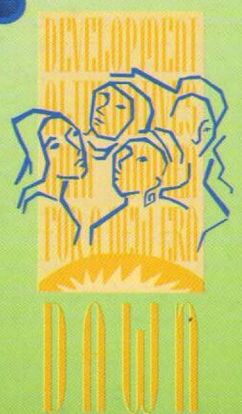
SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN THE ENGLISH-SPEAKING CARIBBEAN

A Study of Abortion, Maternal Mortality and Health Sector Reform in Barbados, Jamaica, Suriname and Trinidad and Tobago



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A Study of Maternal Mortality, Abortion and Health Sector Reform in Barbados, Jamaica, Suriname and Trinidad and Tobago

DEVELOPMENT ALTERNATIVES WITH WOMEN
FOR A NEW ERA (DAWN)

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Acronyms and Abbreviations

ASPIRE	Advocates for Safe Parenthood Improving Reproductive Equity
AWOJA	Association of Women's Organisations in Jamaica
AYSHR	Advocates for Youth Sexual and Reproductive Rights
CAFRA	Caribbean Association for Feminist Research and Action
CARICOM	Caribbean Community and Common Market
CBO	community-based organisation
CDB	Caribbean Development Bank
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CLAD	Central National Accountants Agency
CRC	Convention on the Rights of the Child
CSME	CARICOM Single Market and Economy
CSO	Central Statistical Office
DHF	District Health Facilities
EHC	Enhanced Health Centres
EU	European Union
EWMSC	Eric Williams Medical Services Complex
FPATT	Family Planning Association of Trinidad and Tobago
FTAA	Free Trade Area of the Americas
FWCW	Fourth World Conference on Women
HSRP	Health Sector Reform Programme
IADB	Inter American Development Bank
ICPD	International Conference on Population and Development
IUD	intrauterine device
LGBT	lesbian gay bisexual transgender
MCH	maternal and child health
MDGs	Millennium Development Goals
MHWH	Mount Hope Women's Hospital
MICS	Multiple Indicator Cluster Survey
MM	maternal mortality
MOH	Ministry of Health
MTCT	mother-to-child transmission
NGO	non-governmental organisation
NHIS	National Health Insurance Scheme
NWHRA	North Western Regional Health Authority
PAHO	Pan American Health Organization
PLWHA	people living with HIV/AIDS
RHA	Regional Health Authority
RHS	Regional Health Service
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
TGE	total government expenditure
TOP	termination of pregnancy
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
WHO	World Health Organization
WTO	World Trade Organization
YMCA	Young Men's Christian Association

Introduction

By Peggy Antrobus

It is of some significance that the research for this report was completed in 2004, a year that marked the 10th anniversary of the United Nations International Conference on Population and Development (ICPD), held in Cairo, Egypt, as well as the 20th anniversary of the DAWN Network.

ICPD is widely acknowledged as having forged a new path with its groundbreaking Programme of Action, which underscored the links between reproductive health and women's rights and empowerment. DAWN's platform document (Correa 1994) was particularly instrumental in helping to build understanding of these linkages and of the importance of the political and economic context in which health services are provided.

A year later, in 1995, the Fourth World Conference on Women (FWCW) in Beijing, China, extended the ICPD agenda with formal recognition of the importance of sexual rights and health to women's reproductive health.[1] And then came the backlash. Feminists in the Caribbean as elsewhere found themselves struggling for implementation of the ICPD policies against the continued erosion of health sector budgets,[2] the strengthening of the religious right and the spread of the HIV/AIDS virus.

Evidence of a backlash against women's sexual and reproductive rights has also been evident in the Five- and 10-year Review sessions of the ICPD Programme of Action and the Beijing Platform for Action,[3] where advocates have been challenged to maintain the goals and advance the process.

This makes it all the more important for Caribbean women's advocacy to formulate strategies for addressing these issues. Publishing this report at this time allows us to draw on new insights from the continued pressure being exerted on sexual and reproductive health and rights worldwide, including in the Caribbean. There is a clear role for the publication and widespread use of this research in this process. Studies on health sector reform from a gender perspective are long overdue in the Caribbean, and this study should be invaluable for those who are concerned about how health sector reform relates to the ICPD outcomes.

Since the 1980s, there has been a major restructuring of the Caribbean state, leading to the virtual abandonment of the more holistic approach to development inherent in the promise of independence. Under the leadership of the Caribbean Development Bank, the adoption of structural adjustment policies and the Washington Consensus by Caribbean governments in the Nassau Agreement of 1984 signalled the erosion of the power of labour, the retreat of the state from its commitment to broad-based, socio-economic justice and the crumbling of a social contract based on principles of equity and social justice.

Cuts in social services and benefits to the poor; rising unemployment and the expansion of the informal and 'underground' economy; the privatisation of public services and assets; the increase in violence and the weakening of trade unions – all came to symbolise the policy framework of structural adjustment in this region, and throughout the world. In the 1990s these trends were consolidated by trade liberalisation and the binding trade agreements of the World Trade Organization (WTO), and by the new 'consensus' around a variety of public sector 'reforms'.

The consequences of these policies for women have been devastating, particularly for their health. Because of their central role in the care of people within households and in public services such as health,

education and social welfare, women, especially those who were poor, were placed in triple jeopardy as a result of the cuts in social services: they were disproportionately represented among those who lost their jobs; they lost services that are essential to social reproduction; and they were expected to fill the gaps created by the cuts.

UNICEF's path-breaking study on the impact of structural adjustment policies on vulnerable groups recognised that 57 per cent of health care takes place within the home and that many governments were using this to justify cuts in primary health-care spending (Cornia et al. 1987). The shifting of responsibility for many areas of health care from the state to the private sector and to the household, where most families cannot afford private health care, meant that women spent more time taking care of sick or disabled family members and, consequently, lost hours of paid employment. Often, this was at the expense of their own health.

The central place accorded to the Millennium Development Goals (MDGs)[4] in policy dialogues and the major policy concerns surrounding the spread of HIV/AIDS provides a strategic opportunity for addressing the links between the goals of poverty reduction, gender equality, improvements in maternal health and combating HIV/AIDS, and for the adoption of an integrated approach to these problems.

At a meeting of the researchers that took place in Barbados at the end of the first stage of the research, there were already signs that the findings could provide the impetus for new initiatives. There is especially need for discussions on the links between health sector reforms and the outcomes of the ICPD; between sexual and reproductive rights, abortion and maternal morbidity and mortality; and between gender equality and women's empowerment and the spread of HIV/AIDS. In the context of the central place accorded to the MDGs in policy dialogues and in setting aid agendas, this study provides data that can be used to highlight these linkages and strengthen the work of feminist advocacy in this area.

The Caribbean women's movement needs to play a major role in this dialogue and in the planning and implementation of programmes. This study is part of that contribution. However, many have noted a lack of energy and the absence of direction in the Caribbean women's movement today around issues that are of central concern to Caribbean people, and women in particular.

Margaret Gill, the president of the Caribbean Association for Feminist Research and Action (CAFRA)[5], argues that the movement has been 'destabilised' by four factors: the notion of difference; the belief in the near impossibility of penetrating what she terms "amalgams of power" (patriarchy, colonialism/neo-colonialism, capitalism and statism); the male backlash; and "late 20th century instabilities of the concept of the nation state"

While I agree with this analysis, I think an important point is missing. In a regional workshop on empowerment sponsored by the Women and Development Unit (WAND)[6] of the University of the West Indies in the 1980s, Caribbean women identified two sources of empowerment that are seldom mentioned or discussed: spirituality and sexuality. By this they did not mean either 'religion' (which they considered oppressive) or 'sexual activity' (which some considered problematic). They were speaking of internal experience or a sense of connectedness with the self; comfort with one's body, with 'the spirit within' that reaches out to our relationship with others.

It is in that sense that I believe a necessary element in any efforts to re-energise the women's movement in this region must be the opportunity to understand sexuality and how this relates to both the forces that empower us as individuals, as well as to those pitted against a movement for gender equality and women's empowerment. The launching of a discussion on sexuality can serve not only to promote a better understanding of issues around the spread of HIV/AIDS and gender relations in general, but also to

empower women to find renewed energy for the larger challenges facing our region today. This study can provide the impetus for starting the conversation.

The current inertia in Caribbean women's activism certainly stands in contrast to the leading role they played in Cairo and Beijing. The Convenors of both the NGO forums that were held in conjunction with the official conferences were Barbadian women – Nita Barrow convened the forum in Nairobi, while Billie Miller convened the one in Cairo.[7] They followed in the footsteps of Gloria Scott and Lucille Mair of Jamaica, who were among those who took leadership in the activities around International Women's Year (1975) and the ensuing UN Decade for Women.

Billie Miller's selection as convenor of the NGO forum for ICPD was in recognition of her commitment to women's reproductive rights and her considerable political skills in this contentious area. As a minister in the Barbados government, she single-handedly and successfully gave the region its first progressive legislation on abortion. Dame Billie's international leadership in this field is reflected in her presidency (1991-1997) of the Board of International Planned Parenthood Federation (IPPF) Western Hemisphere Region, current presidency of the Board of Directors of the Inter-American Parliamentary Group on Population and Development for the Caribbean and Latin America, and many other initiatives in this field. Most recently, the leadership of Dr Jacqueline Sharpe of Trinidad and Tobago in both Cairo and Beijing was recognised by her appointment as world president of IPPF.

Moreover, the advances in women's sexual and reproductive rights and health that occurred at ICPD and FWCW would not have been possible without the dedicated, imaginative, skilled (professional and political) and sustained work of a number of Caribbean women in the lead-up to the conferences and at the meetings themselves. Working both as members of government delegations as well as with NGOs, in the official conferences and in the NGO forums, Caribbean women played crucial leadership roles.

In the case of ICPD, under the leadership of the DAWN network[8], women from around the world worked to make the draft Programme of Action more reflective of women's needs and concerns, and ultimately to shape the document that was adopted in Cairo. Because of the strong opposition to the conference, mounted by an alliance of the Vatican and the Muslim Brotherhood working with conservative governments around the world, the successful negotiation of this was a major political feat and Caribbean women played a major role.

At that time, I was the General-Coordinator of the DAWN network,[9] and was assisted by Audrey Roberts (Jamaican resident in the Bahamas) who did most of the work around this issue, organising regional and inter-regional meetings and supporting the DAWN team in Cairo. At the regional level, CAFRA played a major role in mobilising women in the Caribbean around the issue, as did many of the family planning associations (FPAs). Caribbean women involved in this process included Nelcia Robinson (CAFRA, St. Vincent), Margarette May MaCauley (CAFRA, Jamaica), Jacqueline Sharpe and Grace Talma (Trinidad & Tobago, FPA), Denise Nobel-Debique (Trinidad and Tobago), Monique Essed-Fernandes (Suriname) and UNFPA's youth ambassador, Chantal Monro-Knight (Barbados).

In the lead up to the conference women's organisations around the region[10] organised women's input in national reports and participated in the preparatory committees (Prep-coms) where the document was revised and in the Women's Caucus where women from around the world developed strategies for influencing their governments.

At the conference, the presence of Caribbean women on government delegations greatly facilitated NGO access. They included women like Jacqueline Sharpe and Grace Talma (Trinidad and Tobago, FPA) Carol Narcisse (Association of Women of Jamaica, AWOJA, and one of the researchers for this project) and

Beverley Miller and Yvette Delph (Barbados Ministry of Health). The engagement of health-care professionals and representatives of FPAs and women's organisations on official delegations was particularly crucial to counter the compliance of diplomats who were more easily influenced by religious conservatives. Meanwhile in the NGO forum, national groups like Sistren Theatre Collective and Women's Media Watch (Jamaica) and regional networks like CAFRA mobilised CARICOM participants to play a crucial role in generating political will. In the process leading up to the Beijing conference, the regional UNIFEM office[11] took the lead in coordinating the work of the various networks – CAFRA, DAWN Caribbean and others.

The presence of feminists and representatives of women's organisations on the official delegations at Beijing was crucial for the extension of the gains on reproductive rights and health already achieved at ICPD by the inclusion of sexual rights in the Platform of Action. These included 'veterans' from ICPD such as Jacqueline Sharpe and Grace Talma, who took leadership in the advocacy around the issue.

The recounting of these experiences should help remind us of the effectiveness of strategies that involve a partnership between women's organisations and movements and the state, linking technical, professional and political skills for the achievement of shared goals. The publication of this study can provide the opportunity for rekindling this partnership.

Peggy Antrobus was coordinator of the Women and Development Unit at the School of Continuing Studies, University of the West Indies, Barbados from 1978 to 1995, and is a DAWN founding member and former general coordinator.

