal abortions; to do this the study would have to be extended to examine data from regional mortuaries.

Health institutions generally only admit to offering post-abortion care services and professionals use euphemisms such as “manual vacuuming” and “family planning” even when it is obvious that abortion services are available.

Nigeria

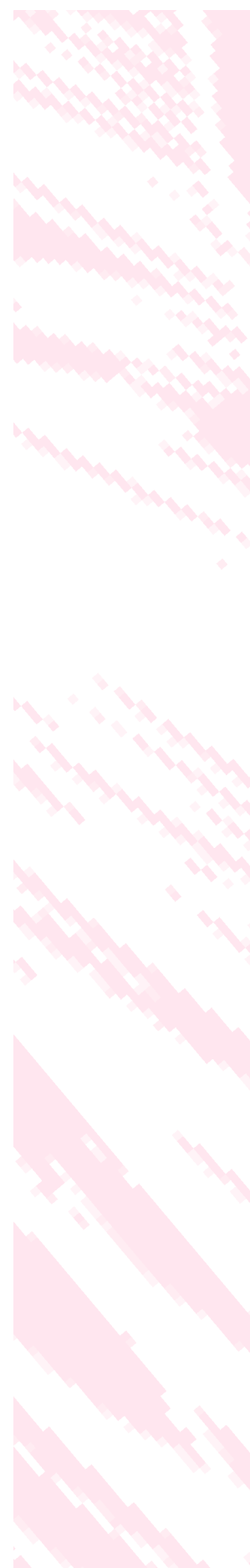
Statistics on maternal mortality in Nigeria vary quite widely. In 2000, WHO estimated the rate at 800 deaths per 100,000 live births. In 2002 the research by Oye-Adeniran and colleagues provided a higher estimate of 1000 deaths per 100,000 live births. The National Reproductive Health Policy and Strategy to achieve Quality Reproductive and Sexual Health for all Nigerians adopted in 2001 uses the 1999 Multiple Indicators Cluster Survey (MICS), conducted by the Federal Office of Statistics in collaboration with UNICEF to estimate “maternal mortality ratio at 704 deaths per 100,000 live births, with a wide geographical disparity ranging from 166 per 100,000 live births in the Southwest to 1,549 per 100,000 live births in the Northeast (Madunagu and Olaniran, 2005)

An estimated 40 per cent of pregnant women experience pregnancy-related health problems during or after pregnancy and childbirth. More than 70 per cent of all maternal deaths are due to five major complications – hemorrhage, infection, unsafe abortion, pregnancy-related hypertension, and obstructed labor – while 15 per cent of women suffer serious or long-term complications such as pelvic inflammatory disease and infertility.

Low levels of access to and utilization of quality reproductive health services play a significant part in the high maternal mortality rate in Nigeria. Only 31 per cent of deliveries, for example, were recorded by the 1999 NDHS to have taken place within health facilities. Maternal deaths as a result of high-risk teenage pregnancies also contribute significantly to the high maternal mortality rates recorded in different parts of the country, while complications resulting from unsafe abortion account for 30-40 per cent of all maternal deaths in Nigeria. As has already been mentioned, the 2001 policy guidelines set as a target the reduction of maternal deaths by 50 per cent by 2006. The guidelines also recommend improvements in post-abortion care, but fail to mention paragraphs 8.25 from the ICPD Program of Action and paragraph 106.k from the Beijing Platform for Action that call for a review of existing punitive legislation.

As mentioned before, since 2001 studies have been carried out to generate greater understanding of the problem such as the one performed by Engender Health that — which in addition to identifying the various obstacles listed in the previous chapter — concludes that despite high level of awareness of exiting policy guidelines among key MoH officials, this information had not been effectively disseminated to lower levels of implementation. The report also underlines that several policy and legal barriers still exist, which hinder access to maternal services.

Lastly, it is important to analyze briefly the circumstances surrounding unsafe abortion and its impact on maternal mortality. It is estimated that 610,000 abortions are performed each year. According to research by the Committee Against Unwanted Pregnancy (CAUP), the complications resulting from unsafe abortion include: infection (29percent), uterine perforation (14percent), bleeding (13percent), bowel injuries (3percent), genital tract infections (2percent). In the same study, 16.5 per cent of women experiencing complications did not receive medical treatment. This is compelling evidence that, despite much investment in research to understand better the correlation between unsafe abortion and maternal mortality, a consistent policy to make services accessible and improve post-abortion care is not yet in place.



Box 20: Maternal health services in Cross River State

In Nigeria the DAWN research included a survey of four maternal health facilities in Calabar, which is the capital town of Cross River State: the Maternity Annex at the University of Calabar Teaching Hospital (UCTH) (a public tertiary level facility); the General Hospital (a public secondary level facility); the NYSC Clinic (a public primary level facility); and the Biocee Maternity Home (a private health care facility providing primary and some secondary level care). The survey examined knowledge among personnel of existing policy guidelines, staffing, availability of basic and comprehensive emergency obstetric care, correlation between antenatal care and delivery figures, and identification of maternal mortality cases in the facilities between March 2002 and February 2003. The main findings of the survey were:

Knowledge of policy guidelines – The National Reproductive Health Policy was available and known by personnel at the General Hospital. But it was not available or known at the Maternity Annex of UCTH, the highest-level facility in Cross River State), nor at the NYSC Clinic or Biocee Maternity Home.

Staffing – The UCTH Maternity Annex had 37 obstetrics and gynecology doctors (O&Gs), 27 resident doctors and 131 nurses/midwives. In contrast, the General Hospital had only one O&G doctor and 10 MDs specializing in other areas and 237 nurses/midwives. The NYSC Clinic had 5 untrained traditional birth attendants on its staff. The Biocee Maternity Home had 1 visiting doctor, 1 nurse/midwife and four properly qualified visiting matrons. In 2002 no nurse/midwife or doctor in any of the four facilities was trained in Life Saving Skills (LSS).

Care provided – The UCTH Maternity Annex is staffed and equipped to deal with deliveries in pregnant women with various complications. The General Hospital only carries out normal deliveries, obstructed deliveries and Cesarean sections. The NYSC Clinic takes only normal deliveries, while the Biocee Maternity Home does the same, but the visiting doctor does vacuum extraction on rare occasions.

Antenatal and delivery care discrepancies – The percentage of women who delivered at the four facilities in relation to the number of those who were registered in the facilities for antenatal is very low: just 18 at the Maternity Annex, 43 at the General Hospital, 19 at the NYSC Clinic and 41 at Biocee Maternity Home. These discrepancies are problematic as they suggest problems in the referral system and most importantly the “loss” of pregnant women that may have been at risk. As the country report points out, this raises a series of questions: Where did these women deliver? What were the outcomes of their pregnancies? What are the factors behind this trend: cost of delivery care? Ill-treatment by health personnel? Lack of transportation at the time of delivery? Religious or cultural beliefs?

Maternal deaths – 25 maternal deaths were identified in the period under study (March 2002-February 2003), 23 of which occurred at the Maternity Annex and 2 at the General Hospital. This pattern is explained by the fact that UCTH facility is the one to which complications are referred. No deaths were recorded at the NYSC Clinic or Biocee Maternity Home. The top four causes of maternal deaths at the Maternity Annex were cervical cancer (6 or 26.1 percent of total cases), septic abortion (5 or 21.7percent), anemic heart failure (4 or 17.4percent) and eclampsia (3 or 13.0percent). These figures strongly indicate, on the one hand, that consistent strategies to reduce maternal mortality in Nigeria must identify and tackle unsafe abortion as one of its main causes. On the other hand, they also suggest that maternal mortality reduction strategies must be articulated with broader policy responses to S&R health in order to prevent health problems that appear as associated causes of these deaths, such as cervical cancer and anemia.

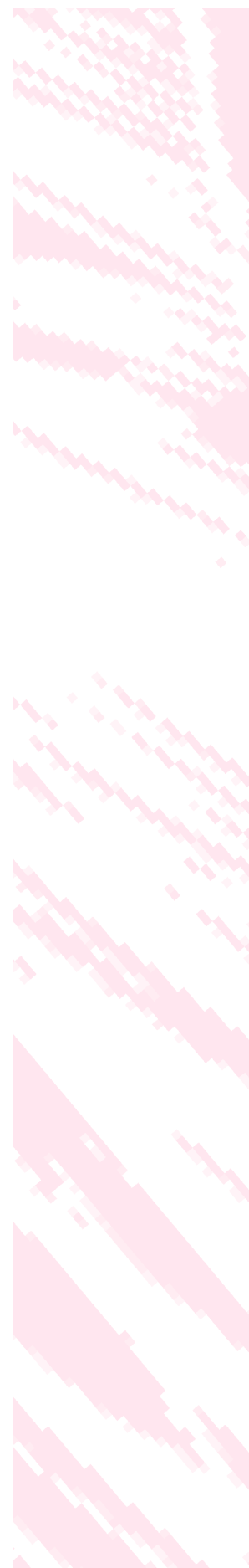
The Philippines

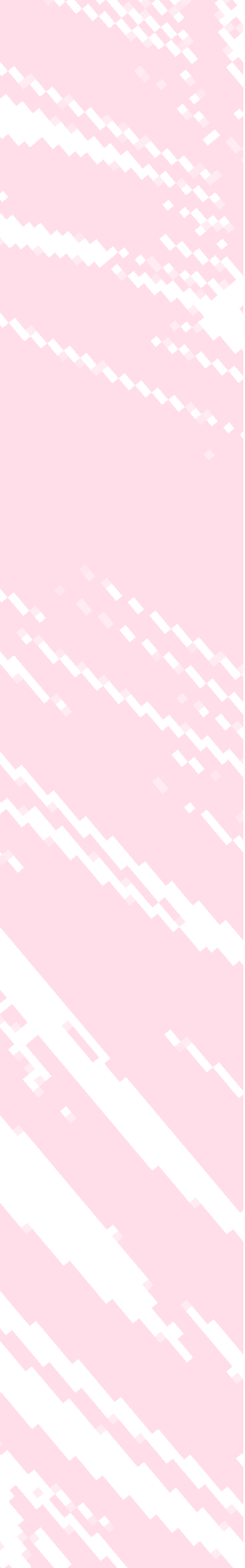
The country report informs that in 1998 maternal mortality rates were estimated at 60 per 100,000 live births (Viado, 2005). In 2003 the Philippine Report on the Millennium Development Goals stated that the lifetime risk of dying from maternal causes is about one in every 100 Filipino women. Maternal deaths represented less than 1 per cent of total deaths in 1998, but accounted for about 14 per cent of all deaths among women of childbearing age. Hypertension (27 per cent), postpartum hemorrhage (18 per cent), abortive pregnancy (9 per cent), and pregnancy-related hemorrhages (8 per cent) were the main causes of maternal deaths in that year. Filipino women continue to be deprived of adequate professional obstetric care. Still today, a substantive proportion of antenatal, delivery, and postpartum care remains in the hands of traditional birth attendants.

The Second Women's Health and Safe Motherhood Project, drawn up in February 2003, set a target of reducing the maternal mortality rate from 60 to 40 per 100,000 live births by late 2004 (funded with US\$ 40 million from the World Bank). It focuses on the key factors in women's lack of access to health and safe motherhood, such as financial and physical problems, poor transportation in emergencies, lack of skilled personnel and problems arising from devolution. It is a six-year project that aims to: (a) assist disadvantaged women of reproductive age gain access to high quality and cost-effective reproductive health services and enable them to attain safely their desired spacing and number of children; (b) assist in the development and implementation of systems within the framework of the Health Sector Reform Agenda (HSRA). The project provides support to local delivery of women's health and safe motherhood service package and to the national structures that sustain decentralized health care.

Unsafe abortion is major public health problem. A study by the University of the Philippines Population Institute (UPPI) in 1994 reports 300,000 to 500,000 cases of induced abortions a year, or 46 induced abortions every hour. One in every five of these cases ends up in hospital due to complications. Based on 1994 DoH records, 12 per cent of maternal deaths were due to abortion-related complications, and the most vulnerable are poor women. From 1994-1998 abortion and related complications were the third leading cause of hospitalization in DoH-managed hospitals.

In the light of the above data, in May 2000, the DoH issued the Prevention and Management of Abortion and its Complications policy (PMAC) that aimed to address "the health and medical care needs of many Filipino women who have had abortions, regardless of the cause." This program is so far the only MoH abortion-related regulation adopted since the Ramos Administration instituted the Philippine Reproductive Health Program in 1998. The policy document addresses not only the medical aspects of abortion but also its other social dimensions, namely prevention, treatment and counseling. Its goal is to "improve the quality of health care services for the





prevention and management of abortion”. In 2001 reproductive health advocates and progressive parliamentarians presented to Congress House Bill 4110, or the Reproductive Health Care Agenda Act, to provide a legal framework for this policy initiative. But as will be seen below, the Catholic Church immediately attacked the proposal and the debate did not follow through.

Given the overall conditions of S&R health in the country, the policy initiatives on maternal mortality reduction and post-abortion care described here are clearly an advance. But the country report raises concerns regarding their implementation and outcomes. In relation to maternal mortality, attention is called to the fact that the Basic Health Insurance Scheme does not cover a wide range of women’s health needs and this may have unexpected impacts on pregnancy risks. Most importantly, the prevention and spacing of pregnancies is highly compromised as publicly delivered family planning has dropped to its lowest levels after the shift in emphasis to only natural methods. In addition, four years on the implementation of PMAC remains rather weak. Research by Likhaan (2004), a respected women’s health organization, found that quality post-abortion care is not yet obligatory in government hospitals and women’s experiences with medical personnel range from refusal of admittance, discrimination, public humiliation, treatment without anesthesia, to abandonment after treatment.

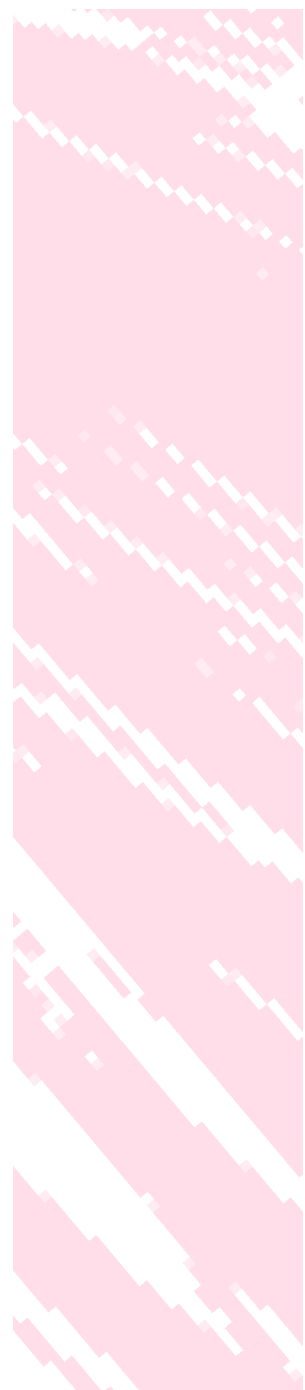
Last but not least, the country report underlies the lack of government commitment and funding. When it was being completed the Arroyo government was in a very precarious position, facing its most serious political battle for survival amidst charges of corruption and fraud during the last presidential elections.

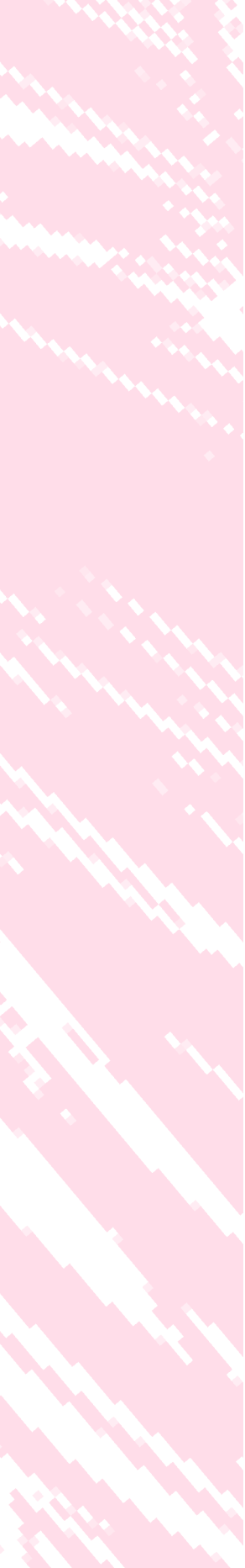
X. Unsafe abortion and law reform: Ongoing struggles

In most countries in the DAWN sample the S&R health advocacy agenda and current policy debates go beyond the consistent inclusion of unsafe abortion in maternal mortality policy frames. As shown in Box 21 below, in Barbados and Ghana abortion performed by a medical doctor is legal, whenever certain criteria defined by law are fulfilled. In all other countries abortion is illegal. But except in the cases of Jamaica, the Philippines and the Penal Code of Northern Nigeria, existing legislation includes exceptions, such as when the woman's life is at risk, rape, incest, and fetal abnormalities. Even in the case of Jamaica where the law is very restrictive, Common Law precedents provide margins of access to abortion, so long as it is performed by medical doctors.

Another striking commonality across the countries is that two cycles of legal reform efforts aimed at eliminating the penalization of abortion can be identified. The first key period in most cases is the 1980s, when either the issue was raised for the first time or, as in the case of Barbados and Ghana, abortion legislation was effectively reformed. The second period of reactivation of abortion struggles began in the mid 1990's and clearly intensifies after 2000, despite the unfavorable global political climate. In the period under study in the DAWN research, efforts aimed at reforming national abortion legislation or at addressing the health risk of unsafe abortion were presented in Argentina, Bolivia, Brazil, Uruguay, Trinidad and Tobago and even the Philippines, where the abortion debate was practically silenced following the 1987 Constitutional Reform. Also in the case of Mexico, a state-level legal reform had occurred in the Federal District.

Another aspect to be highlighted is that the advocacy strategies and political through which unsafe abortion become a policy issue in public arenas are also different in each of these periods and vary across countries. By and large the legal reforms that have occurred in the 1980s were rather "silent" and involved a relatively small groups of actors, in particular medical doctors and policy makers, of which the Barbados case is a compelling illustration. In contrast, during the same period, in Brazil and the Philippines abortion gained visibility as a national policy issue in the context of post-dictatorship Constitutional reforms.





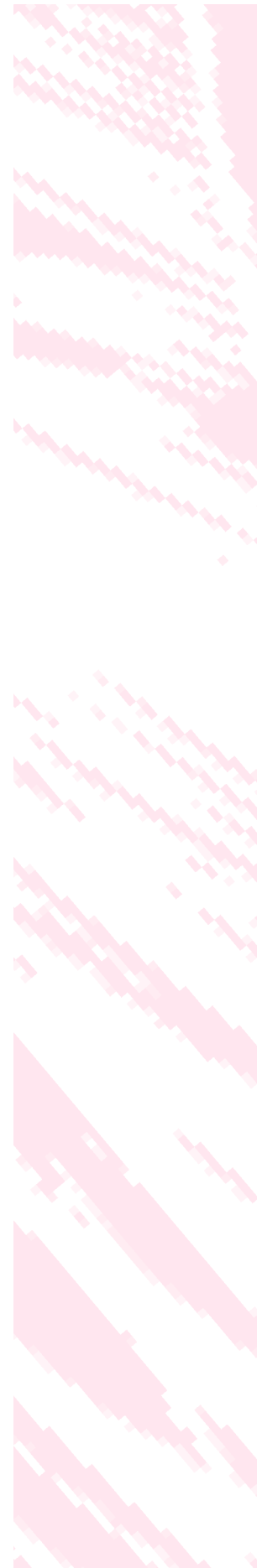
Current abortion debates and initiatives for legal reform are evidently much more “noisy” than they had been in the 1980’s. They also involve a much wider range of political actors as well as public campaigns. One exception is Ghana where present efforts to make the existing legislation better known and safe abortion more accessible are unfolding in a manner that has much in common with the strategies adopted in the 1980s in Ghana itself and the Caribbean). Though this greater visibility is partially due to the 1990’s global debates, it is also related to openings provided by democratization in the last twenty years, as limited as the exercise of democracy may still be. Most principally the public mobilizations implied in current abortion debates is, eventually, the only strategy that can respond and contain the expanding conservative attacks on abortion.

It should be said as well that contemporary abortion reform struggles are at different stages. The same applies to legislative process they have enhanced; and their degree of success also varies across countries. It is true that nowhere a comprehensive progressive reform has yet been achieved, and everywhere conservative forces have played a major role in blocking progress. But in practically all the countries, abortion rights advocates are resorting to innovative and creative mobilizing strategies and media campaigns.

In addition to legal reform processes, activists are closely watching individual cases to support women who have been prosecuted or to denounce cases of non-compliance with the exceptions defined by law under which abortion may legally be performed. In our sample, this type of strategy has been used in Brazil to provoke a Supreme Court decision on abortion in the case of anencephaly and also in Mexico where one abortion case directly related to sexual violence – the Paulina case – was taken to the Inter-American Commission on Human Rights. It is also worth mentioning that in Ghana, where existing legal provisions did not eliminate the practice of unsafe abortion, since 2003 policy guidelines have been adopted to increase knowledge of the law among women and health care providers. Lastly, in Nigeria, where policy conditions are very restrictive, strong and articulated advocacy efforts exist to stimulate public debate on unsafe abortion and its relation to maternal death rates. These trends and realities should be highlighted and valued as extremely positive signs of vitality and resistance, bearing in mind the regressive political climate prevailing at global and most national levels.

Box 21: Abortion Laws in Latin American Countries

Country	Abortion Laws
ARGENTINA	The first chapter of the Penal Code, which deals with “crimes against persons”, defines abortion as a crime (articles 85 and 86). The original text of the code dates from 1921. Although the Code has been modified on various occasions since then (the last reform was in 1984), the definition of abortion as a crime against life has been retained. The second paragraph of article 85 establishes the two circumstances in which abortions performed by a doctor are not penalized. The first is when the woman’s life is at risk and the second is in cases of rape, although only in those cases where the victim is mentally disabled and her legal guardian requests legal authorization.
BOLIVIA	Article 266 of the Penal Code states that abortion will not be penalized in cases of rape, kidnapping (if the perpetrator does not subsequently marry his victim), incest and when the woman’s life is at risk.
BRAZIL	Article 124 of the 1940 Penal Code defines abortion as a crime and establishes two circumstances in which it is not penalized: when the woman’s life is at risk and in cases of rape.
MEXICO	In Mexico, Penal Codes vary from state to state and consequently the restrictions on abortion are not universal. While in Yucatan abortion has been legal since the 1920s (although not easily accessible), in most states it is allowed only in cases of rape and when the woman’s life is at risk, while in a few it is restricted only to the latter type of cases. The Federal District Penal Code was reformed in the year 2000 and access to abortion was expanded to include cases where the woman’s health is at risk and severe fetal abnormality, and services were established to ensure effective implementation. URUGUAY In Uruguay, abortion was decriminalized when the Penal Code was re-written in 1934, but made illegal again in 1938. Law No. 9763, which is still in effect, fixed a penalty of 3-9 months’ in prison for women who abort and a 6-24 months’ prison sentence for the person who carries out the procedure. If the woman dies, imprisonment in the latter case is extended to 3-6 years. But there are attenuating circumstances allowing judges to use their discretion to reduce the penalty or even to waive the woman’s punishment: to defend the honor of the husband, wife or other member of the family, in cases of rape, and for reasons of health or economic necessity. For these attenuating circumstances to apply, the abortion must be performed within the first three months of pregnancy.



Box 22: Abortion Laws in Caribbean Countries

BARBADOS Under the *Medical Termination of Pregnancy Act* (1983-1984), termination of a pregnancy in the first 12 weeks may be performed by a medical practitioner if he/she is of the opinion, formed in good faith, that continuing the pregnancy would involve risk to the life of the pregnant woman or harm her physical or mental health; or that there is substantial risk that if the child were born, it would suffer such physical or mental abnormalities as to be seriously handicapped. A written statement by a pregnant woman stating that she believes the pregnancy was caused by rape or incest provides sufficient grounds to claim damage to mental health. For pregnancies from 12-20 weeks, the opinions of two practitioners are required; and for pregnancies of over 20 weeks, three practitioners are required. Written consent of a parent or guardian must be given for the termination of pregnancy in patients under the age of 16 or of a period of unsound mind of any age. Termination of pregnancy is free of charge when it is accessed through the public health system and complies with the legislation.

JAMAICA In Jamaica, abortion is a felony for anyone performing it on a woman or for a woman who attempts to induce an abortion by using any instrument, poison or other means. People performing or having/attempting abortions are subject to life imprisonment with or without hard labor. The penalty for procuring any poison or instrument for provoking an abortion is three years with or without hard labor. Although the Penal Code provides no exceptions, in common law specific exceptions have been established, following the precedent set by the ruling in the English case *Rex vs. Boume* which concluded that abortion would not be unlawful when the operation was performed in good faith for the purpose of preserving the life of the mother. This created conditions for the public health sector to provide abortions in certain circumstances: (a) when two doctors recommend it on the basis that the pregnant woman is physically or mentally at risk; (b) in cases of pregnant teenagers under the age of 17, when accompanied by a parent and if proof of age is provided; (c) in cases of rape or incest, provided that the woman is able to provide evidence that the pregnancy resulted from the crime committed against her.

SURINAM Abortion in Surinam is illegal under old Dutch legislation that was never modified. A woman who intentionally aborts is subject to three years imprisonment. The person conducting the abortion is subject to four and a half years' imprisonment and up to 12 years if it was performed without the woman's consent. If the woman dies, the penalty is increased to six years and in the second case to 15 years. If the person performing the abortion is a physician, midwife, or pharmacist, the penalties may be increased by a third and the person can be barred from practicing. But an abortion can be performed to save the woman's life, although the law is not enforced. Most key persons interviewed by the DAWN research team were convinced that abortion was legal in Surinam. In practice, the only barrier to having a safe abortion in a hospital is money or distance, that is the ability of women to reach the facility.

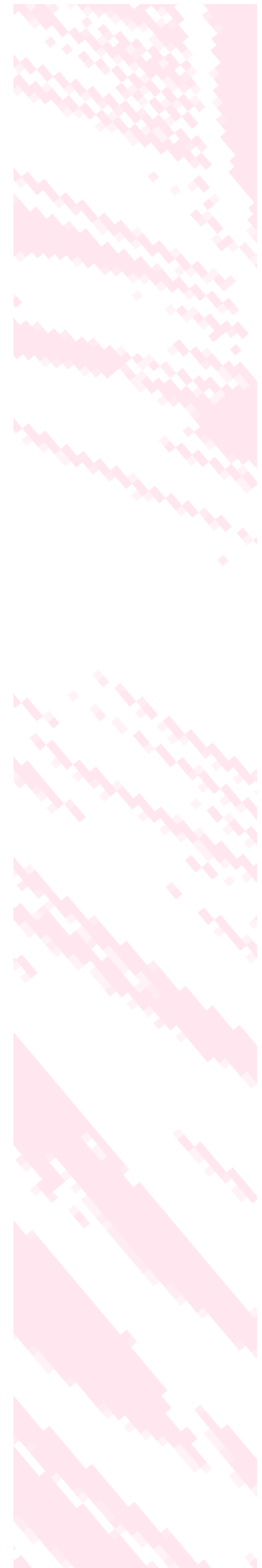
TRINIDAD & TOBAGO Sections 5 and 6 of the *Offences Against the Person Act* (1925) define abortion as a crime. The law states that any woman who *unlawfully* procures a miscarriage or any person who unlawfully causes a woman to miscarry is subject to four years' imprisonment. In addition, any individual who *unlawfully* supplies a woman with an instrument to procure a miscarriage is subject to two years' imprisonment. The law does not provide any guidance to medical practitioners about when an abortion can *lawfully* be performed. As a result, medical practitioners believe that abortion is illegal in all cases.