Endnotes

[1] Although this was on the agenda in Cairo, governments were not yet ready to adopt the language of sexual rights.
[2] This is due to a number of factors including the loss of revenues from tariffs and the privatisation of government assets due to the spread of neo-liberalism through the WTO.
[3] This conference advanced the ICPD Platform by linking reproductive health and rights to 'sexual health and rights'.
[4] The MDGs address some of the goals of ICPD and Beijing Platform for Action, namely poverty, education, health and environmental sustainability. See www.un.org/millenniumgoals.
[5] CAFRA is the most enduring and significant regional network of feminists. From 1991-1996 CAFRA's Coordinator served as Regional Coordinator for DAWN Caribbean. This paper was presented as the basis for an e-mail discussion.
[6] WAND served as DAWN's Secretariat from 1991-1996 during my terms as General-Coordinator.
[7] In the event, Billie Miller, a minister in the Government of Barbados, was not able to be in Cairo due to the fact that she was in the midst of an election campaign at the time.
[8] This network of Third World women scholar-researchers was launched at the NGO Forum in Nairobi in 1985, the Forum convened by Dame Nita Barrow of Barbados.
[9] The DAWN Secretariat was based at the Women and Development Unit (WAND), School of Continuing Studies, UWI.
[10] Examples of these at national level were the Association of Women in Jamaica (AWOJA) and the FPA of Trinidad and Tobago.
[11] By this time Audrey Roberts worked as a consultant to UNIFEM and played a major role in managing the process leading up to the conference. Sandra Edwards (Barbados) of the DAWN Secretariat provided administrative support for the DAWN team.

Executive Summary

This compilation of existing and new research demonstrates that individual sexual and reproductive health rights, despite the importance of such rights in the lives of Caribbean people, have yet to be fully realised. This is particularly true for women and girls. Several trends in the data collection process are of note:

- There is a dearth of information and data on maternal mortality and unsafe abortion in the Caribbean region.
- Where data is collected, there is no standardisation of the collection process and data is not collected systematically, making it impossible to compare data inter- and intra-country.
- Data collected is often not disaggregated by gender, sex or socio-economic status, providing an unclear picture of the reality of Caribbean people's health.
- Indicators do not necessarily reflect the nuanced experiences of women. For example, the presence of laws regulating abortion does not necessarily limit a woman's access to safe abortion when she has the money and resources to seek abortion.
- However, women who do not have these means or who may feel that they will be stigmatised may turn to unsafe methods of abortion. While anecdotal evidence suggests that many women, in fact, arrive at hospitals to remedy incomplete abortions, there is no data to understand the dynamics or conditions of these women's lives.

Other specific systematic challenges include:

- Stigma and discrimination faced by women seeking sexual and reproductive health services, particularly abortion-related services.
- Stigma and discrimination faced by members of sexually diverse communities seeking medical services.
- Lack of integration of sexual rights into traditional reproductive health rights programmes.
- Lack of integration of prevention of mother to child transmission (PMTCT) programmes and maternal and child health initiatives.
- Lack of integration of HIV/AIDS programmes into reproductive health programmes.
- Gender analysis and programmatic considerations not thoroughly integrated into programmes and planning.
- Lack of programmes focusing on male health needs around reproduction and including men in the reproductive process.

These challenges in the collection and analysis of data can be remedied if appropriate priority is given during the health systems reform processes to the institutional and other support needed to implement better data collection functions. Systematic challenges can be overcome through the re-alignment of segments of health services to better fit the needs of individuals accessing care.

Recommendations: Steps to Reduce Maternal Mortality as it Relates to Abortion

Several steps have been identified that would reduce the incidence of incomplete and unsafe abortions. These recommendations should be closely examined in the context of health sector reform.

Legislation and Policy

- Prioritisation of women's health issues, both in general and specifically in regard to abortion-related maternal mortality and morbidity.
- Integration of HIV/AIDS programmes into reproductive health services.
- Sensitisation of hospital staff to diversity of clientele, particularly in relation to sexual diversity.
- Legislative reform pertaining to abortion in order to create an environment where safe and legal abortions can be obtained.
- Initiatives to educate women about the potential harm of unsafe abortion and about medical abortion and to encourage a safe and sterile provider.
- Conducting of research to understand the impact of external factors (e.g., religion) on decision-making relating to reproductive health.
- Comprehensive education programmes for the school population, including information on

abstinence, teen pregnancy, contraceptives, abortion, HIV/AIDS, etc., in an effort to reduce these problems.

Data

- Standardisation of collection of quantitative data in hospital (private and public) settings to facilitate consistency in the presentation of data on maternal mortality and abortion in individual countries and across the region.
- Collection of qualitative and quantitative data on:
  - women's access to abortion services, experiences with abortion providers and experiences with abortions;
  - the prevalence of self-administered abortion in the region;
  - the impacts of violence against women, particularly as it relates to the ability and desire to access abortion services;
  - the relationships between violence against women, socio-economic status, rape and incest and contraceptive delivery services, etc.
- All data should be disaggregated by age, sex, gender, socio-economic status, race, rural/urban location and other appropriate criteria.

Focus on Gender

- Integration of a gender perspective throughout the health reform process and in the design of health reform strategies.
- Training of health-care providers to prevent stigmatisation and discrimination of individuals seeking abortion-related services.

Focus on Services; Integration of Programmes

- Integrate PMTCT programmes into maternal and child health programmes, assessing clearly the impact of PMTCT on the lives of both mothers and children.
- Broaden the scope of reproductive health services to include sexual and reproductive health with a focus on a rights-based approach.
- Increase focus on adolescent sexual and reproductive health services, including legislative and policy reform to rectify current laws that act as barriers for young people attempting to access safe services.
- Train service providers in abortion counselling and support to better serve the needs of the patient in countries where abortion is legal

Research on External Factors that Affect Reproductive Decision-Making

This research begins an important discussion on the issues that affect reproductive decision-making. Understanding the reproductive choices of individuals should translate into appropriate policy responses and service delivery.

The following is an initial list of topics to be explored in the context of improving health:

- The impact of religious fundamentalism on health policy and service delivery.
- The stigma and discrimination faced by members of the lesbian, gay, bisexual and transgender (LGBT) community when attempting to access health services.
- The stigma and discrimination faced by sexually active young people and women.
- The impact of economic vulnerability on sexual decision-making.
- Understanding how the personal politics of service providers affect reproductive decision-making on the part of their clients/patients.
- The diversity of factors among the various socio-economic, regional and ethnic groups in the region that affect decision-making relating to health (sexual and reproductive health rights in particular)
- The impact of violence against women on women's sexual and reproductive health.
- The inter-relationship between HIV/AIDS and other STIs on sexual decision-making.

This undertaking by DAWN Caribbean is a first attempt at an individual and comparative understanding of health sector reform, maternal mortality and abortion in the region.

In completing this research DAWN aims to support the work of advocates, policy makers, researchers, health professionals, activists, students and members of government to further motivate, inform and benefit the lives of Caribbean people.

1. Sexual and Reproductive Rights in the Caribbean: Backdrop and Methodology

Backdrop to the Research

The United Nations International Conference on Population and Development (ICPD) was held in Cairo, Egypt, in 1994. It is seen as a milestone in the history of work in the field of population and development and in the women's movement, in shifting the paradigm of population programmes from pure population-related objectives to enshrining the values of women's reproductive health and rights. The Fourth World Conference on Women in 1995 led to the Beijing Platform for Action (PfA). The five- and 10-year reviews of both the ICPD Programme of Action (PoA) and the Beijing PfA have renewed global commitment to women's health.

The ICPD PoA (1994) states that:

"Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health-care programmes should provide the widest range of services without any form of coercion."[1]

The Beijing Platform for Action takes the language of the ICPD further by recognising a woman's right to control her sexuality and sexual relations on an equal basis with men (Center for Reproductive Rights 2002). The Beijing PfA is therefore seen as a key international instrument relating to women's reproductive and sexual health rights (Ahmed nd).

There are five strategic objectives outlined in the Beijing Platform for Action specific to health:

- Increasing women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services;
- Strengthening preventive programmes that promote women's health;
- Undertaking gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS and sexual and reproductive health issues;
- Promoting research and disseminating information on women's health;
- Increasing resources and monitoring follow-up for women's health.

The World Health Organization's working definitions of sexual health and sexual rights are as follows (Girard 2004):

Sexual Health: Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Sexual Rights: Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of health in relation to sexuality, including access to sexual health and reproductive health services;
- seek, receive and impart information in relation to sexuality;
- sexuality education;
- respect for bodily integrity;
- choice of a partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when to have children; and
- pursue a satisfying, safe and pleasurable sexual life.

The ICPD PoA was adopted by 179 countries. The consistently strong support and advocacy for the PoA by the Caribbean can be attributed largely to the mobilisation and leadership of the women's rights movement. The region reaffirmed its commitment to women's rights in the 10-year review process. The first of three regional meetings in the process was held in Port of Spain, Trinidad and Tobago, on 12 November 2003. At this meeting Caribbean governments came forward with a Declaration stating that they:

1. Reaffirmed their unequivocal commitment to the principles and actions contained in the PoA and the document "Key Actions for Further Implementation of the Programme of Action of the International Conference on Population and Development", in particular, with respect to ensuring reproductive rights and health, gender equality, equity and the empowerment of women; and
2. Reaffirmed their commitment to the goals contained in the Millennium Declaration, and recognised that the implementation of the ICPD POA and the Key Actions is essential for the achievement of the Millennium Development Goals (MDGs).

The commitment of Caribbean countries was once again reaffirmed at the third of the three regional meetings, at the Economic Commission for Latin American and the Caribbean (ECLAC) 30th Session, which took place in San Juan, Puerto Rico. The Caribbean once again reaffirmed full support to ICPD in a statement read by Trinidad and Tobago on behalf of the Caribbean region, saying that:

"We have embraced the Cairo Programme of Action as our own, and are pursuing its implementation in the context of social, cultural, political and economic realities of our countries in line with universally recognised rights.

"We also reaffirm our endorsement of the Port of Spain, 2003 and Santiago, 2004 Declarations as the frameworks to guide the implementation of the ICPD Programme of Action in our countries over the next 10 years."

Research Methodology

Inspired by the 10-year review of the ICPD PoA, DAWN Caribbean has sought to understand how the commitment to the ICPD has affected women's lives. It is doing so through an exploration of how objectives to decrease maternal and abortion-related mortality and morbidity have been integrated into health sector reform processes.

The research process was launched in September 2003 with the recruiting of a lead researcher and a research team consisting of a researcher in Barbados, Jamaica and Suriname. In February of 2004, Trinidad and Tobago joined the team.

Utilising primary sources where possible, including data collected for country studies prepared for ECLAC for the 10-year review of the Cairo policy framework and progress of implementation in the countries identified, DAWN identified four main areas within the ICPD on which to focus for data assessment. Data was also gathered through research and formal and informal interviews. These areas were chosen because they imply a feminist perspective on population-related policies:

- The enabling environment;
- Sexual and reproductive health policies and programmes and the exercise of sexual and reproductive rights;
- The role of non-governmental organisations (NGOs), and governmental and non-governmental relations; and
- Financial aspects implied in the implementation of reproductive health programmes.

Researchers in each country created a country case study that examined the following:

- Basic demographic and social and economic indicators for the country, including gender-based data;
- Policies prevailing before Cairo: role of governments, role of international agencies; role of civil society organisations;
- Preparations for Cairo;
- What has happened in the post-Cairo period: what governments and international agencies have done (or not) to implement ICPD;
- Identification of relevant, country-specific ICPD recommendations that are to be drawn from the ICPD PoA elements listed before;
- Presence and role of reproductive health and rights advocacy community;
- Presence and role of ICPD Agenda adversaries;
- Health sector reform as it pertains to women's health;
- Maternal mortality policy;
- Abortion law and policy; and
- Abortion data and statistics.

The research explores the relationship between health sector reform, maternal mortality and abortion within the broader context of gender-based policy in the region.

Further, in August of 2004, DAWN Caribbean researchers and members of regional feminist organisations met in Barbados to evaluate a way forward for the DAWN Caribbean sexual and reproductive health and rights research. The discussion gave rise to the framing of several questions that will be critical to the continuation of sexual and reproductive health research and advocacy on the issues. These questions are as follows:

- What have Caribbean women achieved in regard to sexual and reproductive health and rights in the past 20 years?
- How should the women's movement tackle the fundamental problem of undervaluation of women's lives?
- Given the poor state of public health globally and in the Caribbean, how can the women's movement raise the priority of women's health?
- How can the Caribbean move away from the current response to women's health, which addresses women's needs primarily within a reproductive capacity?
- How can the response to women's health needs find a space between the dominant discourses of HIV/AIDS and maternal and child health?
- How can sexual rights and sexual health be brought to the forefront of the discourse on health, particularly given the impact of the HIV/AIDS epidemic?

Unfortunately, due to limited resource and human capacity, the research is not able to address each of the broader questions outlined above. However, this research does act as a step in creating the platform on which this important dialogue can occur.