Box 23: Abortion Laws in African Countries and the Philippines

GHANA Until 1985, abortion in Ghana was illegal under the Criminal Code of 1960 (Act 29, sections 58-59 and 67). Ghana enacted a new abortion law in 1985 (Law No. 102, 22 February), which states that abortions are illegal unless carried out in a hospital or designated clinic by a registered medical practitioner or gynecological specialist. If the above conditions are met, abortion is permitted when continuing the pregnancy will pose serious risk to the life of the pregnant woman or injury to her physical or mental health. Abortion is also permitted when the pregnancy is the result of rape, abuse of a mentally disabled person or incest or where there is a substantial risk of a serious physical abnormality or disease in the fetus. The law is, however, silent on whether socio-economic reasons constitute grounds for abortion or what the gestational age limits for legal abortion are, leaving considerable room for interpretation.

NIGERIA In Nigeria, legal references to abortion are contained in the Criminal Code of Southern Nigeria and the Penal Code of Northern Nigeria, which derive directly from 19th century British legislation. Both legislations are draconian, as they criminalize the most diverse practices leading to miscarriage such as the administration of drugs and poison by the women herself or another person, or simply the procurement of substances and objects that may cause miscarriage. Penalties range from three to four years' imprisonment. The Criminal Code of Southern Nigeria, however, allows surgically performed abortions in order to preserve the mother's life. On the other hand the Northern Penal Code does not allow for any exception and includes the penalties for people who, by using force against a woman, may unintentionally cause her to miscarry.

PHILIPPINES Legal premises that restrict access to abortion are present in both the Constitution and the Penal Code. Article 2 (Section 12) of the 1987 Constitution states that: *"The State... shall equally protect the life of the mother and the life of the unborn from conception..."* In the Penal Code, abortion is addressed in Articles 256-259: (1) The pregnant woman who performs intentional abortion on herself, or consents to the performance of an intentional abortion on herself. (2) Any person who commits intentional abortion through violence or by administering drugs with or without the woman's consent. There are no exceptions, not even to save the mother's life. Physicians, however, perform abortions in the case of life-threatening risks, basing their decision on medical criteria.



Argentina

Despite the existing punitive legislation it is estimated that between 500,000 and 700,000 clandestine and unsafe abortions are performed annually in Argentina. In the year 2000, roughly 79,000 cases of incomplete abortion were treated by the health system. Though the largest percentage (roughly 40,000 cases) were of women aged between 20 and 29, 11,000 girls and adolescents aged between 10 and 19 also had incomplete abortions that year. The number of cases had increased by 46 per cent since 1995, which suggests that the number of clandestine abortion also expanded.

Abortion providers range from “friends and neighbors” that have knowledge of traditional methods to midwives, nurses, druggists and doctors. But as knowledge increases about Cytotec (Misoprostol), druggists are becoming the main source of information about and means to terminate unwanted pregnancies. It has also been suggested that the increase in the number of consultations because of incomplete abortions may be related to the use of Cytotec, as it provokes blood losses that scare women and make them seek out health care more frequently than when other methods are used. Significantly, up until 2003, no specific policy, program or measure had been adopted with respect to post-abortion care. Women that consult at a public health service after an abortion do not get specific counseling or referral to family planning. Only very recently have some hospitals started using manual intra-uterine aspiration techniques.

As in other countries, the costs and risks of clandestine abortion vary widely across income sectors. Women who can afford to pay are less likely to suffer health or criminal consequences. On the other hand, poor women may not only risk their health, but be more exposed to prosecution. In 1998 in the Province of Santa Fé, a woman with an incomplete abortion who sought medical attention in a public hospital was reported by the doctor who attended her in the emergency ward. This case reached the provincial level Supreme Court, which ruled that the “doctor had not violated ethical standards”.

Regarding women’s chances of accessing procedures permitted by law, many problems can be identified. The required legal procedures are not clear-cut, and women generally are not familiar with information about which circumstances allow for abortion to be performed, and what should be done to have access to it. Very often, health professionals delay the bureaucratic procedures that are required in order for the interruption of the pregnancy to be authorized. There has been a series of controversies and negative decisions in cases where women or doctors have requested judicial authorization to perform an abortion in circumstances allowed by the Penal Code. One dramatic example concerned a woman who, having requested authorization to abort a severely malformed fetus, had to wait three months for a negative decision.

Since 1983, 14 provisions aimed at reforming the abortion law have been presented to Congress. Three of them proposed the legalization of abortion. Two of them aimed at making the law more restrictive by eliminating the two

circumstances under which abortion is not penalized. Five proposals simply modified the wording of the articles defining those exceptional circumstances. And finally, one provision aimed to incorporate the protection of the unborn in the Penal Code.

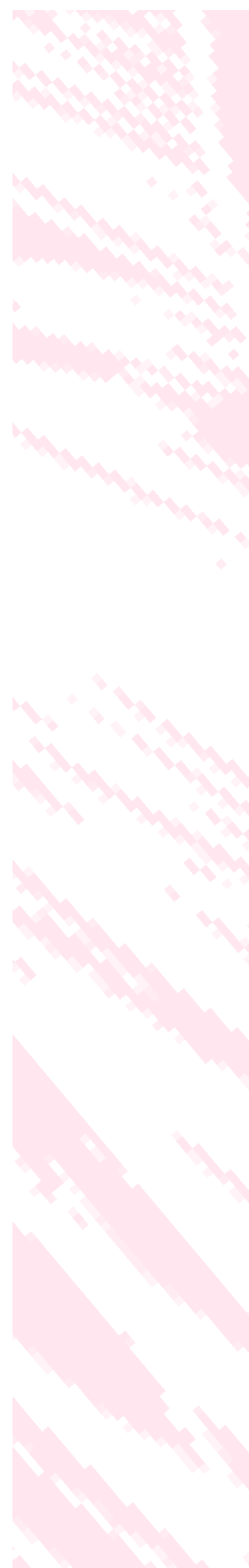
In recent years, however, four progressive bills were presented to the House of Representatives:


- The Socialist Bloc presented a bill proposing the decriminalization of abortion by modifying and enlarging the circumstances in which abortion is not punished;
- The feminist grouping “Women for self-determination and the right to choose”, through Representative Luis Zamora, presented a comprehensive bill on “*Sex education, contraception and legalization of abortion*”;
- Feminist Representative Maria José Lubertino presented two proposals. The first aimed at ensuring that the private, public and social security system (*Obras Sociales*) provide information, counseling and procedures in the two cases allowed by the Penal Code. The second proposes the expansion of the exceptional cases to allow for the termination of pregnancy in cases of severe fetal abnormality.

Abortion remains the unresolved sticking point of S&R self-determination in Argentina. It must also be noted that the attacks against abortion by conservative sectors have not diminished since the adoption of the National Sexual and Reproductive Policy. Following approval of the Reproductive Health Bill in 2002, the Supreme Court has emitted an unfavorable decision regarding emergency contraception and on at least two occasions judges have taken regressive decisions in relation to abortion in cases allowed under the existing legislation.

However since 2004 very positive developments have occurred at the level of the civil society. On May 28, 2005, a National Campaign for Safe and Free Abortion was launched by a coalition of 80 feminist and women’s groups. The initiative presently involves other 300 organizations engaged with human rights and social issues at large, as well as singers, actresses and other personalities. It is aimed at building a political consensus around a draft legal provision to decriminalize and legalize the abortion, as to ensure that women who decide to interrupt an unwanted pregnancy have access to free and safe procedures in all public hospitals as well as in the social security network (*Obras Sociales*). The arguments it raises in favor of legal reform is that abortion is a major public health problem as well as and women’s human rights issue.

The campaign also demands that access to safe abortion is guaranteed in the two cases of which under article 86 of the Penal Code are already exempt of punishment (women’s life risk and rape). To ensure access to services in these cases is critical because quite often health professionals refuse to





perform the procedure. In August 2006), medical doctors denied access to abortion in the cases of two disabled minors. In one of these cases the abortion was performed but just after a decision was issued by the supreme court of justice of the province of Mendoza. In the other case, which occurred in Buenos Aires, the family had to resort to a private clinic because no public service would do the procedure.

Bolivia

The Bolivian Society of Gynecology and Obstetrics estimates a total of 60 deaths per 10,000 abortions performed. According to calculations made in 1995, roughly 115 unsafe abortions occur each day, which adds up to between 40,000 and 50,000 cases a year. Data collected by the Population Policy, Research and Analysis Unit (Unidad de Políticas de Población, Investigación y Análisis, UPPIA) estimate that 69 per cent of abortions occur among adolescents (aged 14 to 19 years). It is also estimated that a third of maternal deaths is due to induced abortions. One of the causes behind unsafe abortion is the lack of knowledge about and easy access to reliable methods of contraception. In spite of the advances observed in recent years, according to the 1998 DHS, 26 per cent of women in unions in urban areas and 39 per cent in rural areas have unsatisfied family planning needs.

Another aspect that needs to be addressed when analyzing the problem is the link between abortion and sexual violence. In Bolivia, 7 out of 10 women suffer some type of violence, whether physical, psychological or sexual. Research carried out in 1997 by the Vice-Ministry of Gender Affairs, Generations and the Family identified 25,875 cases of gender violence, of which 26 per cent were cases of sexual violence. For 1998 available data show a total of 3,321 cases of rape and sexual abuse. According to reports of the Judicial Technical Police, in 2001 642 minors were raped by members of their families. In a number of these cases the girls or women may get pregnant. However, although the law allows for abortion in the case of rape, until very recently the procedure was not accessible. Health services demand legal authorization and often judges do not grant it. On the other hand, enforcement of the law as far as penalization of abortion is concerned led to 118 women being prosecuted between 2000 and 2001.

Since the 1990s, debates and advocacy efforts around legal abortion have mainly pushed for implementation of Article 266 of the Penal Code, which defines those situations in which abortion can be performed without punishment. Since after ICPD cases of women who had got pregnant as a result of rape were publicized, and formal petitions were presented to judges requesting access to the procedure. In September, 1998 a first interruption of a pregnancy resulting from rape was performed in the city of Sucre in the case of adolescent raped by her own father (Dominguez, 1999). Between 2000 and 2002 two seminars were organized to debate proposals for the effective regulation of access to services in those cases allowed under the existing law.

The first, involving doctors and service providers, was open to the general public, while the second had 400 participants, including criminal judges, judicial officials working in a variety of courts and at the Brigade for the Protection of the Family, congressmen and women and senators, and law students. Although these efforts do not guarantee access to services in all cases, they have increased awareness in society about existing legal possibilities for pregnancy termination.

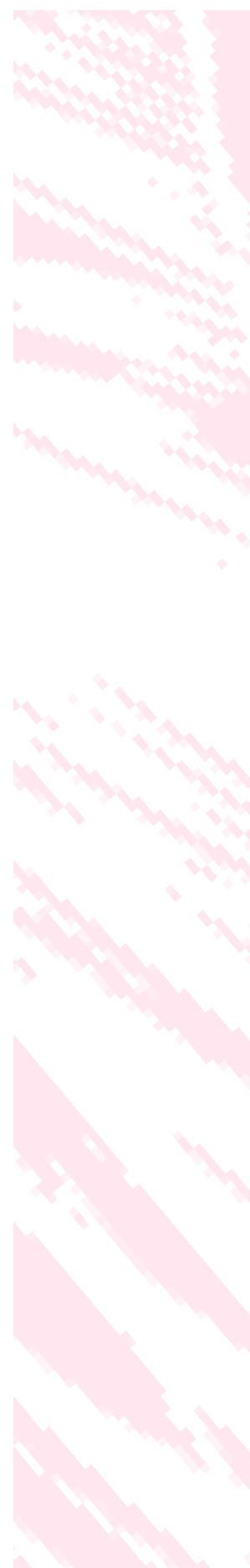
The next step was the drafting of a bill on the Legal Interruption of Pregnancy that aimed to fill procedural gaps in order to ensure provision of abortion in the cases permitted by law. The proposal established definitions, conditions and procedures with respect to recognition of the exception, woman's consent, gestational age limits, types of services and other criteria for the legal termination of pregnancy. It also defined the responsibilities and obligations of the Attorney General's Office and the health system. Lastly, it modified articles 201 and 266 of the Penal Code, regarding the falsification of medical certificates in those cases of legal exceptions to criminalized abortion. In 2002 and 2003 efforts were focused on disseminating the draft bill.

Brazil

Estimates regarding unsafe abortion range from 700,000 to one million a year (Corrêa and Freitas 1997). In 2006, 236.365 incomplete abortion cases were treated by SUS. Unsafe abortion is the fourth highest cause of maternal mortality nationally, but in a few contexts for which specific data has been collected it emerges as the first cause in certain periods (Valongueiro, 1996). Laurenti (2004) concludes that abortion accounts for roughly 12 per cent of maternal deaths among women of reproductive age.

Since the late 1970s the Brazilian feminist movement has publicly called for the decriminalization of abortion. The first proposed reform to the penal code was presented to Congress in 1983, when the country was still under the military regime. In the early 1990s three proposals to make abortion legal were presented, which did not get beyond the congressional Health and Social Security Committee, and during that decade a few congressional skirmishes took place over the issue of abortion. But also since the mid-1980s, the feminist movement had been advocating for making pregnancy termination in the two cases permitted by law accessible on the public health system. In 1989 the São Paulo municipal health department created the first legal abortion service and by 1994, three other services had been established.

In August 1997 a major controversy over abortion took place in Congress regarding a bill (PL-20/1991) that sought to guarantee abortion services through SUS in the two cases permitted by law. As the congressional struggles continued, the Cross-Sectoral Commission on Women's Health (CISMU) managed to get the National Health Council to pass a resolution requesting the MoH to regulate the "legal abortion" provision in SUS. The protocol (Norma Técnica de Atenção aos Agravos sofridos por Mulheres e Meninas



Vítimas de Violência Sexual) also contains guidelines for counseling and clinical procedures in cases of interruption of pregnancy and establishes the rules for financially reimbursing them. Since , since until then no definition of payment for these type of procedure had been established hospitals and doctors used this as a pretext to not provide the service. Finally released in October 1998, this protocol also became a major target for conservative sectors, who have argued against it on a variety of grounds. However, since 1998 the number of services providing abortion has greatly expanded.

Another main positive trend evolving since the mid 1990s was that women, couples and physicians started appealing to the judiciary to grant authorization for abortion in cases of severe fetal abnormality. By the early 21st century more than 1,000 authorizations had been granted, particularly in the case of anencephaly.

On the other hand, since 1997, anti-abortion groups have been sprouting and gained influence in local and national legislatures and the judiciary. Various cases occurred of anti-abortion groups performing “rescue operations” on women who were trying to access legal abortion procedures in cases of rape and fetal abnormality. And in the first years of the 21st century a string of denunciations were made against women who had resorted to abortion. One first case was detected in Recife (Northeast) in early 2001 and this trend would intensify in subsequent years.

Box 24 - Abortion in Brazil: Providers and women Denounced

Between 1999 and 2004, twenty one doctors were denounced for having practiced abortion to the São Paulo Regional Council of Medicine (a body in charge of regulation of medical practice). In 2004, ten of them have been discharged, four cases were still underway and seven professionals had been submitted to formal disciplinary process.

Between 2002 and 2004 feminist organizations have identified through the media and other means four cases that illustrate the strategies used by anti-abortion groups. In Rio, in 2002, a 24 year old woman that had used Cytotec searched a public hospital and was accused by the female doctor who received her of having committed infanticide. After the medical procedures she was handcuffed to her bed and then taken directly the prison. Through efforts made by a local feminist organizations (Advocaci) in collaboration with a well known criminal law firm she was released almost three months later. In 2003, a poor woman living in the metropolitan area of Rio was denounced by neighbors through the police hotline. The police came to her house and pressured her and her husband and they finally “confessed” the crime and told where the fetus had been buried. She was also taken to the police station, having been relieved after some days because once again the same feminist NGO had taken her case on board.

Two other cases were registered that involve anonymous denunces to the police. In 2003, in Bahia, a women who worked as a cleaner was caught by he police after somebody called the police inform that she was selling Cytotec in her neighborhood. A year later, a women and her friend who had helped her to abort were also denounced through the hotline and taken to prison. While the women who aborted paid a bail and was released, her friend was imprisoned.

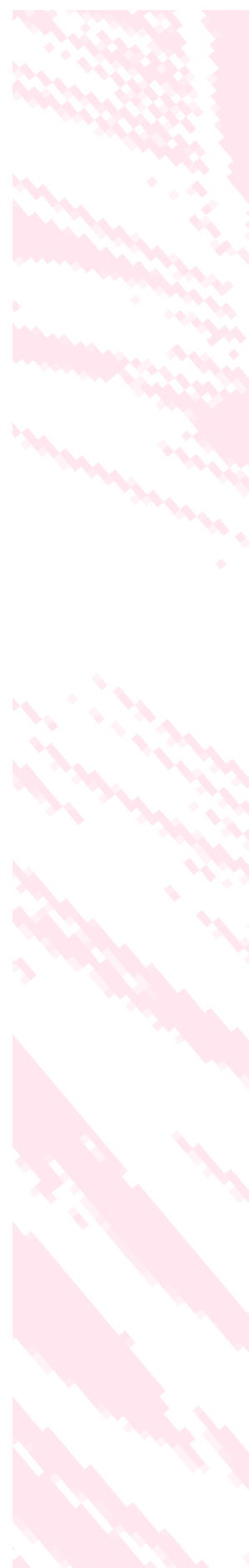
In 2003, at the beginning of the Lula administration, the scenario concerning abortion reform was contradictory. More progress had been made than in other countries in the region in terms of making abortion allowed under the Penal Code available on SUS and introducing new jurisprudence regarding termination of pregnancy in cases of fetal abnormality. On the other hand, the struggle for legalization had been stalled for many years. The victory of the PT was seen as opening up a window of opportunity for moving forward, since the party program includes the legalization of abortion and all bills pursuing that aim that were pending in Congress had been proposed by PT parliamentarians or PT allies.


When the new legislature began in 2003, the debate also heated up in Congress. In March-April a newly elected PT Congressman decided to revive a bill decriminalizing abortion from the early 1990s. In reaction conservative forces flooded the Commission on Social Security and the Family with regressive proposals, among them a bill proposing the creation of a government hotline to report women who abort. These developments prompted the re-energizing and remobilization of the Brazilian feminist movement around the issue of abortion and in early 2004 a new feminist platform was created to push for the legalization of abortion, the *Jornadas* (Jornadas Brasileiras pelo Direito ao Aborto Legal e Seguro).

During the same period, the judiciary also became a contested terrain. As we have seen in previous years, the number of judicial authorizations allowing for abortion in the case of grave fetal abnormalities had increased substantially and, in reaction anti-abortion forces increasingly mobilized through juridical efforts aimed at impeding these procedures. In light of that, a number of feminist NGOs – Anis, Themis and others – that had been working more systematically in the area of therapeutic abortion devised a strategy to achieve a higher court ruling to resolve these controversies, among other because they usually delay the procedure, forcing women to reach childbirth. The strategy prioritizes anencephaly cases that account for 10 per cent of all deliveries performed by SUS.

In early 2004, anti-abortion groups targeted one anencephaly case in the State of Rio, for which the woman had initially got a local level judicial authorization. They constructed a legal suite calling for the “habeas corpus” of the fetus. This appeal reached the Supreme Tribunal of Justice (a second level federal court), which suspended the previous authorization. In reaction Anis and its partners decided to take the case to the Supreme Court, which accepted it. But when the judgment was finally handed down, the baby had been born and died. Nonetheless, the Court debated the case and the majority declared themselves to be in favor of the authorization. Following this, the advocacy strategy shifted towards using a special juridical instrument (ADPF) that can be used at high level courts to contest legal norms and judicial decision by demonstrating that they contradict constitutional principles.

The ADPF was presented on behalf of the National Confederation of Health Professionals (jointly with Anis). Among other elements, the petition





argued that to take an anencephaly pregnancy to term produced unnecessary suffering to the woman and infringed her dignity as a person (constitutional principle). It also argues that the abortion in the case on anencephaly does not infringe the constitutional principle of right to life, given that the possibility for the fetus to become a full human being is null. It therefore request that the Supreme Court to issue a decision that would allow doctors to anticipate childbirth in the cases of anencephaly and this procedure should not be considered a crime.

This initiative got a good deal of media coverage and generated opinion polls in which the vast majority declared themselves to be in favor of expanding legal abortion to include severe fetal abnormalities incompatible with life. A first vote occurred in July 2004, when the Court decided that it would accept the claim and scheduled a final decision for 2005. However, after June 2005, as the corruption crisis escalated, the Supreme Court and other Federal institutions would become practically paralyzed with respect to other substantive debates. In 2006 another delay is likely as it is an electoral year.

As indicated in the previous chapter, in addition to the Congress and judiciary fronts, another area in which public abortion controversies have arisen was in relation to the MoH “Technical Norm to Guide Humanized Care for Unsafe Abortion” (see Chapter IX). Almost immediately after the post-abortion care MoH protocol was approved in December 2004, medical professional association led by the Federal Council of Medicine (CFM) publicly contested the a regulation there included in respect to abortion in the case of rape.

As to provide greater precision new Protocol defined that women requesting to interrupt a pregnancy resulting from rape, the Protocol based on what is established in the 1940 Penal Code defines that a police certificate to prove that the woman has been raped is not required for the abortion procedure to be performed. This particular premise was contested by medical doctors who said that since the rape would not be proved by a police investigation, they could be at risk of being accused of practicing illegal abortions. Two visible factors were at play behind this public controversy. The first was the hidden influence of conservative voices within the medical field itself. The second was the fear of doctors who do not oppose abortion but do not want either to be more directly engaged with the issue to be denounced by conservative colleagues.

But underlying the lack of credit in what women themselves declare was also at play. Or t say it differently: women would systematically lie to get a free abortion in the public health system. This assumption had, in fact been openly used by conservative sectors to attack first “legal abortion” protocol since it had been had been adopted in 1998. The CFM formal complaint to the MoH hampered the publication of the text and at the same time triggered a series of public debates and dialogues in which feminist organizations were also involved.

In June 2005, when a new Health Minister was nominated, he suspended the Protocol. A series of high level debates ensued that finally led to the publication of the Protocol. This would be followed by technical debates conducted by the national coordination of the Women Health Policy with SUS health professionals in all regions of the country. From there on the knowledge and adoption of the Protocol has expanded in the public health network. In regard specifically to “legal abortion” procedures it is important to mention that the new regulation also includes few clauses related to objection of consciousness. In relation to that, relevant actors who are monitoring the implementation of the Protocol have observed that a large number of medical doctors are resorting to these clauses to automatically avoid being directly engaged with the procedures.⁵³

However, the main development in the struggle for the legalization of abortion would derive directly from the *Jornadas*. In 2003, the new Special Secretary for Women’s Policy planned a national conference to discuss its policy priorities with women’s organizations. The conference, scheduled for July 2004, was preceded by municipal and state-level conferences. The *Jornadas* defined as their main strategy influencing the conference to ensure that its outcomes included a recommendation to revise existing punitive legislation on abortion. The strategy worked well and a recommendation was adopted.

Despite some initial uncertainty with respect to how the Secretary would incorporate the recommendation in December, the Minister announced the creation of a Tripartite Commission – involving the Executive and Legislative branches, as well civil society representatives – to discuss the recommendation and propose a reform bill. The civil society representation the Brazilian Women’s Coalition (AMB-Articulação de Mulheres Brasileiras), the Central Workers Union (CUT-Central Única dos Trabalhadores), the Mercosul Women’s Forum (Fórum de Mulheres do Mercosul) the National Feminist Network for Sexual Reproductive Health and Rights (Rede Nacional Feminista de Saúde), the Brazilian Federation of Gynecology and Obstetrics (FEBRASGO) and the Brazilian Society for the Progress of Science (SBPC).

The composition of the Commission immediately sparked a public controversy since it was defined that Christian religious voices would be represented by the National Council of Christian Churches and not by specific Catholic or Protestant institutions. This provoked open protest by the National Conference of Bishops (Catholic). Despite this initial conflict the Commission functioned quite smoothly from March to August. At the civil society level, in the process leading up to the Commission’s work and beyond it, *Jornadas* expanded its partnership with youth groups, the LGBT community, and sectors of the popular social movement to support the Commission’s work. It also refined its media strategies and cultivated relations with key journalists and formers of opinion. The contribution of the *Jornadas* was vital in the policy process, as the draft prepared by them provided the foundation for draft provision that was adopted by the Commission in August 2005. In



⁵³ In 1995 when a partial constitutional reform was initiated the anti-choice lobby used the occasion to push again for the inclusion of the right to life from the moment of conception premise in the constitutional text. But the proposal was defeated once again.

general lines the text proposes that until the 12^{ond} week of pregnancy abortion is to be decriminalized. This time frames is extended to 20 weeks when the pregnancy results from rape and no limit is defined for abortion in case of life risk or fetal abnormality incompatible with life, when this is to be determined by the medical team. Abortion would remain illegal when performed without the woman´s consent. The provision also defines that the procedures performed under these criteria must be provided freely by SUS and also have its costs covered by private health insurance.

However, by the time the Commission concluded its work in August, the political corruption crisis was at its height and by then it was already clear that no commitment or support for this outcome could be expected from high levels of government. In July, the President, speaking at an event to launch a campaign to raise the self-esteem of Brazilians said that: *“Brazilians should not be exclusively concerned with economic problems, but should also devote our attention to the recovery of family and religious values”*. In the week following the presentation of the bill by the Commission, he sent a letter to the National Conference of Bishops, to “explain” the corruption crisis, in which he also addressed a recently approved law on bio-security (which includes aspects relating to stem cell research) and the law provision that had been delivered by the Tripartite Commission few days earlier. In the words of a well known op-ed writer (Petri , 2005) this was like handing over these controversial issues on a plate to the Church hierarchy :

“When it was well on its feet the Lula government was doing well when dealing with social issues: it sanctioned the stem-cell research law, it distributed emergency contraception in public health clinics, has made efforts to reduce racial inequality un universities and – most principally – has created a special commission to review the outdated abortion legislation. Now that it is stumbling on its feet [because of the corruption crisis] it has started to sell its soul to devil also in relation to social themes. The most recent case is identified in the letter sent by Lula to the Catholic Church hierarchy to salute the opening of the annual General Assembly of the National Conference o Bishops. The most revealing section is found in the 6th paragraph that reads as follows: “I want to re-affirm my position in the defense of life in all its aspects and in all its meanings. The debates currently evolving in the Brazilian society, in its religious and cultural plurality, are being followed and stimulated by our government, which, however, will not take any measure that may contradict Christian principles.

As the Executive branch would not commit itself to supporting the draft produced by the Tripartite Commission, the tabling of the bill in Congress was delayed several times. But finally on 28 September – the Latin American Day for the Decriminalization of Abortion – the Minister herself went to the congressional Committee on Health and Social Security to hand over the text to Representative Jandira Feghali (from the Brazilian Communist Party Partido

Comunista do Brasil, PCdB), who since the late 1990s has been the rapporteur of all abortion bills. The ceremony was much lower profile than expected by those engaged with the process since 2003.