Selected Countries

The DAWN policy research is closely articulated with advocacy strategies. For that reason, the choice of countries to be studied in the region required that organic connections existed between the women's movement of the Caribbean and the country research teams.

The four countries selected – Barbados, Jamaica, Suriname and Trinidad and Tobago – each has a population greater than 250,000 people. Specific to the research Barbados and Suriname have more liberal abortion policies than Jamaica and Trinidad and Tobago. In regard to maternal mortality, Jamaica, Suriname and Trinidad and Tobago have higher rates of maternal mortality than many countries of similar size (with the exceptions of Belize, Guyana and Haiti). Trinidad and Tobago was

specifically chosen because of the recent activities around abortion in reaction to the group ASPIRE, which has re-ignited the abortion debate in the public sphere.

Limitations of the Research

One of the greatest challenges facing research and analysis is the lack of accurate and high quality data. The Caribbean region reflects the challenges occurring globally in regards to abortion data, particularly in countries where abortion is illegal. Data around maternal mortality is also inadequate due to weak reporting structures, and misclassification of information. For example, PAHO's publication, *Health Conditions in the Caribbean*, notes that there is a lack of standardisation in recording mortality data: not all stillbirths are weighed, and some deaths of babies that weigh over 500g may be registered as abortions (Pate 1987).

The uneven collection of data and lack of accuracy by monitoring structures have challenged the researchers of this report to highlight these gaps. Further, lack of standardisation of the data prevents consistent comparison from one country to the next. Additionally, raw data is available in some countries in which NGOs have worked to compile and collect information. The complexity of data is illustrated by the situations existing in Trinidad and Tobago and Barbados. Despite abortion being illegal in Trinidad and Tobago, the exploration of abortion records and data by ASPIRE has generated information and numbers. However, in Barbados, where abortion is legal[2], it is suspected that abortions are often misrecorded and the use of abortifacients, confirmed by researchers, means that there is less information on abortion in general.

Report Structure

This report is a presentation of available data and concluding recommendations. The first section of the paper presents the broad country contexts, allowing for an understanding of the health sector reform processes addressed in section two. The third and fourth sections of the paper present research findings on maternal mortality and abortion in the region and the final section brings the data together to draw the connections between health sector reform, maternal mortality and abortion in the region. Finally, the report makes recommendations for the better integration and prioritisation of maternal mortality and morbidity in the health sector reform process – an integral step in improving the status of women's health in the region.

Endnote

[1] Available at www.unfpa.org/icpd/icpd_poa.htm

[2] When pregnancy poses a risk to the life of the pregnant woman, grave injury to physical or mental health, substantial risk to the child, or is a product of rape and incest.

2. Social, Economic and Political Context of Sexual and Reproductive Health Rights in the Caribbean

Regional Overview

The Broad Context

The Caribbean is a socially, culturally and economically heterogeneous region characterised by wide disparities in wealth and income among its English-, Spanish-, French- and Dutch-speaking countries. These disparities are well illustrated in Table 1, which does not include the very high-income, English-speaking territories of the US and British Virgin Islands and the Cayman Islands.

The countries of the region are characterised by similarly high domestic wealth and income disparities and high levels of social exclusion in what are historically highly stratified societies. Following decolonisation in the 1960s and 1970s, most regional governments prioritised social development in order to right some of the serious health and educational deficits that had accrued over the past centuries of slavery and colonial rule. With the significant exception of Haiti, which has been independent for 200 years, most countries were generally successful at this. This is evidenced by the large middle class in most Caribbean countries. However, significant parts of the population of all Caribbean countries remained trapped in deep structural poverty, without access to adequate health, housing and sanitation facilities and not benefiting from their countries' educational services.

By the 1980s, ideological shifts in development strategy, combined with global economic shocks arising from the 1970s oil crises, led to structural adjustment programmes of various sorts across the independent Caribbean. These policies generally led to cuts in social services provision that adversely affected the poor, leaving them more deeply ensconced in poverty and deprivation. Further, large cuts in government employment, critical in small developing economies with generally low levels of private sector development, threatened to return many of the newly created middle class to

Table 1: CARICOM Countries – Size and Social Indicators

Country	Area (km^2)	Population (1997)	GINI coefficient	HDI rank 2000
Antigua & Barbuda	442	69,747	0.525	37
The Bahamas	13,864	288,000		33
Barbados	431	264,500	0.460	30
Belize	22,966	230,000	0.510	58
Dominica	750	76,000	0.488	51
Grenada	345	99,500	0.504	54
Guyana	214,970	770,139	0.423	96
Jamaica	10,991	2,515,500	0.372	83
Montserrat	103	5,000		
St Kitts & Nevis	269	42,600	0.445	47
St. Lucia	616	149,621	0.468	88
St. Vincent & the Grenadines	389	111,000	0.448	79
Suriname	163,820	418,921		67
Trinidad & Tobago	5,128	1,270,000	0.420	50
TOTAL CARICOM	**435,084**	**6,310,528**		

Source: CARICOM (2000)

poverty, while many of those who were already poor were threatened with indigence. Structural adjustment approaches to public sector management did little to improve government efficiency. Combined with increasing fiscal crises, this resulted in many public sector institutions being unable to address the increasing social and economic problems that were affecting the citizenry (Jackson 2004).

Today, one sees a slight retreat from the austere economic policies recommended by the Washington institutions over more than two decades. However, economic policy-making has come to be dominated by concerns with fiscal management to the exclusion of long-term employment and income-generating strategies that might raise large sections of the Caribbean's population permanently out of poverty. As such, the region continues to amble along depending for its survival on a few externally driven industries such as tourism, agricultural commodities and mineral and petroleum extraction, while governments appear unimaginative in the face of pending crises including the ending of historical trade preferences and the HIV/AIDS pandemic (Jackson 2004).

Economic Trends

In 1989, member states of the Caribbean Community (CARICOM) agreed to establish the CARICOM Single Market and Economy (CSME) with the purpose of achieving a greater level of integration than is possible under the existing treaty. Objectives of the CSME include "free movement of goods, services, capital and persons, more intensive coordination of macroeconomic policies and economic relations and the harmonisation of laws governing trade and other economic activities within the common market area". The establishment of the CSME would also increase the bargaining power of CARICOM countries in arenas of international negotiations such as the World Trade Organization (WTO) or Free Trade Area of the Americas (FTAA). However, progress towards the establishment of the CSME has been slow (Jackson 2004).

A recent report prepared for the 10-year review of the International Conference on Population and Development (ICPD), 'Review and Appraisal of the Implementation of the Cairo Programme of Action in the Caribbean', puts forward that "small domestic markets, insularity and dependence on a narrow range of goods and services characterise most Caribbean economies. The recent globalisation process poses significant challenges to small developing economies".

While a few Caribbean countries have maintained economic growth, growth rates of many others have declined. During the 1990s, they experienced a shift in industry from agriculture and mining to the services sector while manufacturing remained stagnant. Agriculture accounted for 13.5 per cent of output in 1990 and 9.5 per cent in 1999, manufacture represented 12.7 per cent and 11.6 per cent while the service sector increased output from 39.1 to 46.6 per cent (Jackson 2004).

Unemployment in the region is high, ranging from approximately 12-20 per cent (Pate 2002). Young men and women have been most hard hit by high rates of unemployment, with young females disproportionately affected.

HIV/AIDS in the Caribbean Region

The Caribbean is second only to sub-Saharan Africa in HIV/AIDS prevalence. Haiti currently has the highest rate of HIV/AIDS infection in the region at 6.1 per cent of the adult population (ages 15-49). Fifty per cent of those cases are women (see Table 2). The Bahamas, Belize, the Dominican Republic, Guyana, Jamaica and Suriname also have HIV+ populations where women make up 40-50 per cent of the cases (Population Reference Bureau 2003). Rates among the youth populations are high as well: in The Bahamas in 2001, 3 per cent of females and 2.6 per cent of males between the ages of 15-24 were found to be HIV+. In the 15-24 age group in Belize, the Dominican Republic, Guyana, Haiti, Jamaica, Suriname and Trinidad and Tobago, female prevalence rates are also higher than male.[1]

In addition, the epidemic also has a further impact

on women. In the Caribbean, as in other parts of the world, women often carry the burden of caring for those members of their family living with HIV/AIDS. Women in the region are also often the primary heads of households. High numbers of women living with and affected by HIV/AIDS, therefore, means potentially devastating impacts on the stability of the Caribbean household. Special attention thus needs to be paid to the way the epidemic affects the lives of women as individuals, as caregivers and as the heads of their households.

Table 2: HIV Data for Selected Caribbean Countries (end of 2001)

Country	Adult (15-49) HIV Prevalence Rate (%)	Total Number of Adults Infected (15-49 years)	Female Infections (% of adult infections)
The Bahamas	3.5	6,100	44.3
Barbados	1.2	2,000	--
Belize	2.0	2,200	45.5
Cuba	<.1	3,200	25.9
Dominican Republic	2.5	120,000	50.8
Guyana	2.7	17,000	50.0
Haiti	6.1	240,000	50.0
Jamaica	1.2	18,000	40.0
Suriname	1.2	3,600	50.0
Trinidad and Tobago	2.5	17,000	32.9
Caribbean	**2.3**	**429,100**	**48.8**

Source: UNDP, Caribbean Regional Report on the Implementation of the Millennium Development Goals (MDGs), 15 November 2003

Financial and Implementation Strain on the Health Sector

In addition to understanding the enormous impact of HIV/AIDS on the lives of individuals, especially women, it is also necessary to recognise the burden HIV/AIDS places on the health sector.

Treatment of HIV/AIDS is seen as a major challenge in the region. While several countries and territories (including Barbados and Cuba) provide treatment for all people living with HIV/AIDS (PLWHA), many countries (including Dominica and Trinidad and Tobago) have noted difficulties experienced by PLWHA in accessing anti-retroviral therapy.

One of the most basic ways for individuals to protect themselves and those around them from contracting HIV is through knowledge of their own status. However, there are barriers to knowing this. In Dominica, for example, the cost of testing acts as a barrier. Confidentiality is another factor in an individual's decision to seek testing services for HIV, especially in the smaller Caribbean countries.

In addition, stigma and discrimination are major issues facing all people infected and affected by HIV/AIDS in the Caribbean as these have an impact not only on an individual's day-to-day life but also on her or his ability to seek treatment in a health-care system that does not respond appropriately to PLWHA. Related stigmas associated with sexual diversity and transactional sex also have an impact on an individual's ability to seek out HIV/AIDS services and increase vulnerability to contracting the disease.

HIV/AIDS and Sexual and Reproductive Health and Rights: Linkages and Disconnects

Despite the intrinsic connections between HIV/AIDS and sexual and reproductive health and rights (SRHR), programmes and policies addressing the two areas are often planned and implemented in isolation from one another. Absent from the approach to both areas is the necessary focus on a variety of SRHR issues.

The issue of diverse sexuality has historically been – and continues to be – marginalised, particularly because of historic and current stigmatisation of the lesbian, gay, bisexual and transgender (LGBT) communities. HIV/AIDS has offered the opportu-

nity to discuss diverse sexualities; however, the emphasis remains on control of, rather than respect for, these.

Another issue of particular relevance to the HIV/AIDS epidemic and SRHR is the vulnerability of young girls and boys to HIV/AIDS and other sexually transmitted infections (STIs) due to engagement in sexual activity with older individuals. This phenomenon is often discussed in relation to transactional sex, and particularly in reference to older men and younger girls. While the issues of transactional sex or of older individuals engaging in sexual behaviour with children and young people are acknowledged, few programmes appear to directly address them.

Further linkages must be made within the foundational approaches to addressing issues of SRHR and HIV/AIDS. The absence of these efforts will continue to contribute to an increasing incidence of HIV/AIDS due to lack of appropriate knowledge and inadequate access to quality information that a comprehensive approach would provide.

Violence Against Women

Violence against women in the Caribbean continues to occur at a consistently alarming rate. It comes in many forms: within the home, random and targeted sexual offences, and the abuse of young women and girls in and outside the family. In Jamaica, 3,844 people were assisted by the Kingston Crisis Centre in 1998. Of these, 1,037 were reported as victims of domestic violence and an additional 1,510 were recorded as 'domestic crisis'. In 1997, 1,857 cases of sexual offences were filed, 40 per cent involving rape and bodily harm (UNDP Jamaica 1999). In Suriname, data revealed that 69 per cent of women in conjugal relationships had reported abuse in the context of the relationship (Constance 2001).

Violence against women in the Caribbean contributes to a lower standard of health for women. Continued high rates of violence indicate a failure in the legal and health systems to address the nuanced dynamics of power that contribute to the vulnerability of women and their inability to take action against offenders.