As could have been predicted, the conservatives immediately attacked the proposal and requested that the Committee on Health and Social Security organize a public hearing to discuss the text. This took place in November and was an appalling and shameful show of strength by anti-choice members of Congress and organizations. The next chapter, in early December, was the voting on the text itself at level of Commission on Social Security and Health. Given the extremely unfavorable climate, Representative Feghali tried to negotiate a new shorter draft, simply proposing the decriminalization of women and providers, without including any of the positive measures contained in the original text. But even this watered-down version of the bill did not get the necessary support, as a few key voices in the Committee made it clear that they would not accept the decriminalization of providers. The decision was therefore made to postpone the vote until the following year. In March 2006, overall conditions in Congress were unfavorable as result of the impact of the corruption crisis and also because the House's performance in electoral years is known to be very poor. Consequently the text was not voted on, and given that 2007 heralds the start of a new legislature it is not at all clear what will happen next to the new Feghali draft.⁵⁴

What is clear, however, is that anti-abortion forces gained strength in 2005. A Parliamentary Bench for the Defense of Life that includes several PT representatives was created, and organized a seminar in the House itself right after the December debates on the bill. Another big event was scheduled for July 2006. Meanwhile the *Jornadas* are revising their strategy in the light of this new and more complicated policy environment.

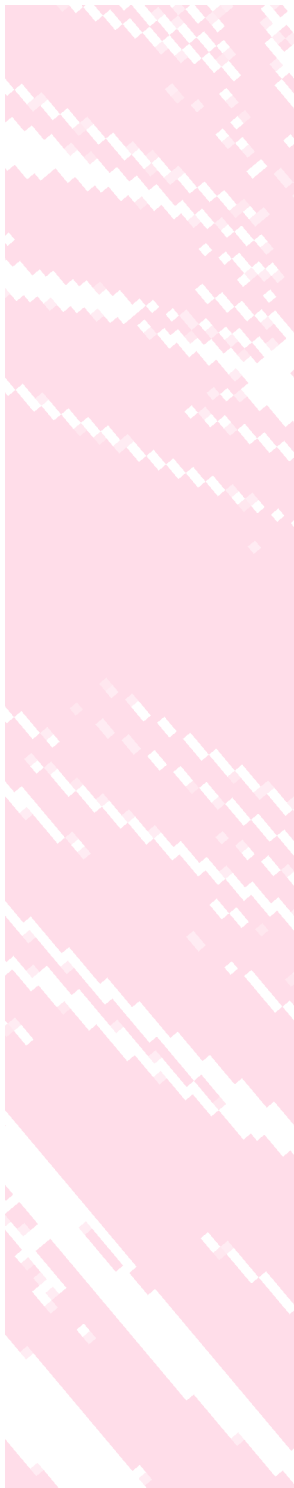
Mexico

In Mexico Penal Codes vary from state to state. In Yucatan abortion has been legal (although not easily accessible) since the 1920s, but in most other states it is allowed only in cases of rape or when the woman's life is at risk, while in a few states it is restricted to these latter cases. The information available with respect to sexual violence is an indicator of the policy relevance of abortion, particularly in the case of rape. Access to services in those cases where abortion is not penalized is practically non-existent. Estimates of the number of abortions performed in Mexico vary widely. In 1994, the Committee for Risk-free Maternity calculated this figure to be 850,000 each year, while the Alan Guttmacher Institute gave a much lower figure of 533,100. Two years later CONAPO estimated the number to be 110,000, but in 2000 it raised this figure to 200,000.

After ICPD and Beijing the broadening of existing norms and ensuring that abortion is accessible in the cases allowed under existing legislation became central objectives of the Mexican feminist agenda. Mexico is probably the



⁵⁴ In August 1997, two months before Pope John Paul II's visit to the country, the Commission on Constitution and Justice approved the bill. The Minister of Health declared he would invoke the Presidential veto. The President of the Supreme Court spoke out in favor of the bill. Catholic and evangelical representatives tried to call for a plenary vote. It all ended with a shameful public hearing later in the year and the debate around the bill died out. This happened immediately before and after Pope John Paul II's visit to the country, and it was clear that the right-to-life Congressional groups were acting up for the Vatican.



Latin American country where reproductive rights advocacy is strongest, as well as being well funded. Since the turn of the century initiatives have focused on a national campaign around reproductive rights,⁵⁵ advocacy for legal reforms in the Federal District and tracking specific cases, which have gained national and international visibility. Nonetheless, conservative moral forces gained great leverage in the late 1990s and further expanded their power and influence during the current administration. This is not surprising as the PAN's origins can be traced back to Catholic reactions in the 1920s and 1930s to the compulsory secularization process pursued by the Mexican revolution. During his electoral campaign in the year 2000, presidential candidate Vicente Fox sent a letter to the Catholic hierarchy stating that if elected he would promote the “right to life from the moment of conception until the moment of natural death” (Ubaldi 2003).

But in the same year, Rosario Robles, who at the time was Governor of the Federal District, sent the State Assembly a bill to expand access to abortion in cases where the woman's health is at the risk or a grave fetal abnormality has been detected. The law was passed and investments started being made to ensure that services would be available. But the implementation of the law had to be suspended because anti-abortion forces appealed against it to the Supreme Court, arguing that it would infringe the Constitutional right to life premise. The decision of the Court ratifying the state law was issued in October 2002.

Also in the year 2000, in the state of Guanajuato, seventeen legislators (16 from the PAN and one from the PRI) approved a penal code reform that eliminated the exception cause allowing for abortion in the case of rape. After numerous mobilizations by women's organizations at local and national levels, and coverage of the case in the international media, the reform was vetoed by the state governor. But in the elections that same year the PAN candidate became the new governor and almost immediately reopened the debate by presenting a bill to reform the first article of the state Constitution in order to enshrine the right to the life from the moment of conception in the text. This initiative was seen by abortion rights activists as a sign that the PAN would try to do the same in other states it governed.

In 2003 also in Guanajuato, a mentally disabled woman who was raped and got pregnant requested authorization to abort, but the judge denied the authorization. In reaction, feminist organizations and other progressive sectors started a legislative battle to reform the state Penal Code procedures in order to ensure that abortion is provided in those cases defined as exceptions by the law. Until 2004, the State Assembly had not yet studied the bill.

However the best-known Mexican abortion case is the history of Paulina Ramírez Hyacinth. In 1999 when she was thirteen, she was raped by a drug addict who broke into her house in Mexicali, Baja California, and ended up pregnant. The state code includes the possibility of abortion being performed in such cases, and her mother requested judicial authorization. The judge

⁵⁵ The provision was presented by Roberto Gowweia, a PT Representative from São Paulo who was arriving at Congress elected by a constituency that traditionally supported abortion rights. His initiative aimed at pushing the agenda forward. However, he did not consult with the feminist movement, which was somehow taken by surprise.

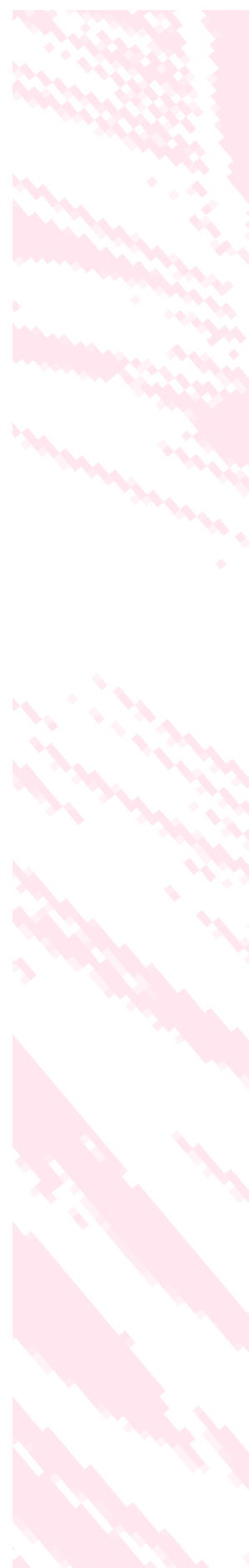
authorized the abortion but the director of Mexicali General Hospital refused to perform the procedure. A second effort was made by Paulina's lawyer to get authorization without success. As Paulina waited in the hospital for the decision, the hospital director allowed anti-abortion activists in to try to persuade her not to terminate the pregnancy. Finally, because of the continuing delays, the pregnancy was taken to term and Paulina had the baby.

Feminist organizations publicized the case widely and started a lawsuit against the hospital director for having violated medical confidentiality, as well as Paulina's privacy and liberty. As the Mexican court consulted was not favorable, Mexican feminist organizations in partnership with the Center for Reproductive Rights took the case to the Inter-American Commission on Human Rights. In 2006 a landmark settlement was reached with the Mexican government, in which the government agreed to, among other things, pay reparations to Paulina, provide her and her son significant compensation for health care and education, and issue a decree regulating guidelines for access to abortion for rape victims. In addition to the relevance of this decision to Paulina herself and abortion advocacy in Mexico, the Inter-American Court decision is also a major breakthrough because this is the first time that the Court address and positively judges an abortion case from the perspective of women's human rights violation.

Uruguay

As previously mentioned, between 1934 and 1938, under the dictatorship of Gabriel Terra, abortion was legal in Uruguay. Historical research has shown that the return to more restrictive legislation occurred, among other reasons, because of the pressure brought to bear by Catholic forces, who considered the law to be immoral (Sapriza, 1999). The penal law No. 9763 of 1938, which is still in place today, condemns women who undergo abortions to three to nine months in prison, while the person who performs the procedure receives a jail sentence of 6 to 24 months (if the woman dies this is extended to 3-6 years). However, there are extenuating circumstances that allow judges to use their discretion to reduce or even waive the penalty: defense of the honor of the husband (in the text expressed as "one's own honor"), wife or another member of the family; rape; health reasons; and economic need. But for the extenuating clauses to be applicable, the procedure must be performed by a doctor within the first three months of the pregnancy.

The terms of the law are unacceptable in many respects when the contemporary Uruguayan context is brought to mind. For instance, the first extenuating circumstance that refers to the preservation of "one's honor" as the man's or husband's honor blatantly contradicts the gender equality principles adopted in national legislation in recent decades. It is also clear that the 1938 provision transferred to "the medical order" the normative power to perform and/or punish abortion. The early decline in fertility observed in the country at a time when modern contraceptives were not available suggests that



abortion performed by medical professionals had been widely available, at least since the late 1930s, which. This, however, did not guarantee access to safe procedures to all women.

With respect to the number of abortions performed, one recently published study (Sanseviero, 2003) claimed that 33,000 abortions were carried out in 2003 in Uruguay. However, Briozzo (2003) considers that it is extremely difficult to infer the rate of induced abortion on the basis of the data used, and using as a parameter international frameworks designed to calculate abortion prevalence he suggests variable ratios of 1 to 3 abortions per live birth and concludes that figures would oscillate between 50,000 and 150,000 pregnancy terminations each year.

The first bill aimed at decriminalizing abortion was presented to Congress in 1985, which was the same year that the country completed its return to full democracy. Then in the 1990s, immediately before and after ICPD and Beijing, other bills would reach the House of Representatives, which, however, never went beyond being studied by the parliamentary committees:

- In 1985, Colorado Party representatives Daniel Lamas and Victor Vaillant presented a decriminalization bill.
- In 1993, a new bill on Voluntary Interruption of Pregnancy was presented by Frente Amplio representative Rafael Sanseviero; in 1994 the bill was unanimously approved by all members of the House's Bioethics Committee, who came from all the political forces with parliamentary representation.
- In 1998, another Frente Amplio representative, Raquel Barreiro, presented a new bill, the text of which was mainly based on the 1993 bill.

This last bill was moving slowly through the parliamentary system, when in 2001, the wide dissemination in society of data and stories regarding the increase of abortion-related maternal deaths generated a new wave of public debates on unsafe abortion. This climate led the House of Representatives' Committee on Health and Social Security, with prompting from the Special Parliamentary Committee on Gender and Equity, to carry out a thorough review of the three different bills on the decriminalization of abortion that had been presented to Parliament since 1985. As a result of this process, a new bill was drafted, based mainly on the proposal presented in 1998. In drafting the new text, the Committee on Health and Social Security held a series of consultations with a wide range of social actors such as feminist organizations, medical doctors and religious leaders. MYSU (Mujer y Salud en Uruguay, Women and Health in Uruguay), the National Beijing Follow-up Commission (Comisión Nacional de Seguimiento de Beijing) and CLADEM were major players in this strategic dialogue.

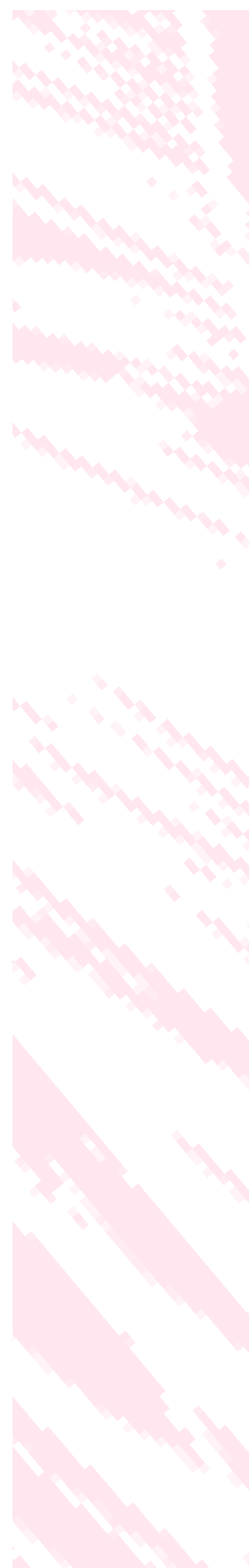
This process led to the drafting of the Bill for the Protection of Reproductive Health, which clearly identified the State as primarily responsible for guaranteeing the necessary conditions for the whole population

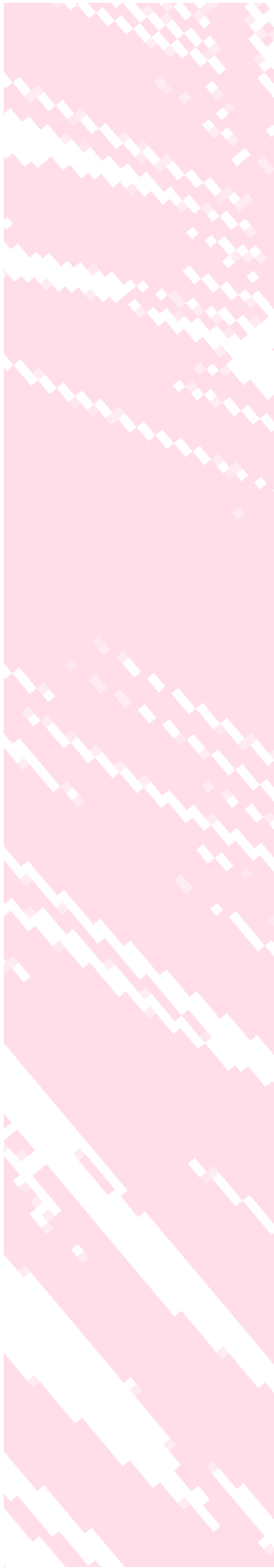
to enjoy the full exercise of their S&R rights, without discrimination of any kind. The text included the following contents:

- The Ministry of Public Health must enhance efforts to ensure that: sex education is incorporated at all levels of the public education system; that access to family planning services is provided on the public health system and that proper training for human resources is implemented towards that end; measures are adopted to reduce unsafe abortion-related maternal mortality.
- All women have the right to decide about termination in the course of the first twelve weeks of pregnancy if they state to the physician that the circumstances deriving from the conditions under which they got pregnant, or economic, social, family, age or other constraints limit their possibilities of taking the pregnancy to term.
- Physicians must inform women about adoption options, as well as of existing maternity support programs and offer adequate pre- and post-abortion counseling. Clinical records must be kept of consultations and procedures.
- In cases where gestation exceeds twelve weeks, termination can only be performed when the woman's life is at risk or when severe fetal abnormalities incompatible with life are detected.
- In the case of minors the presence and authorization of a legally responsible adult is required and in cases when this is not possible the case should be decided by a Family Law judge;
- When complying with these conditions and criteria, the procedure should be free of charge not just on the public health system, but also in the case of all other health care providers.

The House of Representatives voted through the bill without any amendments on 10 December 2002. This half sanction of the bill by the lower House was an unprecedented advance for the country, representing a landmark victory not just for Uruguay but also for the whole region. But to become effective and enforceable, the provision had yet to be approved by the Senate and fully sanctioned by the President.

Throughout 2003, the Senate Committee on Health interviewed various civil society constituents as it studied the bill. The Committee could not reach a consensus that would allow the text to be sanctioned without going to a vote. Therefore the proposal was sent for discussion in the plenary of the Senate early in 2004. At that point the growing social mobilization in support of the bill had created an extremely favorable environment for its approval. A public opinion poll performed in March that year concluded that 63 per cent of Uruguayans approved of the proposed law. The Senate debate began on 13 April, continued the following day, and culminated on 4 May when, despite the evident support within society, the bill was defeated by four votes (17 votes against and 13 in favor of the law).





This negative result, however, did not diminish the public debate either in the media, or within society at large. As the country was heading towards a presidential election in which the left-wing Frente Amplio was predicted to win, the strategy adopted by abortion rights advocates was to try to feed into the campaign process a proposal for the provision to be brought back to the vote in the very first year of the new legislature, since the potential victory of the Frente Amplio would change the composition of the Congress in a direction more favorable to the law (as we saw above, most previous proposals to decriminalize abortion had been made by progressive parliamentarians).

In October, 2004 the Frente Amplio candidate Tabaré Vázquez, a respected cancerologist, was elected in the first round of the presidential elections. But in early 2005, even before the presidential inauguration, he publicly declared that if the bill were re-presented and passed, he would veto the law. Though this was a watershed, the political debate did not vanish. Throughout 2005 pressure was brought to bear upon members of parliament who supported the bill. In November, when a regional meeting of S&R rights advocates took place in Montevideo a meeting was held in the Congress Annex, during which strong critiques of the legislative stalemate were voiced by Uruguayan activists.⁵⁶

Despite the current stalemate it is critical to highlight and value the Uruguayan political process that took place from 2002-2004 and transformed the legal abortion agenda into much more than a women's or feminist issue, but rather a non-negotiable item of the progressive democratic agenda. The country report's evaluation of the trajectory of the debate lists the following enabling factors and trends:

- In 1999 the active participation of the country in the ICPD+5 Review process re-activated at country level the debate on unsafe abortion as major public health issue.
- In 2001 the public uproar created by the significant increase in abortion-related deaths prompted, for the first time, the public positioning of many sectors, particularly doctors.
- In 2003 women's organizations and their allies created the National Coordination for the Defense of a Deeper Democracy that would become the major platform for mobilizing dialogue and debates within society and for lobbying Congress in support of the law.
- National level mobilization engaged a wide range of sectors beyond women's organizations and progressive physicians: youth groups; faith-based organizations such as progressive Methodists, the Valdenses Church and Afro-Uruguayan religious groups; ordinary women and men attending public debates; and international activists who visited Uruguay specifically to contribute to the process. The strategy also included efficient media strategies and the public opinion poll that was crucial for putting pressure on Senators and introducing the abortion debate in the 2004 electoral process.

⁵⁶ It must be said as well that the positive move evolving in neighboring Uruguay was an important source of inspiration for the new Brazilian initiative

The main disabling factors and actors identified by the analysis were: the hierarchy of the Catholic Church; neo-Pentecostals who acted as allies of the Catholic Church hierarchy; anti-choice groups, which used as their main slogan against the law the phrase: “*We want to save both!*”; Catholic professionals working in the public health system and the judiciary. It also mentions transnational forces such as the US Congress members who sent faxes to all members of the Senate, and the Vatican itself, which maneuvered discreetly at high policy levels. Last but not least, the personal moral position of President Vázquez is openly criticized for breaking a long-standing tradition in Uruguayan politics of the primacy of secular principles over individual beliefs.

Barbados

The *Medical Termination of Pregnancy Act* 1983-1984 provides for the lawful termination of pregnancy. In accordance with this Act:

- Treatment for the termination of a pregnancy of not more than 12 weeks duration may be administered by a medical practitioner if s/he is of the opinion, formed in good faith, that the continuance of the pregnancy would involve risk to the life of the pregnant woman or give injury to her physical or mental health; or that there is a substantial risk that if the child were born, it would suffer such physical or mental abnormalities as to be seriously handicapped.
- The written statement of a pregnant woman that she reasonably believes that her pregnancy was caused by an act of rape or incest is sufficient to constitute the element of grave injury to mental health required by the law.
- For pregnancies between 12–20 weeks duration, two practitioners are required; and for pregnancies of over 20 weeks, three practitioners are required.
- Written consent of a parent or guardian must be given for the termination of pregnancy for a patient under the age of 16 years or for a patient of unsound mind of any age.
- Termination of pregnancy is free if it is accessed through the public health system and satisfies the conditions set out in the legislation.

Between 1997 and 2001, 2,927 procedures were performed in Queen Elizabeth Hospital (QEH) (cases ranging between 550 and 650 per year). The number of teenage users that resorted to the service in those years ranged from 84 to 123 (104 in 2001). There are currently no statistics available on the number of deaths or illnesses attributable to abortions. Private sector doctors are supposed to report data on abortions, however, this is not respected and there is underreporting (Barbados ICPD review, UNFPA).

While abortion is legal in Barbados, anecdotal evidence suggests that many women continue to undergo unsafe abortions, a hypothesis confirmed by the

admittance of women needing post-abortion care after seeking services in the private sector. Such cases are often recorded under miscarriage or complications of pregnancy and therefore data is not available to determine the frequency of such problems.⁵⁷ In addition, the use of Misoprostol (Cytotec), a well-known abortifacient, has been documented in Barbados.

Box 25: Abortion law reform in Barbados: A “Quiet” Advocacy Campaign

The liberalization of abortion laws in Barbados came about through the quiet advocacy of Billie Miller, currently acting as Minister of Foreign Affairs. Her own interest in abortion law reform came from her work within the family planning sector, where she interacted with many women of diverse ages who were seeking out abortion services. Miller has also spoken of the need to address the consequences of violence faced by young girls and women in the case of incest and rape.

From 1976–1981 Miller was Minister of Health and Social Security. During this time she struggled to find the right time to introduce legislation that would reform the existing abortion laws. Fearing a political backlash, Miller’s party dissuaded her from tabling abortion legislation around election time. Miller decided that she would begin a campaign of “silent” advocacy, canvassing stakeholders in abortion laws and policy. She met with members of various churches, community leaders, and fellow Ministers in government offices to convince them that liberalizing abortion policy was a key element in protecting women’s lives and health. Miller admittedly feels that she benefited from the fact that Barbados has only a small Catholic community, traditionally one of the strongest voices of opposition in the region and the world against women’s health rights.

After spending six years on her own campaign, Miller felt that it was time to propose the legislation. In order to introduce the legislation, Miller first had to draft a bill. However, the issue did not receive priority in the Attorney General’s Office. In an unprecedented effort to take matters into her own hands, Miller raised funds through IPPF to hire someone to draft the bill.

When the bill was drafted, Miller once again was told that it was too close to elections to table legislation on abortion. In 1981, Miller was appointed Minister of Education and Culture. Despite the fact that she no longer held her post in the MoH, she brought the bill to cabinet and it was passed with no objection. Miller’s work through her quiet campaign of advocacy and activism paid off in the end with legislation that continues to save women’s lives today.

Jamaica

If the woman does not fit the criteria defined by Common Law jurisprudence, she cannot access abortion on the public health service and must either pay a relatively high price for a safe private procedure or seek cheap “back street services”. This explains the previously mentioned association between unsafe abortion and maternal mortality.

In political terms, there has been little disagreement, in Jamaica, over abortion to protect the life and/or health of the mother. Indeed, protestant church leaders have indicated its agreement with this approach. It is abortion

⁵⁷ Leila Adesse, IPAS Brazil, personal communication, in September 2006

on demand, defined within a reproductive rights framework that is so strongly opposed as a “sin” by church leaders and other vocal conservative sectors in society. The right to terminate a pregnancy is viewed as going against traditional norms of the role and “place” of women and as a challenge to dominant definitions of masculinity, which suppose that men have decision-making priority, even in relation to unwanted pregnancy. A woman’s autonomous decision to terminate a pregnancy is often considered to undermine a version of “masculinity” that is based on sexual prowess and virility, which is manifested in having many children.

The law has not been formally changed to date precisely because a backlash by the churches – in particular the Roman Catholics – and dominant male voices is expected. It is important to note that both religious leaders and popular entertainers and singers have spoken out against abortion as a crime. At the policy level this is reinforced by the absence of a rights perspective, in particular in relation to those issues that concern women and their lives.

The fact that abortion is illegal creates an environment of secrecy, the fact that abortions are nonetheless available on the public health service, but only in certain cases, means that many women whose circumstances do not meet those criteria must either pay for the procedure to be done privately, resort to “back street” arrangements or carry the child to term. Management of the complications deriving from unsafe abortions is part of routine obstetric care in hospitals. In early 2005, the Medical Council of Jamaica said it would present a policy statement to the MoH to facilitate a review of the abortion legislation. The motive for this statement is to generate a better understanding of abortion-related maternal deaths. The Medical Council is calling for a new law modeled on the law in Barbados.

Surinam

Figures on abortion cannot be obtained from hospitals since abortions are registered under curettage. Findings of the 1992 CPS suggest that 88.7 per cent of all women aged 15-44 never had an abortion. Stichting Lobi, however, estimates that between 8,000 and 10,000 abortions take place annually, with a large number among women under the age of 24 (Leckie 1997).⁵⁸ This implies almost a 1:1 ratio with live births annually. A sample survey of clients at the Lobi clinic revealed that 34 per cent of the women had had at least one abortion.⁵⁹ In 1999, a study done in the interior suggests that young girls are very well informed about both modern and traditional abortion methods (Terborg and Boven 1999).

Understanding traditional abortion has been difficult since different ethnic and cultural groups practice different methods and little research has been conducted on the topic. For example, the Javanese use massage techniques for all their reproductive problems, while Maroons mostly use herbs. Since women in general are reluctant to talk about abortion, there are no scientific data on whether it works or whether it is safe. Anecdotal evidence tells the



58 One main player in this negotiation was Representative Rafael Guerra (from PSDB) a doctor and a well known and widely respected advocate of public health issues in the Brazilian Congress.

59 In fact during the 2006 electoral process the minimalist Feghali draft was systematically used by the Catholic Church to accuse her of proposing “abortion without limits” (because the text as it is does not define a period during which the procedure can be performed, such as the usual 12 weeks of pregnancy). Jointly with other electoral episodes involving Feghali and the bishops this would lead to her defeat in the run for the Senate in the state of Rio.



story of one family (partly Maroon, partly Creole) in which women tell each other to drink the milk of a very young coconut. It is said to loosen the fetus and “rinse” it out of the womb. There has been no “scientific” effort to determine how effective such methods may be.

Stichting Lobi promoted discussions on abortion several times, through live debates and television talk shows. Although it is silently tolerated, abortion as a right is not advocated. It is interesting to note that even women activists and health workers have ambivalent attitudes towards abortion. Recent research in a peri-urban neighborhood shows that 45 per cent of health workers consider abortion murder, and think it should be forbidden (Terborg et al. 2004).

The gap between law and practice is not exceptional. In Surinam most of the legislation concerning public morals and/or indecent acts dates from half a century ago. For example, providing sex education is classified as pornography under art. 293 of the Criminal Code. The general public is probably not even aware that abortion is illegal. Doctors probably want to let sleeping dogs lie (religious groups), and the women’s movement so far has not been able to reach a collective standpoint (support for ICPD notwithstanding). Therefore, there is currently no group actually lobbying for abortion to be made legal, since its being illegal does not pose a problem. The fact that abortion is such a sensitive issue is, ironically, also a protection; even when parents, for example, might want to bring charges against a doctor who performed an abortion on their daughter, in the end they would choose not to do so because of the public embarrassment it would cause them.