Poverty and Education

In 1996, the World Bank estimated that 38 per cent of the total population in the Caribbean was poor. This ranged from 5-65 per cent of national populations. The poor in most countries are found among older persons, women, young males, unemployed youth and unskilled workers. Poorer families in the region tend to have more children, be less educated and be single-parent households (UNFPA and ECLAC 2003).

Access to education in the region is widespread, as demonstrated by overall literacy rates ranging for most countries between 92 and 99.8 per cent. Government spending on education is high, ranging between 2.5 and 9.8 per cent of GNP. Girls often outperform boys in school, but women still have a greater chance of being unemployed as well as being paid less then men.

Regional Demographic Overview

The Caribbean region has seen a drop in the total fertility rate from 5.07 in 1950-1955 to 2.47 in 1990-1995. Moderate population growth can be seen in the region at a rate of approximately 1 per cent per annum.

Females make up approximately 50.3 per cent of the total population. There has been a decrease in the crude birth rate from 26/1,000 in 1980-1985 to 22.4/1,000 in 1990-1995. During these times the infant mortality has also dropped from 23/1,000 to 21/1,000 (Pate 2002). Life expectancy at birth has increased, averaging about 68 years. Approximately 30 per cent of the Caribbean population is below the age of 15. Less than 60 per cent of the entire Caribbean population is between 16 and 60 years old (UNFPA and ECLAC 2003). Basic indicators for the countries included in this report can be found in Table 3.

Table 3: Basic Indicators for Selected Caribbean Countries (Ca. 2004)

	Contraceptive Prevalence	Total Fertility Rate	Average Population Growth Rate	% Births with Skilled Attendant	Infant Mortality
Barbados	53.2 (1994)	1.8	.6	91	14.7/1,000
Jamaica	62.8	2.8	.6	97.8	19.0/1,000
Suriname	42.1 (2000)	2.2	.9	85	29.1/1,000
Trinidad and Tobago	52.7	1.7	.6	99	21.1/1,000

Source: UNFPA Caribbean tables monitoring pre- and post-ICPD reproductive health environment. UNFPA Caribbean. Downloaded 11 August 2005. http://caribbean.unfpa.org/default.aspx?tabid=205

The Socio-Political Context

The Caribbean Women's Movement

A recent paper by Margaret Gill[2] outlines thoughts on the status of the women's movement in the region. She states that while the Caribbean women's movement has always been on somewhat unsteady ground, it currently rests on even less stable foundations than ever before. She cites five factors contributing to this destabilisation:

1. The notion of difference (exploring, critiquing and understanding the idea of universal sisterhood);
2. Notions of the total or absolute power of patriarchy, colonialism, neo-colonialism, capitalism and statism – in other words, the belief in the near impossibility of penetrating these amalgams of power (creating strategies, recognising the strength of women's organisations and presence);
3. The male backlash (the idea in popular imagination and further in academic and programmatic rhetoric that in fact men are marginalised, given education indicators);
4. The 20th century instabilities of the concept of the nation state;
5. Loss of funding.

In the introduction to this report, Peggy Antrobus connects these ideas to two other issues that came out of a regional workshop sponsored by the Women and Development Unit (WAND) of the University of the West Indies (UWI) in the 1980s: sexuality and spirituality, which were identified as sources of empowerment for Caribbean women. These are necessary and missing elements in stabilising and reenergising the women's movement in the region.

A universal point of concern and related activism for members of the Caribbean women's movement relates to health and, in particular, access to and quality of care in the region and the impact of the HIV/AIDS epidemic.[3] Mobilising around global human rights conferences has been a major success of the Caribbean women's rights movement. These meetings include the Fourth World Conference on Women (in which Caribbean women shone as leaders); the recent ICPD 10-year review; and various trade-related conferences, which demonstrated that the greatest impact of current trade policies is often on the female agricultural workers of the region. This ability to organise and drive change is testimony to the capability of Caribbean women to come together as a unifying force.

Along with those issues identified by Gill, new struggles built on old dogmas continue to challenge women's rights in the Caribbean, the rise of religious fundamentalisms being one in particular.

Religious Fundamentalisms[4]

The history of religion in the Caribbean is as complex as the histories and experiences of the various groups of people that make up the population of

the region. African-Caribbean, Indian, Chinese, Syrian, Lebanese and Amerindian populations bring their own practice of faith and associated culture. For many, the experience of religion has been one of movement and community building, as seen within the Liberation Theology movement for many Catholics and the experiences of Indians in the Caribbean, particularly in Guyana and Trinidad and Tobago. While many of these experiences have been positive, fundamentalist practices of faith in the region, as in many other parts of the world, have often promoted religious dogma that is most damaging and controlling towards women.

Addressing the challenges posed by religious fundamentalism in the region is difficult. Unlike Latin America, which is dominated by the Catholic Church, or many countries of Central and South Asia that are dominated by prevailing discourses on Islam, the Caribbean does not put forward a singular religious ideology that drives conservative politics. Some countries have majority populations within one religious group, for example, Catholicism in Dominica or St. Lucia. Other countries, such as Suriname and Trinidad and Tobago, have large populations of Christians, Hindus and Muslims, each with their own fundamentalist factions. Such diversity has not, however, prevented unity among those that seek to deter individual rights: in Guyana, religious groups came together to speak out against efforts to protect rights around sexual orientation.

In regard to sexual and reproductive health and rights (SRHR), religious discourse has been influential in recent debates, including those on the issues of the decriminalisation of homosexuality and sex work in Barbados, discrimination on the basis of sexual orientation in Guyana and abortion in St. Lucia. In each of these cases, various religious groups (Christian groups and individuals in general, Catholics, Muslims and Hindus) spoke out on a particular issue.

The recent rise in fundamentalism may be partly attributed to a reaction by the people of the Caribbean to increased levels of poverty, a slowdown in economic growth, a loss of local culture (due to the increased presence of American media) and an increase in crime and violence. Such factors have been blamed for 'moral decay' and have inspired a return to faith-based communities in efforts to reclaim what is seen to be lost in regards to community. In addition to these socio-economic factors, however, one cannot ignore the co-optation of many churches by an evangelistic presence of church bodies from North America. And this problem is not limited to the Christian church, as many Hindu and Muslim communities have also been greatly influenced by rising levels of fundamentalism in South Asia (countries of origin for the Indo-Caribbean community). Finally, one must look to the changing nature of monies coming into the Caribbean for HIV/AIDS (and the development community) that have been earmarked for faith-based groups that, in turn, increase the influence of religious bodies in areas of HIV/AIDS and SRHR.

The lack of a singular religious institution does not negate the influence of religion and religious beliefs on policy and legislation that govern SRHR. Rather, the ubiquitous and often undefined presence of religion needs to be further assessed and analysed, particularly in the lives of those people charged with advocating for and driving policy. The undefined nature of the way religion operates in the Caribbean makes it difficult but necessary to understand.

Very little research has been done on the impact that religion is having on the SRHR movement in the Caribbean and in particular on the women's movement. However, it is becoming clear that there is an important need to undertake this in order to tackle negative outcomes of the growing influence of religious bodies, particularly on individual rights in the area of sexual and reproductive health.

Regional Support and Dissent for ICPD from Non-Governmental Actors

Regional support for the ICPD Programme of Action and the Beijing Platform for Action has come from various groups including women's and feminist organisations 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; implementing organisations such as national family planning associations and Stichting Lobi of Suriname; and UN bodies such as UNFPA and UNIFEM, through encouraging the participation of governments and activists in the ICPD +10 review process.

Despite the activity of a few vocal groups, however, there is a dearth of activism and action around the ICPD Programme of Action. All four countries covered in this report have noted that the Programme has not generated a great deal of activism and action, nor does it seem to inspire work around women's health. This dearth in activism is not because the issues addressed in the Beijing Platform for Action and the ICPD Programme for Action are not relevant to Caribbean women. To the contrary, women in the Caribbean face continued inequality in the socio-political and economic contexts of their countries, as illustrated by this research. The rise of HIV/AIDS speaks to the need for a further integration of rights approaches in addressing the pandemic.

Because of the limited attention paid to the ICPD in mainstream consciousness regionally, there has been little dissent around its Programme of Action in particular. However, specific issues that are related to women's reproductive health and rights have come under attack in several Caribbean countries. A good example is provided by the recent abortion debates in St. Lucia and Trinidad and Tobago, between anti-abortion Roman Catholics and other religious organisations on the one hand and advocates for safe and legal reproductive services on the other, which led to the shelving of proposed legislation to allow abortion in some circumstances.[5] Public debates around homosexuality and sex work in Barbados, which led to the squelching of a proposal to decriminalise these acts, demonstrate the strength of a movement that seeks to legislate behaviour on moralistic and often religious grounds rather than human rights or science and behavioural science-based rationales.

The neglect of women's health in the Caribbean, particularly SRHR, is reflected in continued valuation of women's lives based on their reproductive capabilities, as seen through maternal and child health (MCH) programmes that historically focus on women of reproductive age. With more funding dedicated to HIV/AIDS, women's health issues are increasingly dichotomised into two streams: MCH or HIV/AIDS. Other health issues, in particular those related to sexual health and sexual rights, are marginalised. Specific issues in the region affected by the neglect of SRHR include the challenge of increased tubal ligations in Trinidad and Tobago, limited access to contraception across sexually active populations and a lack of focus on sexual pleasure.

Country Profiles

Barbados

Context

Barbados is the eastern-most Caribbean island and extends over approximately 430 km^2 divided into 11 parishes (PAHO 2002). The 2002 UNDP Human Development Report ranked it 31st among 174 countries. The population is approximately 270,400, with some 35,000 people living below the poverty line (Ministry of Health 2003).

Barbados gained independence from the United Kingdom in November 1966 and operates as an independent state within the Commonwealth. It has a democratic (two party) system of government, with parliamentary elections held every five years. The two parties are the Barbados Labour Party (BLP) and the Democratic Labour Party (DLP). The Parliament, which has legislative power, consists of 21 members of the Senate and 28 members of the House of Assembly. The Government is a constitutional monarchy, however, and the Head of State is the Queen of England, who is represented by the Governor General. Executive power resides with the Cabinet, the principal organ of policy. Judicial authority is vested in

the Supreme Court, which is comprised of the High Court and the Court of Appeal. The Privy Council consists of members appointed by the Governor General. Barbados does not have a local government system and thus all political, fiscal and administrative responsibilities are managed under the central government (European Commission, nd).

Demographics

Table 4 provides a demographic overview. The 14th Population and Housing Census in 2000 reported that the total population of Barbados was 268,792 individuals: 129,241 (48 per cent) males and 139,551 (52 per cent) females (Ministry of Health 2002). Fifty-one per cent of this population is considered urban. Life expectancy of males in 2004 was approximately 71 years and for females 77.6 years. In 2001 the contraceptive prevalence rate was 55 per cent for any method of contraceptive, the infant mortality rate was 11/1,000 live births and the maternal mortality ratio was 33 (UNFPA 2001). The percentage of births with a skilled attendant was 91 (UNICEF 2002).

In 2002, 97 per cent of females and 98 per cent of males above the age of 15 were literate. In 1998, 100 per cent of urban populations had access to potable water and 99 per cent had access to basic sanitation (data for rural populations not available). Eighty-five per cent of Barbadians own the houses that they live in (not necessarily the land); 90 per cent of households have running water; 90 per cent have electricity; 80 per cent have telephones; 85 per cent have refrigerators and 42 per cent have motor vehicles (Ministry of Health 2002).

Economic Profile

Barbados is described as a small, open economy and over the past 30 years it has moved from a reliance on sugar to become a services-based economy (Ministry of Health 2002). The main industries are tourism and financial services. Offshore financial services and informatics are also the main foreign exchange earners. The unemployment rate is approximately 9.3 per cent. Real GDP declined by 2.6 per cent in 2001 from 3.0 per cent in 2000 (European Commission, nd).

Gender-related Policies

Since the ratification of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1980, Barbados has taken several steps to reform policy as it pertains to women being able to pass on citizenship to their children and the rights of women in common law unions around property (Government of Barbados et al. 2003).

The ratification of the Convention on the Rights of the Child (CRC) in 1990 led to the introduction of legislation around the *Family Law Act* to address the rights of children to maintenance from non-biological fathers who are in lasting relationships with mothers. However, this law has not gained public support from men (ibid.).

In 1992, the *Domestic Violence Protection Orders Act* granted protection orders in circumstances of domestic violence. The legislation provides protection for both male and female victims of domestic violence, in addition to couples in common-law unions (ibid.).