Trinidad and Tobago

Under Trinidad and Tobago’s *Offences Against the Person Act* of 3 April 1925, Sections 5 and 6, Chap. 11:08, abortion is a criminal offense. This law states that any woman who *unlawfully* procures a miscarriage or any person who unlawfully causes a woman to miscarry is subject to imprisonment for four years. In addition, any individual who *unlawfully* supplies a woman with an instrument to procure a miscarriage is subject to imprisonment for a period of two years. As it currently stands, the law is extremely ambiguous because it does not provide guidance to medical practitioners about when an abortion can *lawfully* be performed. As a result, medical practitioners believe that abortion is illegal in all cases. Consequently, when they perform abortions – which many private doctors do – they do so under the cover of secrecy.

The number of abortions performed is unknown. Crude estimates exist but in no way do they truly reflect the number of operations that are performed every year. According to one public hospital, in 1999 dilation and curettage procedures (D&C) were performed 1,177 times, and 615 times from June–September 2000.⁶⁰ While data regarding abortions is available for public health institutions, it only reflects the small percentage of women who experience abortion-related complications. Thus, all abortions that do not result in complications remain unrecorded. In addition, those performed at private services are not registered, even though it is estimated that 60 per cent

⁶⁰ The best known initiative is the National Alliance for the Right to Choose (*Alianza Nacional por el Derecho a Decidir*) comprising GIRE (*Grupo de Información para la Reproducción Elegida – Chosen Reproduction Information Group*), *Católicas por el Derecho a Decidir* (*Catholics for a Free Choice*), *Equidad* (*Equity*), IPAS/Mexico, the Population Council and the Johannesburg Initiative.

of private gynecological practitioners offer these services.

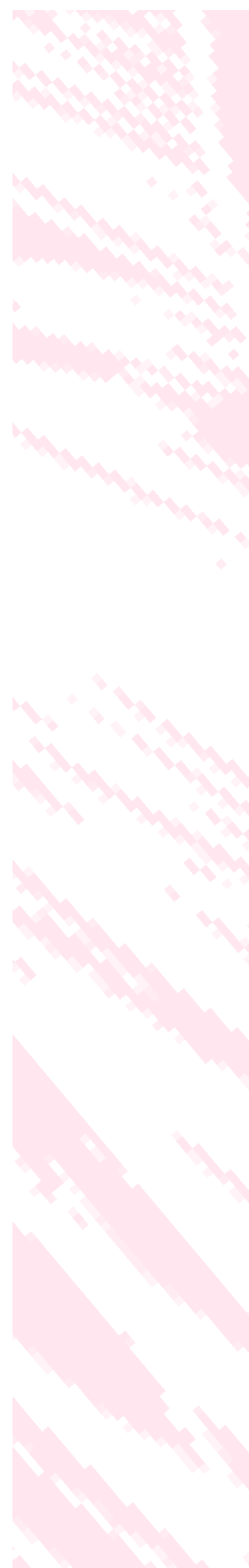
ASPIRE – Advocates for Safe Parenthood Improving Reproductive Equity – a gender equality and reproductive rights NGO, based on its own research (2000), has estimated that over 51 per cent of all women will have at least one abortion by the age of 44, and that the total number of abortions is about 19,000 every year.

The fact that all abortions are considered criminal, except for abortions performed to preserve the life of the woman, also means that generally health care providers do not receive official, structured training on abortion services. In addition, the government anyway does not regulate their services and therefore any abuses or malpractice that may occur may not be remedied. Women are sometimes subjected to abuse during termination of pregnancy procedures and are left to suffer in silence. Public hospitals and clinics by and large only offer post-abortion care services. Consequently, women who cannot afford private doctors' fees are forced either to carry their pregnancies to term, to seek unsafe abortions from providers who are not trained to deliver health services, or to self-induce an abortion.

But in 2000 ASPIRE publicly announced that it was calling on the Trinidad and Tobago government to reform the criminal abortion law and enact a civil law that would allow abortion upon request in the first trimester. The group has attempted to generate public discussion and dialogue on the issue. The dialogue involves the Churches (all denominations, but its most strident opponent is said to be the Roman Catholic Church), lawyers, doctors, youth groups, social workers, human rights activists, and grassroots leaders and individuals.

Letter writing is part of the strategy in attempting to change the law, and so the organization frequently sends letters to the editors of the daily local newspapers. Not all of the letters sent are published, but when the letters are published, it is a catalyst for public debate. Radio and television programs are also used as a means to debate legal abortion. More recently, Aspire announced that it will be circulating a statement of support that individuals and organizations can sign on to express their agreement with the campaign to urge the government to change the abortion law. The abortion law reform campaign has been strategically devised to include not only public debate through letters to the editors of newspapers but meetings with interest groups, parliamentary representatives, and ministry officials. In addition, ASPIRE has a website, www.ttaspire.org, that provides information to the public.

With respect to the government and parliamentarians, the group has completed a draft Women's Choice on Pregnancy Bill, which was made public on 28 May 2004. It has sent a copy of this draft bill to the Attorney General and, jointly with Lawyers for Reproductive Rights, has requested a meeting with the Attorney General to discuss the status of the current criminal law. But until September 2006, the government of Trinidad and Tobago had not responded to the ASPIRE's call to address the issue of unsafe abortions in Trinidad and Tobago. In fact the Draft Constitution recently laid by Prime



Minister Patrick Manning in Parliament is poised to reignite the debate on abortion, as it seeks to protect human life from the moment of conception.

The proposed text spells out fundamental human rights and freedoms, including clause 5 which enshrines the right to life, liberty and security. Clause 5(2) states: *“Everyone shall have the right to have his life respected and this right shall be protected by law and, in general, from the moment of conception.”* Many organisations and individuals have since spoken out against the draft constitution both in terms of the process and well the contents of the draft. On September 18, 2006 during the sitting of the Senate, the Minister of Public Administration, Lenny Saith, declared that the government of Trinidad and Tobago has no intention of reviewing our abortion law at this time. Quoting from the 19th century statute, he added that the “solution to the problem, is not legislative; rather, effective policing of medical practitioners engaged in this illegal activity” . ASPIRE and the Caribbean Association for Feminist Research and Action (CAFRA-TT) have responded to Dr. Lenny Saith statements, calling attention to the health risks of abortion and international commitments in respect to the issue that have been signed by Trinidad and Tobago and other Caricom countries.

Ghana

The 1985 law reform in Ghana was spearheaded by gynaecology and obstetrics doctors concerned with the harmful impact of unsafe abortion. Among the evidence collected to argue in favour of law reform, one study surveyed the population of student nurses. Among them an abortion prevalence rate of 96.46 per 100 pregnancies was found, with about 40 per cent of them having had more than one abortion, and 17 per cent of all abortions had been performed by non-physicians (Addo 1985). However, as mentioned before, though the procedure is legal when performed by a medical doctor in an authorized health facility, unsafe abortion is still a common practice.

A study conducted in three towns from different regions in the country from December 1998 to March 1999 showed that out of over 750 youth aged 14-24 years, 52 per cent were sexually active, among the women 35 per cent had actually become pregnant and of these, 70 per cent had terminated or attempted to terminate the pregnancy using unsafe methods. Data from the 1998 Ghana Youth Reproductive Health Survey showed that 11 per cent of males and 16 per cent of females aged between 12 years and 24 years who were sexually active also indicated some involvement in terminating a pregnancy. In 2000 Agyei surveyed 120 women who had had abortions and found that just 20 per cent of them had obtained their termination from a health institution.

Existing literature also provides insights into reasons for procuring abortions, which include: the need to delay childbearing (thus effectively using it as a means of family planning); the wish of young women to continue their education, as pregnancy invariably meant automatic expulsion from school; denial of paternity by the partner; fear of sanctions imposed by the

community; or stigma and shame associated with pre-marital child bearing in most communities.

With regard to the means used to terminate a pregnancy in those cases that do not reach services authorized to perform the procedure, a survey carried out in 1997-1998 by Ahiadeke (2001) showed that: 38 per cent of women surveyed in Southern Ghana had obtained help from a pharmacist; 12 per cent from a physician and 11 per cent had resorted to self-medication. On the other hand, research also shows that women in Ghana have rarely been prosecuted at the Accra High Court. In 1999, 172 cases of illegal abortion were reported to the police. In the years 2000, 2001 and 2002, 256, 165 and 177 cases were reported respectively, with only three convictions so far.⁶¹

Research conducted over the years has identified a variety of methods used to terminate a pregnancy. These include inserting sticks into the vagina, drinking concoctions made of grinded blue bottles, hair dye and using leaves from trees such as Mampong Bedu. Women sometimes buy drugs over the counter from unauthorized and fake druggists and hospital based data reports that some women take as many as 20 tablets of chloroquine to attempt to abort the fetus.

These circumstances are unacceptable from both the medical and social point of view since the provisions in the law, even as it stands, leave ample room for women to access abortion services. However legal and safe abortion services remain inaccessible for the women who need it because both women and health providers remain largely unaware of the provisions in the law. In addition, most of the women in need of this service live in rural areas where, even if health facilities are available, the doctors mandated by law to provide these services are rarely found.

The survey conducted by the DAWN team to assess knowledge about the law among health professionals is strikingly illustrative of this lack of adequate information. Two of the institutions recognized that a law permitting abortion exists, but interviewers consider that measures need to be adopted to ensure its “enforcement”, including clear provision for the three exceptions stated in the legal text.


The survey also examined more closely the Koforidua Central Hospital, which is one of the main health facilities in the country providing abortion in the cases defined as legal by the 1985 law. The methodology adopted was qualitative based on direct interviews with individual staff and patients.

Abortion services – Both surgical and medical methods of abortion are available. The surgical method using the manual vacuum aspiration or D&C is more commonly carried out at the hospital because patients usually seek an abortion in the later stages of pregnancy (which is an additional sign of lack of adequate information about the procedure). Drugs used include Misoprostol (Cytotec) and Mifepristone, also known as RU486.

Pre- and post-abortion care – Before an abortion is carried out, a patient is taken through pre-abortion counseling, whereby the doctor ascertains the reasons for wanting an abortion and the health risks involved if the abortion is



⁶¹ Yet more disturbing was the episode that occurred in March 2006, when pressure for the bill to be voted again increased, the President was said to have declared that if his threatened veto were raised by the General Assembly, and the law remained in place, he would consider dissolving parliament and calling new legislative elections.



performed. After the abortion, if there are any complications, the patient is treated and then taken through post-abortion counseling when family planning services are offered. It must be said however that the above services are not offered “openly” but currently in a rather “clandestine” manner due to a lack of familiarity with the provisions of the law in Ghana both on the part of health personnel and among the general population.

Profile of users – Both literate and illiterate women of different ages (15-45 years) resort to the services. Closer scrutiny, however, indicates that educated women tend to turn up at an earlier stage in the pregnancy than illiterate women. This could be explained by the high cost of getting a safe abortion from a health professional. On the other hand, illiterate women, in particular those who are poor, come with the most complications since they use dangerous and unsafe methods to abort. These attempts are also often undertaken at a more advanced gestational age.

Cost – The cost of having an abortion varies from doctor to doctor. According to the doctors interviewed, this is so because there was no consensus yet that hospitals should officially provide abortion services and charge a standard fee for the procedure.

Nigeria

For more than thirty years efforts have been made to reform existing abortion laws. The first attempts can be traced back to the 1970s when professional medical bodies identified unsafe abortion as one of the main causes of maternal mortality and reproductive morbidity. The list of high-level documents and events making public appeals for legal reform is impressive, including: in 1972 the Annual General Conference of the Nigerian Medical Association (NMA); in 1975, the National Population Council gave health and welfare reasons justifying abortion on request; in 1981, the Minister of Health address to 9th Conference of the Society of Gynecologists and Obstetricians of Nigeria (SOGON) also mentioned abortion as a major public health issue; in 1991, the Committee Against Unwanted Pregnancy (CAUP) was already in existence and jointly with the Federal MoH organized a meeting to review existing legislation (1991/92). At present a draft bill, initiated by CAUP in collaboration with a broad range of sectors advocating safe and legal abortion, is ready to be sent to the National Assembly.

As in other settings, despite the stringency of the law, abortion is widely practiced. Women resort extensively to traditional and often risky means to provoke abortion and a series of medical procedures are provided in health services that concretely by-pass the colonial legacy criminalizing abortion, such as:

- “Menstrual regulation” is a common practice in all family planning clinics in Nigeria.
- Antenatal diagnosis is promoted by the government and widely practiced for neural tube defect, Down’s syndrome and sickle cell disease.

- Termination is of regular occurrence in government hospitals for fetal abnormalities like hydrocephaly and anencephaly.

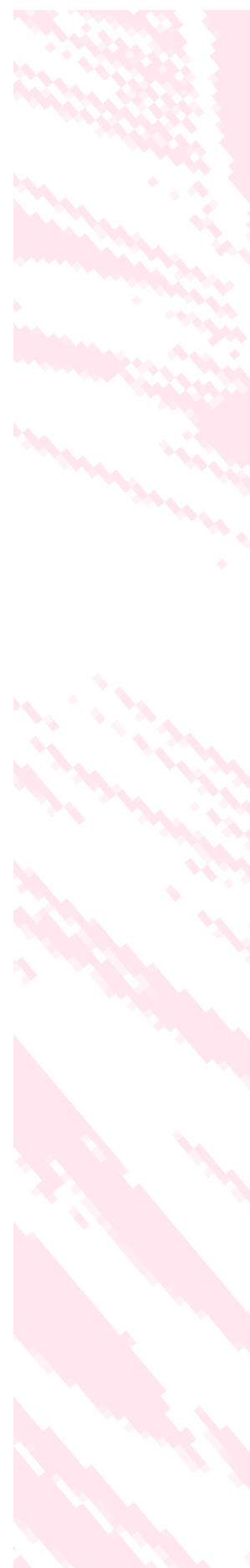
Termination is also done regularly in government hospitals to save the health of a woman, in cases of severe fulminating pre-eclampsia, congestive cardiac failure and other life threatening illnesses.