Table 4. Demographic Overview, 1993-1999, Barbados

Year	Resident Population at Dec 31	Birth Rate (per 1,000 pop.)	Death Rate (per 1,000 pop.)	Rate of Natural Increase (per 1,000 pop.)	Infant Mortality (per 1,000 births)	Rate of Population Growth
1993	263.9	14.3	9.1	5.2	9.8	.3
1994	264.3	13.4	8.9	4.5	8.5	.2
1995	264.4	13.1	9.4	3.7	13.2	.4
1996	264.6	13.3	9.1	4.2	14.2	.1
1997	266.1	14.3	8.7	5.6	13.2	.6
1998	266.8	13.6	9.3	4.3	7.8	.4
1999	267.4	14.5	9.0	5.5	10.0	.2

Table 5: Real GDP Per Capita 1999 (Gender Equality, Barbados)

Female	Male
9,252	14,496

GNI PPP per capita 2000=15,020

In 1992, the *Sexual Offences Act* updated older legislation addressing rape and other sexual offences committed against girls, boys and women. Additionally, the *Sexual Offences Act* also introduces legislation around trafficking. However, husbands cannot be charged with marital rape unless there has been a breakdown in the marital relationship. Homosexuality is illegal and stigmatised (ibid.).

The *Education Act* of 1991 states that the "parent of every child of compulsory school age shall ensure that the child receives full time education suitable to his age and ability" (UNFPA nd).

The *Constitution (Amendment) Act* 2000-18 gives women equal rights with men with respect to the nationality of their children and to equal participation and freedom of assembly and association (ibid.). Article 11, Section 2: Right to protection of health and safety in working conditions includes maternity leave, special protection for pregnant women and support for families. Section 14: Provision of health care services includes information, counselling and family planning services. The legal age of consent is 16; consequently young people 16 and under can be denied access to sexual health information and sex education (ibid.).

Table 6. Women in Decision-Making Positions 2000-2001, Barbados

Position	Total	Male	Female
Elected Members of Parliament	28	24	4
Members of Cabinet	20	16	4
Parliamentary Secretaries	2	2	0
Senators	21	15	6
Permanent Secretaries	25	18	7
Deputy Permanent Secretaries	24	16	8
Directors/Heads of Government Agencies	97	67	30
Deputy Directors/Heads of Government Agencies	50	36	14
Judges of High Court	6	5	1
Judges of Appeal	3	3	0
Magistrates	10	6	4
Parliamentary/Crown Counsels	21	5	16
Ambassadors	11	8	3

Source: Government of Barbados et al. ICPD+10 Field Inquiry Questionnaire. June 2003.

UNFPA Caribbean notes that the rights of Barbadian women are still to be fully realised. This is exemplified by the inability of wives to charge their husband with rape unless they are able to demonstrate that there has been a breakdown in the marital relationship.

Poverty Reduction Strategy

Poverty Alleviation Bureau

Barbados established a Poverty Alleviation Bureau in October 1998 to examine and report on the living conditions of persons and organisations making applications to the Poverty Eradication Fund for assistance (Ministry of Social Transformation 2003).

The main objectives of the Bureau are to :

- Assist in the alleviation and eradication of poverty through the empowerment of individuals and groups by the provision of economic and financial opportunities as well as education and vocational training.
- Establish a cordial and effective working relationship with government agencies, non-governmental organisations (NGOs), community-based organisations (CBOs), individuals and community groups in an effort to reduce inefficiencies, duplication of efforts and wastage of resources.
- Ensure a faster and more meaningful delivery of services.
- Create the climate for young people to gravitate towards the growth and development of small/micro business enterprises.

- Pioneer the development of a new entrepreneurial class (Government of Barbados et al. 2003).

In addition, the Bureau is responsible for developing a strategy for the alleviation and eventual eradication of poverty through community involvement and for providing the necessary technical assistance for the intermediary organisations to enhance their capabilities to service their clients.

The Fund provides assistance to individuals via organisations that usually support projects aimed at alleviating poverty. The major beneficiaries of this effort are women who are heads of households.

Relief 2000

Relief 2000 focuses on the recipients of social assistance and families in need as they are identified by social agencies and similar organisations "as extreme cases of poverty meeting their needs in respect of employment, training, financial assistance, adequate housing and identification to improve their circumstances". There does not appear to be a particular gender element to this programme.

Jamaica

Context

Jamaica is the third largest island in the region and is located in the western Caribbean some 144.8 kilometres south of Cuba, 160.9 kilometres southwest of Haiti and 898 kilometres southeast of Miami. The island has an area of 11, 420 km^2. The capital and major commercial centre, Kingston, is situated on the southeast coast. According to World Bank classification, Jamaica is considered to be a lower middle-income country. Its development profile, however, shows significant income inequality.

Demographics

Information given in the 2004 *Economic and Social Survey* (Planning Institute of Jamaica 2004) indicates that the population of Jamaica at the end of 2004 was estimated at approximately 2,650,900 million with a roughly 1:1 male-female ratio – 49.3 per cent males and 50.7 per cent females (the proportions remained unchanged since 2002). The rate of natural increase was 1.4 per cent, while the actual population growth rate was 0.5 per cent, reflecting the net effect of the pattern of birth and deaths and of external migration (0.9 per cent).

Jamaica's population is highly urbanised, with the urban population comprising 52.0 per cent of the total in 2001. The trend seems to be the growing urbanisation of parishes other than the capital: the parishes recording the highest urban growth rates were St. Elizabeth (3.7 per cent), St. Catherine (2.9 per cent), St. Ann (2.0 per cent) and St. Thomas (1.7 per cent). Urban St. Andrew grew marginally at 0.4 per cent, reflecting its lowest rate ever recorded, and Kingston registered negative growth at 0.12 per cent.

The average household size in 2003 was 3.47, with rural households continuing to be slightly larger with an average size of 3.63 persons (Planning Institute of Jamaica 2003). Households headed by females and those in the poorest consumption group were also larger than the national average, being 3.82 and 5.37 respectively. In 2003 women headed 45.1 per cent of households compared to 44.7 per cent in 2001. There were 52.6 per cent female-headed households in the Kingston Metropolitan Area. These households are more likely to be larger, have more children and be in the lowest consumption quintile. In some 71.4 per cent of households headed by women there is no spouse, as compared to households headed by men, where there is a spouse in 71.5 per cent of cases. This implies that the majority of women who head households are rearing children without the presence of a partner in the home.

Jamaica's population is predominantly young and of working and child-bearing ages. Children under five and those 5-9 years old were 10.4 (271,736) and 10.7 (279,323) per cent of the population respectively in 2001. Adolescents aged 10-19 (244,470 males,

253,439 females) accounted for 19 per cent and persons aged 20-49 were 43.8 per cent of the population (Ministry of Health 2001).

The 2004 *Economic and Social Survey* indicates, however, that persons 60 years and over are the fastest growing segment of the population – increasing at around 1.5 percent annually – and are projected to be 12.5 per cent of the population in 2020. This fact has implications for the provision of health services and care facilities, the nature of the labour force, pension reform and the provision and design of social safety net programmes.

The growth rate has been consistently below 1 per cent since 1997. The report makes special note of the fact that the current growth rate is below the projected rate of 0.8 per cent, and hence Jamaica is on target for achieving its National Population Policy growth target of below 3.0 million by the year 2020.

There has been a decrease in the number of women in the Houses of Parliament from 15 per cent to 12 per cent, but there are still three women Ministers out of a total of 18. There has been a drop in women's presence in local government from 24 per cent to 15 per cent.

Economic Profile

The 2004 *Economic and Social Survey* says the "economy recorded its sixth consecutive year of real GDP growth" of an estimated 1.2 per cent in 2004 (Planning Institute of Jamaica 2004). The point-to-point inflation rate for 2004 was 13.7 per cent per cent, down from 14.4 per cent recorded for 2003 (ibid.).

These positives are overshadowed by significant, underlying threats to the sustainable development of the economy. Several reasons have been given for this, including a shortage of locally produced goods due to drought and hurricanes (Charley and Ivan); an increase in commodity prices, e.g., grain and oil; and higher electricity and water bills.

In 2004, the number of persons in the labour force increased by 0.4 per cent to 1,194,800 (Planning Institute of Jamaica 2004). The overall labour force participation rate was 64.3 per cent. The male labour force participation rate was 73.3 per cent, while the female rate was 55.8 per cent.

The number of employed persons increased to 1,055,200, up from 954,300 in 2002. Female employment increased by 1,900 to 444,300, largely in the wholesale and retail trades, hotels and restaurant services. There were 139,600 unemployed persons, with female unemployment being 16.4 per cent while the male was 7.9 per cent. Female youth unemployment was 40.6 per cent compared to 23.4 per cent of male youth. In 2004, females accounted for 62.3 per cent of the unemployed labour force compared to 61.9 per cent in 2003.

Suriname

Context

The total land area of the Republic of Suriname is 163,820 km^2, excluding disputed territories with neighbouring Guyana, and it is divided into 10 administrative districts. The coastal area (northern lowlands and savannah) is well inhabited while the hinterland (southern highlands covered by tropical rainforest) is sparsely inhabited. Estimates for the year 2000 indicated that the urban districts, Paramaribo and Wanica, which cover only 0.4 per cent of the land area, were inhabited by approximately 68 per cent of the population, with an estimated population density of 470.1 per square km. The district of Sipaliwini, which covers 79.7 per cent of the land area, was inhabited by approximately 5.5 per cent of the population with an estimated population density of 0.9 per square km (Ministry of Health 2000).

Statistics for 2003 show that the population density of the urban areas increased to 1,338.3 for Paramaribo and to 193.1 for Wanica. In Sipaliwini, density has further decreased to a mere 0.2 per square km. It is important to note that for Sipaliwini the sex ratio is the lowest of all districts: 91 males to 100 females compared to a national

101:100 (General Bureau of Statistics 2003). This can be explained by the fact that when the men leave the villages to search for economic possibilities, the women stay behind.

Suriname has a multi-ethnic population with 16 distinct ethno-linguistic groups. The largest groups are the Creole (35 per cent), East Indian (34 per cent) and Javanese (16 per cent), followed by the Maroons (10 per cent), the native Amerindians (2 per cent) and Chinese (2 per cent). The other 1 per cent is made up of Lebanese, Europeans and others (Government of Suriname 1998).[6]

Demographics

Suriname has a pyramid-shaped population structure with 52 per cent of its population younger than 25 years. Data collected for the year 2000 suggest the same structure as the GBS 1995 estimates (Government of Suriname 2001). Table 7 shows population development between 1994 and 2000.

Fertility rates declined from 3.6 in 1980 to 2.4 in 1995. The steady decline is most likely due to increased education in family planning and contraceptive use. Unfortunately, reported fertility rates for 2000 seem to be unreliable. For Multiple Indicator Cluster Survey (MICS) data the Brass P/F procedure was used, with a total fertility rate (TFR) of 3.3 as a result. This seems very unlikely with regard to the declining trend, and so further investigation was warranted (Government of Suriname 2001). The Pan-American Health Organization (PAHO) predicted that the fertility rate would drop to 2.1 for the period 1999-2003.

The *Chief Medical Officer's Report 2000* estimates male life expectancy at birth to be around 70 years of age for 1990-1995, with women living approximately five years longer (Ministry of Health 2000). This is supported by findings of PAHO that life expectancy at birth was 69.1 years for men and 74.1 years for women in 1998. According to other figures however, life expectancy in that year was 68 years for men and 70 years for women (Terborg 2001a).

Since 2001 the Bureau of Public Health has made efforts to improve data collection and monitoring systems. Due to under-reporting, the registered maternal mortality rates (MMR) were 38 per 100,000 for 1990, 45.9 for 1995 and 31.9 for 1996. Based on active hospital surveillance, the MMR was corrected to 153 per 100,000 for the year 2000 (Government of Suriname and NFPA 2003).

Death rates remained steady between 1996 and 1998, then increased in 1999 and 2000. The increase can be attributed to better reporting and case identification of deaths, and to deaths due to causes exacerbated by the economic hardships during those years. The two-fold increase in infant mortality based on registered deaths in the year 1996

Table 7: Development of Population, 1994-2000, Suriname

Year	Start Pop.	Births[a]	Deaths	Natural Growth	Migration Saldo	End Pop.	Crude Birth Rate[b]	Crude Death Rate[b]	Growth in %
1994	413,591	8,418	2, 842	5,576	-1,443	417,724	20.3	6.8	1.0
1995	417,724	8,717	2,696	6,021	- 400	423,345	20.7	6.4	1.3
1996	423,345	9,393	2,894	6,499	-2,022	427,822	22.1	6.8	1.1
1997	427,822	10,794	2,878	7,916	-1,407	434,331	25.0	6.7	1.5
1998	434,331	10,221	2,814	7,407	-2,577	439,161	23.4	6.4	1.1
1999	439,161	10,144	2,992	7,152	- 640	445,673	22.9	6.8	1.5
2000	445,673								

Notes: [a] According to the Ministry of Health (2000), figures for births are not accurate since the CBB used to count early neonatal deaths as stillbirths.
[b] Crude death and birth rates are calculated per average population for that year.

Source: CBB, Demographic Data Suriname 1998-1999

could not be explained, and was not supported by the data retrieved from death certificates. The increase could possibly be due to a data collection or entry error (Ministry of Health 2000).

In the 2000 Suriname MICS, 42.1 per cent of women married or living in union reported current use of contraception. An earlier contraceptive prevalence survey, conducted in 1992, showed that 49 per cent of women aged 15-44 used a contraceptive method. However, wide discrepancies were found between women of different ethnic and age groups (Jagdeo 1993).

The lowest prevalence is among women in the interior. Apart from the difficulties of obtaining contraception, this is also due to the combined effect of cultural beliefs, such as the high value placed on fertility and motherhood, and the overall lower education levels of the people in the interior.

Contraceptive knowledge appears to be high among young people, but this is not necessarily reflected in contraceptive use. In a 2000 study in two high-risk pilot areas, almost all respondents aged 15-24 knew about the pill and condom. Around 30 per cent of these respondents found access to contraceptives easy. All the same, among the respondents age 15-19 only 22.8 per cent used

Table 8: Demographic Indicators, 1998-2000, Suriname

Indicator	1998	1999	2000
Estimated mid-interval population	424,590	430,261	435,797
Stillbirths	228	223	260
Live births	10,221	10,144	9,804
Total births	10,449	10,367	10,064
Women in 15-44 age group	NA	NA	NA
Live births for females 15-44	10,148	9,794	9,279
Fertility rate (live births per 1,000 females 15-44)	NA	NA	NA
Infant deaths	163	227	175
Maternal deaths	9	11	15

Source: Ministry of Health 2000

Table 9: Total Population by Age and Gender: Mid-year Estimates by Age Group and Sex, 1995, Suriname

Age group	Male	Female	Total
0-4	22,422	21,864	44,286
5-14	45,516	44,774	90,290
15-24	40,573	38,642	79,215
25-44	62,782	60,860	123,642
45-64	24,755	26,808	51,563
65+	9,332	10,538	19,870
Total	**205,380**	**203,486**	**408,866**

Source: General Bureau of Statistics, May 1999

Table 10: Population at Census Years by Sex, Sex Ratio and Growth per Annum, Suriname

Census	Males	Females	Total	Sex ratio	Growth p.a.
1950	88,284	89,504	177,788	99	
1964	161,855	162,356	324,211	100	4.6
1972	190,497	189,110	379,607	101	2.1
1980	175,818	179,422	355,240	98	-0.9
2003	241,837	239,292	481,129	101	1.3

Table 11: Vital Statistics Rates, 1995-2000, Suriname

Vital statistics rates	1995	1996	1997	1998	1999	2000
Stillbirth rate[a]	17.6	21	21.4	22.3	22	25.8
Neonatal death rate[b]	9.0	10.7	9.8	9.0	10.8	14.9
Perinatal death rate[c]	27.3	31.5	32.5	32.7	32.6	38.4
Infant death rate[b]	24.7	52.5	22.0	15.9	22.4	17.8
Maternal death rate[b]	0.46	0.43	0.74	0.88	1.08	1.53
Estimated birth rate[d]	21.3	22.7	25.8	24.1	23.6	22.5
Estimated death rate[d]	6.6	7.0	6.9	6.6	7.0	7.1

Source: Ministry of Health 2000

Notes
a per 1,000 total births
b per 1,000 live births
c still birth + early neonatal death per 1,000 total birth
d per 1,000 of population

Table 12: Contraceptive Prevalence among In-union Women by Age Group, Suriname		
Age Group	User	Non user
15-19	29.6	70.4
20-24	50.3	49.7
25-29	52.4	47.6
30-34	60.1	39.9
35-39	58.7	41.3
40-44	47.9	52.1

contraceptives (Terborg 2001b).

Political and Economic Profile

The mining and processing of bauxite became the core of the economy in the late 1950s. It also provided successive governments with the means to distribute wealth without stimulating or developing other sectors of production. The strong and centralised government control that still reigns today is built on a political patronage system, where political factions, followers and friends can be rewarded with civil service jobs, houses and other (artificially made) scarce commodities (Dew 1978).

Of a total population of 481,146 (General Bureau of Statistics 2003), and with an employment figure varying between 11 per cent and 14 per cent, a total of 36,151 civil servants make up 37 per cent of the labour force (General Bureau of Statistics 1998).[7] More remarkable, almost 25 per cent of the total labour force is comprised of desk civil servants (23,987). This army of pencil pushers is more than 10 times the military army (2,042), more than 20 times the police force (1,142) and almost 20 times the total of nurses (1,235) (Ministry of Home Affairs 2003).

In 1996 and 1997, the unemployment rate for women was twice that of men. Although there was a general increase of 6 per cent in employment from 1995 to 1997, job losses occurred in sectors that employ the most women. Women still work mainly in the traditional 'caring' sectors, which pay the least. The Government is the main employer of women, the majority in the lowest echelons (71 per cent of low-level civil servants are female). With globalisation and the economic crisis, female entrepreneurs have disappeared from the formal sector and moved to the informal sector (UNIFEM 2000). In the private sector, the rights of women workers are not well regulated and credit is hardly accessible. The estimated share of females in the economically active population is 32 per cent.

Female Education

The Ministry of Education is the largest government ministry, in terms of both budget and number of employees. Allocations favour tertiary education. With a population of less than half a million people, Suriname maintains a university that offers social, technical and medical studies. The university places a heavy burden on the education budget. In 1996-2000, the annual average allocation per university student was SRG 929,445 (US$422), while for pre-primary and primary pupils it was 264,227 (US$120) (Schmeitz 2002).

The output of the education system at all levels is low, both quantitatively and qualitatively speaking. Each year, 23 per cent of all pupils, at all levels, have to repeat a class, while 23-40 per cent do not pass their exams. The percentage of dropouts is alarming: 7 per cent in primary school and 25 per cent in secondary school (Ministry of Education 2001). For children in the interior, education is not always accessible and is of considerably lower quality.

There is no indication that fewer girls enrol than boys. The percentage of women in higher education has gradually increased over the past years and is now higher than men, but this is not reflected in the proportion of women in leadership positions in the country. Women comprise 9 per cent of university lecturers, 17 per cent of the National Assembly, 19 per cent of the Council of Ministers, 14 per cent of councils of political parties and 5 per cent of medical specialists (Terborg 2001a).

Gender-Related Policies

In the draft report of its consideration of reports of

States parties, the Committee on the Elimination of Discrimination against Women commended Suriname for the appointment of a Commission on Gender Legislation that was given the task of reviewing draft laws related to the international conventions on gender equality and presenting recommendations on new gender-sensitive legislation. In addition, the Committee noted the implementation of the Gender Action Plan (2000-2005), which takes into account the Beijing Platform for Action, the Caribbean Community Post-Beijing Plan of Action and Suriname's national priorities (CEDAW 2002).

Poverty Reduction Policy

Suriname is in 17th place on the World Bank's list of countries with the richest natural resources. At the same time it is the third poorest country in the Caribbean sub-region, behind Haiti and Guyana. Economic inequality has almost doubled in a dramatic way over the last 30 years, leaving the lower 50 per cent of the population with only 20.2 per cent of national expenditures while the top 20 per cent of the population receives 50.5 per cent of national expenditures (General Bureau of Statistics and IDB 2001).

A decline in the prices of bauxite and aluminum, years of internal unrest and war, and suspension of Dutch development aid in 1983 contributed to two decades of social, political and economic instability in Suriname, resulting in soaring inflation and deterioration of infrastructure and social services. In 1994 inflation peaked at 368.5, after which the situation gradually stabilised. According to the General Bureau of Statistics, inflation in 2001 was 38.6.

In 2000, three different estimates confirmed that poverty is a major and complex problem in Suriname. A UNDP-supported study on poverty (Nehri and Menke 2001) estimated that general (food and non-food) poverty could be higher than 72 per cent. The Bureau of Statistics estimated that "the percentage of poor persons in Suriname most probably lies between 49 per cent and 74 per cent" (General Bureau of Statistics 2001), with 20 per cent living in extreme poverty and 31 per cent receiving some form of social assistance. Estimates obtained from the UNICEF-supported MICS 2000 suggest a regionally weighted average of about 73.2 per cent poverty. The poverty studies identified female heads of household, youth (0-24 years), the interior population and senior citizens as high-risk groups for poverty. Based on the income poverty ratio, 91 per cent of persons in the interior live below the poverty line. The years of war, with the interior as primary battleground, forced migration, poor infrastructure and high levels of disease have contributed to a disproportionately poor quality of life for the population there.

Unfortunately, despite all the studies, there is no poverty reduction policy in place.

Trinidad and Tobago

Context

Trinidad and Tobago became independent from Britain in 1962. The country is one of the most prosperous in the region, thanks to petroleum and natural gas production and processing. The tourism industry is also growing. The Government is a parliamentary democracy and the capital is Port of Spain. The bicameral Parliament consists of the Senate and the House of Representatives. Tobago has a House of Assembly with 15 members serving four-year terms.[8] Cabinet is appointed from members of Parliament.

Demographic Data

Most of the demographic data presented here was obtained from the Records Department of the Central Statistical Office (CSO) in the Ministry of Planning and Development. The Trinidad and Tobago Census, which is conducted every ten years, was relied on heavily as were other reports that are published annually such as the Annual Statistical Report.

The average annual rate of population growth was 0.3% in 2000 and 0.7% in 2002. The male popula-

tion (in thousands) was 633.0 in 2000 and 639.7 in 2002 while the female population was 629.4 in 2000 and 636.0 in 2002. Trinidad and Tobago is a heterogeneous society. Its ethnic composition, as quoted in the last census, is 39.6 per cent African, 40.3 per cent Indian, 18.4 per cent Mixed, 0.6 per cent White/ Caucasian , 0.5 per cent Chinese/Syrian/ Lebanese and 0.6 per cent Other ethnic group/Not stated.

There was a decline in general fertility rates from 1992 until 1996, with a slight increase occurring in 1997. According to the World Health Organization (WHO), there is an age-specific fertility rate of 45.9 (PAHO/WHO, 2001:3). The total fertility rate for the period 1995-2000 was 1.7 children per woman.

Life expectancy at birth for females in 1990 was 73.21 years and for males 68.41 years (Central Statistical Office 2000). Statistics do not reveal the impact of economic status, religion, ethnicity, differences of age and geographic location (i.e., urban-rural) on the quality and outcome of life for men, women and children. In 1999 there were 18,321 live births and 228 stillbirths. Table 14 shows the maternal and infant mortality rates between 1991 and 2001.

Contraceptive Prevalence

Contraceptives are widely available in Trinidad and Tobago. There are over 100 government health centres that provide free family planning services to the general public and make available a variety of contraceptives.

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 generally covers rural and marginalised areas. In addition to providing contraceptive delivery service (including emergency contraception), FPATT also offers other sexual and reproductive health-care services. For example, in 2001, FPATT opened the Living Room, a multipurpose youth centre in Port of Spain that focuses specifically on young people's reproductive and sexual health-care needs. In addition, in 1996 FPATT launched its For Men Only Clinics in Port of Spain and San Fernando. Other services provided by FPATT include pregnancy tests, pap smears, urine tests for diabetes, breast examinations, general gynaecological services, counselling, as well as prostate screening and family life education programmes.

Doctors in the private sector also provide a valuable service and promote the use of contraceptives.

The 1987 Demographic and Health Survey conducted by FPATT noted that knowledge of modern methods of contraception was nearly universal, with 83 per cent of women in a union having used a method at some time while 44 per cent practised modern contraception. There are a variety of contraceptive methods available. FPATT inventory includes intra-uterine devices (IUDs), diaphragms, spermicidal, injectables, oral contraceptives, female sterilisation (tubal ligation) and male sterilisation

Table 13: Age Structure, Trinidad and Tobago

Age Group	Population in Numbers
0-15 years	377,035
15-30 years	305,539
30-45 years	224,695
45-65 years	148,776
65 years and over	70,385

Source: Central Statistical Office, 1990 Demographic Report

Table 14: Maternal and Infant Mortality Rates, 1991-2001, Trinidad and Tobago

Year	Maternal Mortality	Infant Mortality
1991	49.18	11.0
1992	60.70	10.5
1993	66.40	12.2
1994	76.20	13.8
1995	67.5	
1996	38.9	
1997	70.4	17.1
1998	44.7	18.5
1999	38.2	17.1
2001	70.4	

Source: Adapted from Central Statistical Office, Population and Vital Statistics Report, 1999 and CEDAW Report, p. 91

(vasectomy). Oral contraceptives, injectables and condoms are, however, the most widely used methods of contraception among couples in Trinidad and Tobago (see Table 15).