The CAUP research findings show that all categories of women and girls in their reproductive years seek abortion services, whatever their level of education, occupational or marital status, etc. Even in the Muslim dominated Northern part of Nigeria, where the law is draconian, abortion cases have been reported by IPAS in their work on Post-abortion Care Services in Kano state. It is estimated that 610,000 abortions are performed yearly and complications from unsafe abortions account for 30 to 40 per cent of maternal deaths in Nigeria (apud Madunagu and Olaniran, 2005)

Having an abortion is never an easy decision to make, and it is not always taken for the same reasons. Studies performed in Nigeria show that girls and women seek to terminate pregnancies for a number of important reasons such as: to postpone childbearing; the woman does not want any more children; the woman cannot afford to bring up a baby; having a baby would disrupt one's education or career; problems in the relationship; the partner does not want a baby; the partner denies paternity and the woman is alone; the woman is too young and still in school; parents object to the pregnancy and throw the girl out of home; the pregnancy implies a health risk, or results from rape or coercion.

The communiqué of the National Conference on Reducing Morbidity and Mortality from Unsafe Abortion in Nigeria organized by CAUP in Abuja (July 2000), states that abortion is a major public health problem in Nigeria, a reflection of societal failures (and not of women's immoral behavior) and a major cause of maternal morbidity and mortality especially affecting young people, aged 10-24 years. The conference also noted that:

- Unsafe abortion is a widespread problem in Nigeria.
- Women seeking abortion belong to virtually every religious and ethnic background.
- Married women comprise 30 per cent of abortion care seekers.
- Abortion has medical, social, economic, legal, cultural and moral dimensions.
- There is a wide gap between awareness of contraceptive methods and usage.
- There is a high level of sexual activity among unmarried young people resulting in unwanted pregnancies and unsafe induced abortions.
- The idea of providing comprehensive sex education in schools as recommended by the National Council on Education has still not been widely embraced in the country.
- Despite the fact that young people constitute over 20 per cent of the population, comprehensive reproductive health services are lacking





generally for this group. Even where such services are available, they are not youth friendly.

- A significant proportion of unwanted pregnancies are the result of sexual abuse and violence against women, especially rape and incest.
- Strict provisions of the criminal and penal codes on abortion in Nigeria have not been effective in reducing the incidence of unsafe induced abortion.
- Though communities' perception of the law on abortion is diverse, there exists a consensus that certain relevant portions of the existing legislation need to be reformed to protect a woman's health and life.

Another study performed by CAUP identifies the profile of women that resort to abortion. Two thirds of them are adolescents and other young people (aged 15-24); one third are married. The majority of all abortion seekers (91 per cent) are aware of contraception but only 37 per cent use a method. Out of the minority that uses contraception, some of them use non-reliable methods e.g. safe period, menstrogen, traditional rings, etc. Half of abortion seekers are not offered any family planning information or counseling on how to prevent repeated pregnancy or abortion.

CAUP jointly with the Alan Guttmacher Institute has also investigated abortion providers in Southern Nigeria concluding that 60 per cent of them are not physicians. Out of the doctors that perform abortions in registered health institutions (private and public) only 18 per cent were obstetricians and gynecologists. The most common method employed is D&C, accounting for roughly 60 per cent of procedures, of which 78 per cent were performed in private clinics/hospitals, which means that probably the main providers are nurses and midwives. Just six per cent of procedures analyzed were performed in public clinics and hospital.

In the light of the long trajectory of struggles to legalize abortion in Nigeria and the persistent resistance of political structures to recognize the scale and negative effect of the problem, the country report concludes: *"While hypocritical religious prejudices continue to violate women's rights to self-determination and choices with regard to their sexual and reproductive rights, girls and women continue to die as a result of unsafe abortion"*.

The Philippines

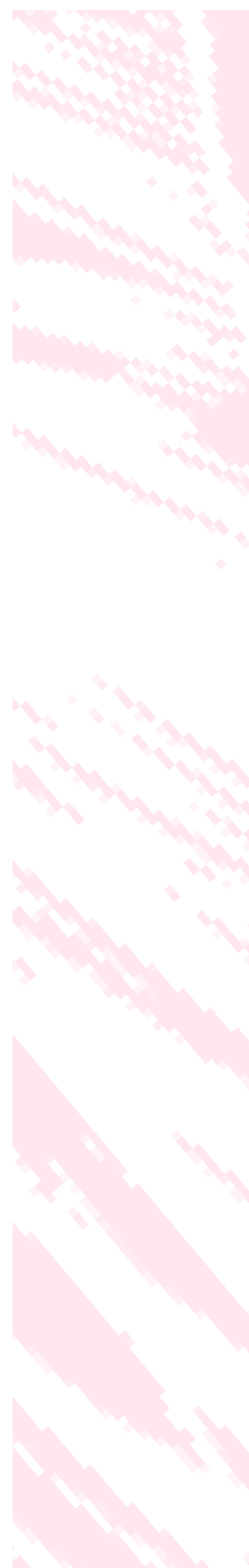
The Filipino Constitutional debates of the 1980s provide a striking illustration of persistent defeats over abortion, occurring at a structural political turning point in national politics. It was the end of a long dictatorship and all forces in society were highly mobilized, including those advocating legal abortion. But Cory Aquino's government opted to win the support of the Church hierarchy for her during the period of transition. The provision on the right to life from the moment of conception was sponsored by a Catholic priest member of the Constitutional Commission and was supported by the Aquino

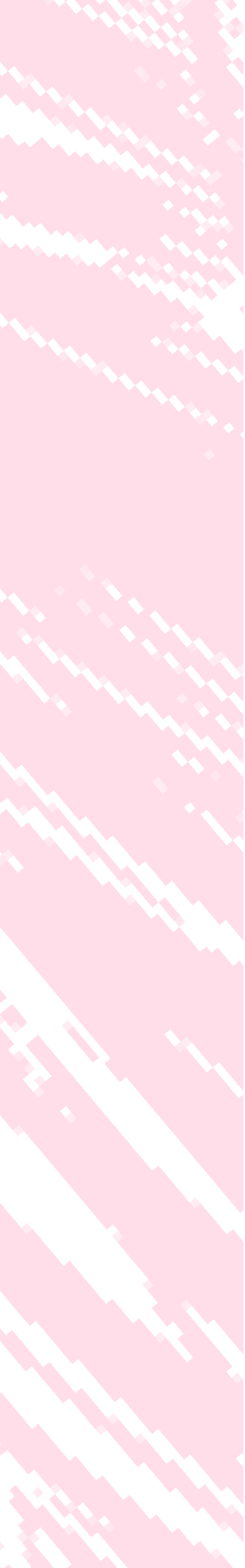
majority. The Catholic Church push clearly aimed to make sure that the Philippines did not adopt liberal laws similar to the 1972 landmark ruling of *Roe vs. Wade* in the United States of America. Interestingly, a Catholic nun and several progressive Catholic members of the Commission objected to its inclusion, but other Commission members with conservative leanings drowned out their voices.

Some feminists, who considered the inclusion of this provision in the constitutional text a major blow to women's rights, regretfully expressed the opinion that, if they had had a choice, they would have traded already-won gender equality provisions for the right to reproductive self-determination. But this is all in hindsight. At the time, the women's movement had its hands full reorganizing and adjusting to the post-dictatorship era. With its roots in a political left-wing tradition that focused more on issues of structural poverty, class and political marginalization – a political movement that also had strong allies in the Catholic Church – the women's movement was not as organized as it has now become in relation to advocacy on women's personal S&R rights. While impassioned campaigns were waged by some individual feminists against the anti-abortion provision in the Constitution, these did not result in any major political pressure and were quickly defeated.

For almost twenty years the call for legal abortion would be practically silenced in the country. In addition to the 1986 defeat, the continuing political instability and the wider women's rights agenda did not leave much room for reviving the abortion agenda. However, in 2001 progressive members of Congress proposed House Bill 4110 or the Reproductive Health Care Agenda Act, which recognizes women's rights to "reproductive self-determination", "*reproductive decision-making*", and "*bodily autonomy*". The bill states that non-recognition of these reproductive rights leads to "*unwanted intrusion of their bodies and other restrictions on women's physical autonomy.*" If passed into law, the health sector would be harmonized nationwide and could look more closely into the reproductive health concerns of women and men, and pave the way for much-needed initiatives on reproductive health. In the context of devolution, local government units would be mandated to take on reproductive health as a concern both within and outside the health system.

The women's movement strongly supported this bill as legislation that genuinely recognizes reproductive health rights, including the right of individuals and couples to make free decisions relating to reproduction. It also praised the bill's promise of access to a full range of S&R health services, education and information. Besides obstacles posed by Constitutional restrictions, predictably, the bill met with fierce opposition from the Catholic Church and other conservative forces. President Arroyo herself threatened to veto the bill in her 2003 State of the Nation Address, calling it a bill that will "try to smuggle in abortion". The bill which limits itself to post-abortion care and management of complications was also immediately interpreted by the Catholic Church as a pro – abortion law.





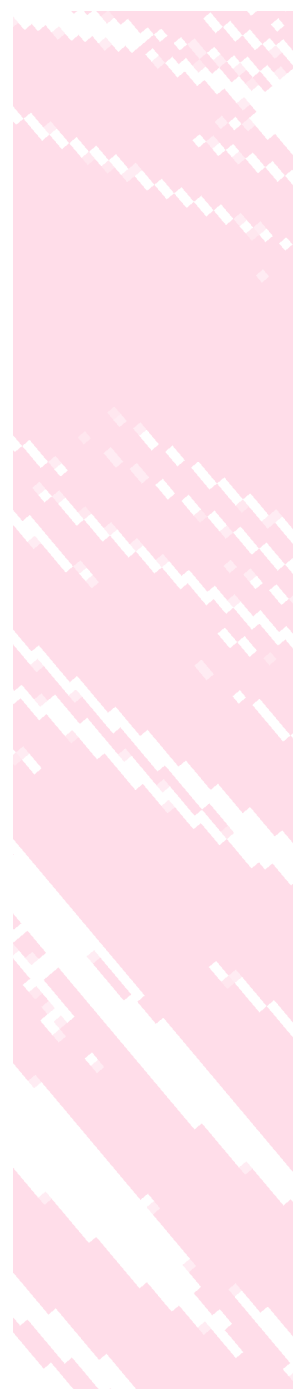
In the wake of this fierce debate, the bill had failed to pass by the close of the twelfth session of Congress. The massive disinformation campaign launched by the Catholic Church has sent reproductive health advocates on the defensive and has taken the bulk of the discussion on reproductive rights back to the basic elements of family planning, particularly the use of contraceptives and natural family planning. Even so the proponents of the bill are undeterred and vow to push for its approval in the next period.

Last but not least, the report conclusions as well as the postscript note by Carolina Ruiz, remind us that in the current context, in addition to fighting the Arroyo administration and the Church, reproductive rights advocates are also challenged to expand consensus on the issue within its own ranks and among close allies, who are still afraid to break off their ties with religious forces.

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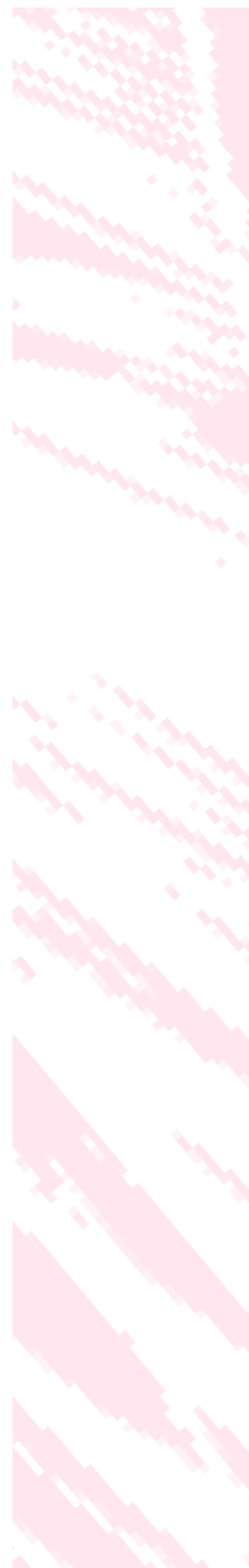


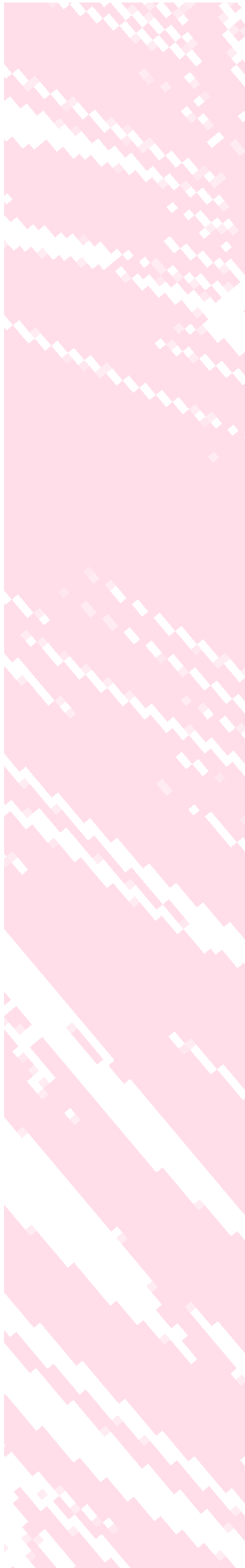
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