Condoms appear to be the second-most popular contraceptive. They are widely available for purchase at reasonable cost in all pharmacies, and an increasing number of supermarkets, grocery and convenience stores and shops. In addition, higglers (itinerant street vendors) who have traditionally sold cigarettes, chewing gum, mints, lighters and other small items with a high turnover rate have begun to retail condoms as well. In pharmacies, condoms are kept behind the counter and, according to FPATT, the need to request condoms from pharmacy staff can inhibit young persons from buying them as they may experience embarrassment in doing so, especially in small societies like Tobago (FPATT 2000). Consequently, the addition of higglers to the list of providers of contraceptives is particularly helpful to younger people.

Table 15: Contraceptive Acceptors by Method, 2000-2002, Trinidad and Tobago

Method	Percentage		
	2000	2001	2002
Oral Contraceptives	49.5	55.0	45.0
IUDs	12.7	8.0	9.0
Condom	14.6	11.0	13.0
Condoms, Spermicides +	1.2	0.9	11.0
Foam	8.0	6.0	6.0
Injection	11.0	10.0	16.0
Diaphragm	0.4	0.1	0
Vaginal Tablet	-	1.0	2.0
Female Sterilisation	-	7.0	5.0
Male Sterilisation	-	1.0	2.0
Creams & Jellies	-	-	1.0

Economic Participation

Sex stereotyping was an essential feature in the shaping of educational opportunities for employment and career goals in the local society in the first half of the 20th century. In 1945, the report of the West Indian Commission recommended that education specifically direct women's careers and functions as "good wives and mothers".

The challenges faced by women in Trinidad and Tobago are not at all dissimilar to those faced by women in other parts of the developing world. Generally men are predominant in the labour force, and women are underpaid in every sector of employment, except when employed by the state. As in other countries, women have a greater opportunity for career advancement in the public sector. A significant development in the history of labour took place in 1998 with the passage of a *Minimum Wage Act*, in part because of the agitation of the local branch of the International Wages for Housework Campaign. In 1996 the *Counting Unremunerated Work Act* was enacted, in which housework and childcare would be recorded as unremunerated work in surveys. Trinidad and Tobago was one of the first countries in the world to ratify this legislation, which required its statistical office to collect the data. In 2000, women's participation rate in the labour force stood at 38.6 per cent and men's at 61.4 per cent.[9]

According to the Central Statistical Office's Report of 1992, women tend to suffer more from long-term unemployment than do men. Older women also tend to have higher rates of unemployment.

Women make up a majority of the workforce in the lower professional categories of teaching, nursing, secretarial and administrative services, manufacturing, and areas of personal services including sales, merchandising and shop clerks. Similarly workers in restaurants and catering establishments and domestics tend to be predominantly female. Conversely men outnumber women at levels of management and as legislators, senior officials and professionals. As a consequence, few women are found in high-level, decision-making positions in either government or the private sector.

Women, then, continue to be at the lower end of the socio-economic ladder and face real labour rights issues, especially in wage discrimination. As no equal pay legislation exists, women are subjected to wages disparate from their male counterparts engaged in similar work. In all occupational groups, women still earn as much as 50 per cent less than men do. Wage differentials are especially

sharp in the private sector.[10] Women's participation in agriculture and the agricultural sector is swiftly diminishing, while the importance of self-employment and entrepreneurship is increasing, especially in the informal sector involving sales of crafts and other small items. Official statistics, however, recorded women as only 31 per cent of own account workers in 2000.

Table 16: School Enrolment, 1999/2000, Trinidad and Tobago

	Male	Female	Both Sexes
Government and Assisted Primary	83,051 (50.9%)	80,155 (49.1%)	163,206
Public Secondary	51,471 (48.8%)	54,071 (51.2%)	105,542

Source: Central Statistical Office, Annual Statistical Digest, 2000, p.57

Many occupations in which females are dominant have active unions. Teachers, nurses and public servants are unionised. A 1999 survey by the Ministry of Labour indicated that, of 61,345 members of 28 trade unions, women accounted for 26,770 or 44 per cent of the membership. They do not, however, represent a significant proportion of the leadership. The same survey also found that women held 7.5 per cent of leadership positions in eight trade unions.

Table 17: Highest Level of Educational Attainment, 1990, Trinidad and Tobago

Education	Male	Female	Both sexes
None	10.5%	11.5%	11.0%
Nursery/ Kindergarten	3.0%	2.9%	2.9%
Primary	48.8%	46.9%	47.9%
Secondary	33.4%	34.9%	34.2%
University	2.2%	1.6%	1.9%
Other	0.8%	1.0%	0.9%
Not stated	1.3%	1.1%	1.1%
TOTAL	**560,934**	**564,194**	**1,125,128**

Source: Central Statistical Office, Population and Housing Census Demographic Report, Volume 11, 1990, pp. 198, 230

Female Education

In the first half of the 20th century Trinidad and Tobago stressed the importance of education. Unfortunately, several ordinances, such as the 1921 *Compulsory Ordinance* (effective in Port of Spain and St. James in 1935) and the *Education Code* of 1935 stereotyped boys and girls and consequently limited their educational achievements. For example, a provision was made for girls of primary school age to receive instruction in domestic science and for the construction/ use of specially approved centres for the same. A similar provision was made for boys though for the pursuit of technical and academic skills. By the 1940s, compulsory primary school attendance was implemented in theory but not in practice. It took another 60 years for compulsory secondary education to be mandated by law.

In 1997, 71.5 per cent of the population was recorded as enrolled at the secondary level (UNDP 2000), and in 2000, 99.9 per cent was recorded as enrolled at primary school level. At both primary and secondary levels, female enrolment as a percentage of male enrolment was substantially higher: at primary school 112 per cent and 120 per cent and at secondary 100 per cent and 102 per cent (UNDP 1998).

Though education attainment levels are relatively similar for the sexes with only slight differences, it is felt that females are out-performing males at schools and much concern surrounds this perception of male under-achievement in education.

In 1990, males exceeded females in the university-educated population (2.2 and 1.6 per cent respectively), overall an extremely small proportion of the population. However, since that time a larger number of females than males have registered and graduated from the University of the West Indies (UWI).

In 1996-97, females as a percentage of matriculation in programmes offered at UWI made up 68.8 per cent of undergraduate degrees, 73.3 per cent of diplomas, 66.8 per cent of certificates, 65 per cent

of advanced (post graduate) studies and 45.6 per cent of higher degrees. Overall, they comprised 56.8 per cent of the total UWI St. Augustine population. In previously male-dominated disciplines like the physical and natural sciences, with the exception of engineering, the number of female students is now equal to or exceeding that of male students.

Table 18: Graduates from UWI St. Augustine, 1991/1992, 1995/1996 and 1999/2000

Degree	1991-1992		1995-1996		1999-2000	
	Male	Female	Male	Female	Male	Female
B.Sc. Agriculture	28	28	23	37	19	60
B.A. Humanities	34	100	53	140	50	171
B.Sc. Engineering	67	10	126	39	157	41
B.Sc. Natural Science	71	96	80	99	98	149
B.Sc. Social Science	66	111	141	290	164	337
MBBS Medical Sci.	28	6	49	36	43	42
Education	-	-	43	132	89	221

Source: Central Statistical Office, Annual Statistical Digest, 2000, p. 65

Females outnumber males two to one in part-time undergraduate programmes. In other forms of tertiary education, e.g. technical/vocational education, males still dominate partly because girls are discouraged from technical and applied science subjects such as metalwork, woodwork and technical drawing due to the continued prevalence of sex-stereotyping. Women are still excluded from skilled trades (auto mechanics, plumbing, electrical technicians) but are encouraged to consider dressmaking and catering.

According to UNDP statistics, however, in tertiary education, females made up 72 per cent of students (UNDP 2000).

In spite of the high rates of school enrolment and attendance, it is estimated that 12.6 per cent of persons 15 years and over and 16.2 per cent persons currently working are illiterate (ALTA 1994). Women have higher rates of literacy than men in the 15-24 and 25-39 year age groups, though among older persons, aged 40-54/55+, women have lower levels of literacy than men.

Gender-Related Policies

There have been several legislative achievements in the promotion of gender equality and women's empowerment, which may be considered forerunners to the Draft National Gender Policy and Action Plan to be presented for review on 30 June 2004. Trinidad and Tobago has followed the lead of the Cayman Islands regionally, and India and Canada internationally, in the creation of an official gender policy. Prior to the policy itself, however, several legislative items have been passed.

The *Domestic Violence Act* No. 27 of 1999 repealed the 1991 *Domestic Violence Act* and widens the definition of domestic violence to include financial, sexual and psychological as well as physical abuse. It also makes provision for the compensation of victims and enlarges the ambit of the protection order. *The Legal Aid and Advice (Amendment) Act* No. 18 of 1999 makes provisions for the granting of legal aid to applications made under the new Act.

In 1998, a *Maternity Protection Act* was passed that is considered a watershed in female labour rights struggles. It entitles all women, except female members of parliament, to 13 weeks of paid leave every two years. Payments are the responsibility of the employer and the National Insurance Scheme, thereby ensuring no loss of earnings for pregnant women and recent mothers. Though termination because of pregnancy is illegal, there are recorded instances of dismissal of pregnant women, especially of temporary and casual workers, proof of the difficulty in uniform application and implementation of the law.[11] By this Act, fathers are also permitted three days leave of absence from work at the birth of their children.

The *Sexual Offences (Amendment) Act* No. 30 of 1994 amended the previous Act to cover all forms of sexual violations and to increase the penalties for violations such as rape, sexual assault, incest and sexual indecency.

The *Equal Opportunity Act* No. 69 of 2000 prohibits discrimination and promotes equality of opportunity irrespective of gender, race, ethnicity, religion, marital status or ability. This Act has not yet passed.

The *Cohabitational Relationships Act* No. 30 of 1998 was implemented in recognition of the high incidence of common-law unions and the rights of common-law spouses. Parties in a relationship for more than five years or having a child out of the union benefit from this Act.

The *Counting of Unremunerated Work Act* No. 29 of 1996 is legislation for the Central Statistical Office and other public agents to facilitate the recording of statistics related to unremunerated work, and the provision of a mechanism to quantify the monetary value of such work.

The *Occupational Safety and Health (No.2) Bill*, 1999 replaced and repealed the *Employment of Women (Night Work) Act*, Section 5 of which forbids the employment of women in night work in Trinidad, and the *Factories Ordinance*, Section 42 of which prohibits the employment of women and young people in factories. It also proposed provisions for pregnant employees by ensuring that the employer shall "...after being notified by a female employee that she is pregnant and upon production of a medical certificate to that effect, adapt the working conditions of the female employee...". Clause 4 of the same Bill proposed to provide that employers of industrial undertakings compulsorily provide separate sanitary conveniences for men and women, and that those for women be properly equipped.

The Ministry of Community Development, Culture and Gender Affairs is responsible for the introduction of the Gender Training and Mainstreaming Programme, a national programme targeting both men and women, facilitated through workshops and seminars on the economic empowerment of women, International Women's Day programmes and gender sensitivity training.

Despite fervent discussions about sexual harassment no national legislation exists. A draft policy on sexual harassment prepared over 10 years ago remains untouched and unapproved by the national Government.[12]

In the absence of legislation, a number of organisations have adopted policies against sexual harassment in the workplace. According to a *Sunday Guardian* article (dated 13 September 1998), the Tobago House of Assembly adopted the Sexual Harassment in the Workplace Policy for all its employees. The National Insurance Board (NIB) of Trinidad and Tobago, in recognition of the problem of sexual harassment, issued an 'Employee Handbook on Sexual Harassment' in an attempt to educate and raise awareness on the matter. An earlier article in the *Sunday Guardian*, 10 September 1994, described it in this way: "sexual harassment in the workplace has reached epidemic proportions in Trinidad and Tobago". Women activists and prominent professionals are therefore making the call for legislation to deal with this urgent issue.

Poverty Reduction Policies

The country is committed to reducing poverty levels as part of its goal of achieving developed nation status by 2020. In the Vision 2020 Programme, there is a sub-committee on poverty that is empowered to investigate the causes of and recommend strategies for the elimination of poverty. Statistics reveal that 31.7 per cent of female-headed households live below the absolute poverty line, and 54.8 per cent live on an income of less than TT$500 a week (approx. US$80). Quite a number of government programmes have been devised to improve the standard of living for women.

Following the World Summit on Social Development (Copenhagen, 1995), which promoted a global strategy to address poverty and inequity, the Government set up a structure in 1996 specifically to eradicate poverty. This included a Ministerial Council on Social Development and a Civil Council on Social Equity, which strove to bring about better coordination of the activities of the sector and the affiliated NGOs. These agencies are serviced by the Change Management Unit

(CMU) for Poverty Eradication and Equity Building.

The CMU has devised several major initiatives for poverty eradication. These include:

- regional participatory workshops that obtain views and perspectives on the needs, priorities and initiatives to address poverty at the community level;
- consensus-building workshops to empower public sector field officers and community consensus-building activities to adopt a community programme to promote partnership between poor communities and corporate sponsors;
- community-based microcredit programmes that provide a credit facility at the community level for access by needy would-be entrepreneurs in areas of funding, training, support and low cost loans; and
- a community telecentres project to make information on all the programmes and services of government agencies available to persons at the community level.

The Government has contracted consultants to design a decentralised integrated system for the delivery of social services. The objective is to ensure that social services are able to effectively reach citizens in the most remote parts of the country and to deliver services in an integrated manner (family support, training, income support and health services) so that the multifaceted needs of any individual or family can be addressed in a holistic manner.

These broad principles of government policy are therefore:

- Decentralised delivery of services;
- Integrated service delivery across agencies;
- Full participation of civil society;
- Empowerment of citizens;
- Mainstreaming of and support to various vulnerable sub-populations including persons with disabilities, socially displaced persons, children in difficult circumstances, single, unsupported female headed households, etc.

The following programmes have been adapted from the Social Sector Investment Programme 2004. These run concurrently with the wider poverty reduction approaches adopted by the Government and are hosted by a number of different ministries:

Women in Harmony: A 1997 survey on living conditions gave rise to this programme, which provides training in agriculture and elderly care for single women between 26-45 years, single female heads of households and unemployed women.

Non-Traditional Skills Training for Women: This is a programme designed to provide technical and vocational training to low-income women. It targets women between 19-25 years and involves training, job placement and programme promotion. The overall objective is to increase the level of skilled labour available in the country. In 2003, 348 women participated in the programme, and the anticipated intake for 2004 was 350 persons.

The Youth Training and Employment Partnership Programme (YTEPP): YTEPP offers training in literacy, numeracy, vocational skills, entrepreneurial development and support services to young people, especially young women.

Unemployment Relief Programme (URP): This ongoing relief programme provides short-term employment relief for all unemployed persons while enhancing the skills of individuals in the community and developing, maintaining and improving the physical and social infrastructure. It is comprised of infrastructure projects, environmental enhancement and a Women's Programme that targets females 17-65 years of age, single parents and female heads of households. It provides employment to 3,050 women every two weeks. In 2003, its projects included sanitation and construction, populated by 6,003 persons, and 28,300 women benefited from the Women's Programme.

Community-Based Micro Enterprise Programme (Micro Enterprise (MEL) Loan Facility

National Social Development Programme (NSDP): This

project targets low-income communities, and its objective is to bring relief to deprived communities with the provision of basic upgrades and amenities and multi-purpose social and recreational facilities. The overarching objective is to improve the standard of living and socio-economic welfare of citizens.

National Enterprise Development Company (NEDCO): NEDCO targets youth and young single mothers who cannot access capital or support for entrepreneurial activity. In 2003, 1,400 new businesses were started and 4,000 jobs were created. Ten per cent of its clients were women.

Export Centres Programme: This programme targets unemployed women between the ages of 25-50 years. It encourages handicraft and attempts to enhance the skills of community-based artisans via cottage industry business encouragement. In 2003, 250 persons benefited from training and 250 trainees graduated from the programme in 2004.

Reach Programme: Reach includes youth and single mothers without access to capital and provides support for their entrepreneurial activity.

Social Help and Rehabilitative Efforts (SHARE): Emergency relief through the provision of food is a nutrition programme that distributes food hampers on a three-month rotational basis to persons who do not qualify for grants of social assistance. It also involves a rehabilitative component and is conducted in collaboration with a network of 129 NGOs throughout the country. Women make up 90 per cent of the clients.

Adolescent Mothers Programme: This community-based project targets pregnant adolescents and teenage mothers and their children. It provides counselling, remedial/continuing education, day care services and training in pre- and post-natal childcare at three established centres. The programme is intended to decrease the number of repeat pregnancies among young women and to break the cycle of inter-generational poverty that may emerge among the target groups due to early pregnancy.

Relief Centres Programme: This programme provides hot meals to destitute persons at three centres in Port-of-Spain. There is also a training component to achieve the Government's thrust towards empowerment and sustainable development. This covers the areas of remedial literacy and numeracy, micro-enterprise management, food preparation and agricultural processing.

European Union Sponsored Poverty Reduction Programme

The Government has also acquired 6 million Euros in funding from the European Union to assist in improving the structure for poverty reduction. A unit has been established to implement what is called the EU-Sponsored Poverty Reduction Programme (EU-PRP). This programme supports the Government in the formulation and implementation of a National Poverty Reduction Strategy that is more responsive to the needs of the most vulnerable groups in the population: poor, single, female-headed households and children and youth from disadvantaged communities.

The EU-PRP pursues a decentralised approach. Under the programme, Regional Social and Human Development Councils (RSHDCs) will be set up in each municipal region of Trinidad and in Tobago. These councils will be comprised of public sector representatives (deliverers of social services) and civil society on a 60/40 basis. Their role will be to assess regional needs and guide regional interventions to address poverty.

The EU-PRP will also attempt to procure up-to-date data on poverty by undertaking a national as well as a regional survey of living conditions. In addition, EU-PRP will provide grant funding to be managed by the RSHDCs to support civil society interventions at the regional level. The EU-PRP thus provides support to the Government in three broad areas:

- Improving the delivery of poverty reduction services through the decentralisation of poverty intervention (microcredit and micro project support).
- Strengthening the institutional framework for

poverty reduction programmes through the establishment of RSHDCs.

- Strengthening the information system on poverty and poverty reduction programmes through the conduct of poverty studies and improving the availability of poverty data. Plans for 2004 include establishing a micro-project and micro-credit fund, strengthening the technical and organisational capacities of the Programme Management Unit of the Office of the Prime Minister, establishing a network of information resource centres, improving the availability of and providing access to information on poverty, and the conduct of poverty audits.

Endnotes

[1] This list may not be inclusive of all countries where this is the case as it is based on available data.
[2] Internal CAFRA paper.
[3] DAWN Sexual and Reproductive Health Regional Research Workshop, August 2004.
[4] Based on dialogue and discussion at the DAWN Regional Workshop (see note 2).
[5] http://edition.cnn.com/2003/WORLD/americas/11/19/st.lucia.abortion.ap/
[6] These figures stem from the 1980 census and thus should be taken as an indication. Not visible in these figures is the large influx in recent years of immigrants from Brazil, China, Guyana and Haiti.
[7] In 1996, total unemployed were 10,699, constituting 11 per cent of the labour potential. From 1993 to 1995 the average percentage of work seekers in the economically active population was 12.3 per cent.
[8] CIA World Factbook.
www.cia.gov/cia/publications/factbook/geos/td.html
[9] Final Draft National Gender Policy and Action Plan, Trinidad and Tobago.
[10] Ibid.
[11] CEDAW Report.
[12] Final Draft National Gender Policy and Action Plan, Trinidad and Tobago.

3. Detailed Data by Country

The Health Sector

Barbados

Overview

The Government of Barbados views health as a fundamental right of all Barbadians. It aims to provide comprehensive health care to all citizens at an affordable cost and ensure that environmental concerns are considered in all aspects of national development (PAHO 2002).

The Barbados National Strategic Plan for Health has stated the following 'vision':

> "The vision for a healthy people is to empower individuals, communities and organisations 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."

The Strategic Plan for Health for Barbados for the years 2002-2012 is based on the Caribbean Charter for Health Promotion, which was developed in Port of Spain in 1993 at the first Conference of Health Promotion (Ministry of Health 2003).

Primary health care is an integral part of the country's health-care delivery system (PAHO 2002).

Cultural Norms in Barbados Governing Health

The notion of the male as the head of the household, despite the large number of female-headed households, continues to be dominant. While there is acceptance of women in the labour force, gender norms dictate that women earn less money and stay in positions that are not high profile. Women are often economically dependent on men, which affects their decision-making ability. Though the dynamic is changing, women are still expected to do unpaid work in the household. They are perceived to be caretakers, and in this light are often faced with caring for sick individuals, particularly those with HIV / AIDS (Government of Barbados et al. 2003).

Gender power dynamics are seen in sexual relations as well. According to the ICPD report completed by stakeholders in Barbados, negotiating sexual relations has been an area of weakness for women in the Caribbean (ibid.).

Policies also dictate some gender norms, and the right of Barbadian women to have full control over their bodies is not a fundamental concept. For example, husbands cannot be charged with marital rape (ibid.). In addition, policies against homosexuality and sex work also affect women's lives, particularly the ability women and men may have in being honest about their sexuality and in turn being able to access appropriate health services. Opinion leaders and individuals opposed to giving out condoms in prisons use the illegality of homosexuality as a basis for the argument that giving protection to men engaging in sex with other men is condoning illegal behaviour.

There are also cultural barriers around accepting young people as sexual agents. Currently, the age of consent for sexual activity is 16. The age of consent law, while perhaps useful in protecting young

children from assault by older members of the community, works against young people who attempt to access sexual health and family planning services. Currently, young people in Barbados have no access to family planning without the consent of their parents.[1]

Table 19: Recurrent Expenditure on Health with the Percentage of Total Recurrent Government Expenditure, 1996-2001, Barbados

Year	Total Govt Expenditure	Total Health Care Expenditure	%	Total Clinical Health Care Expenditure	%
1996-1997	1,533,599,255	232,959,918	15	162,056,564	11
1997-1998	1,704,476,193	226,418,256	13	166,991,050	10
1998-1999	1,818,805,721	178,892,254	10	133,790,864	7
1999-2000	1,928,553,545	284,570,078	15	208,211,646	11
2000-2001	2,042,799,832	280,000,000	14	198,196,962	10

Financing the Health Care System

The Ministry of Finance allocates the budget within the health sector. The Government has independent control over health professionals with regard to legislation around health services; physicians and nurses often stay involved in policy dialogue through trade unions (PAHO 2002).

Expenditure on health services is increasing in both the public and the private sector (see Table 19). Within the last 15 years, an increasing number of health services have been provided by the private sector. Fifty per cent of primary health services are provided by the private sector, and 20 per cent of the population has private health insurance (Ministry of Health 2003).

Private sector expenditure in 1995 was $105.4 million, which was about 30 per cent of total expenditure for health. In the fiscal year 2000-2001, the government allocation for health was $280 million, approximately 14 per cent of total government expenditure (Ministry of Health 2003). The percentage of GDP spent on health in 1999 was 6.6 per cent (PAHO Gender sheet). Hospital services – Queen Elizabeth Hospital (QEH), the Psychiatric Hospital, the Medical Aid Scheme and the Emergency Ambulatory Service – consume the largest share of expenditure, accounting for 53.9 per cent ($151 million) of the budget. The primary pharmaceutical programme was allocated 9.4 per cent ($26.3 million) while 8 per cent ($22.4 million) was allocated to the care of the disabled. Expenditure on direction and policy formulation services was 4.3 per cent ($12 million) of total expenditure (Ministry of Health 2002).

Cost to the individual

Total health expenditure per capita (US$) in 1999 was 506 as a percentage of GDP. Services at government facilities are free of cost at the point of delivery. Under the Special Benefit Service, drugs listed in the Barbados Drug Formulatory are also free at the point of service to persons 65 years of age and over; children under 16 years of age; and persons being treated for hypertension, diabetes, cancer, asthma and epilepsy (PAHO 2002). HIV/AIDS drugs are given to all individuals who request them. Private health services are also offered and are mainly used by those who can afford to pay.

Insurance

The only type of health insurance currently being provided consists of group health insurance services specifically for credit unions, trade unions and other large organisations. Policies tend to be indemnity plans, which reimburse the beneficiary based on a fixed percentage of the cost of health-care service being claimed (Government of Barbados et al. 2003)

Organisation of the Health Sector

The Government operates and runs QEH (a 600-bed secondary and tertiary care facility), four district hospitals for geriatric care, a main geriatric institution, a mental health hospital and half-way house, two rehabilitation institutions for the physically and mentally handicapped, an AIDS hostel, a development centre for disabled children and adolescents and a nutrition centre (Ministry of Health 2003).

QEH provides 24-hour acute, secondary, tertiary and emergency care. It houses 90 per cent of the country's acute care beds and clinical services (PAHO 2002). Challenges it faces include the influence of crime and violence in society, the effect of an aging physical plant and equipment, a nursing shortage and lack of equipment (Ministry of Health 2002).

There is a nationwide network of polyclinics that provide a wide range of preventative and curative services, as well as limited rehabilitative services. These polyclinics and four satellite stations provide traditional public health services such as maternal and child health, family life development, communicable disease control, community mental health, chronic disease programmes, dental health, nutrition and general practice (PAHO 2002).

Each polyclinic serves a catchment area that varies in size from 17,000-50,000 persons (Ministry of Health 2003). Primary health-care challenges include a shortage of staff resources, especially at the clinic level (PAHO 2002).

Private Sector

There are approximately 100 general practitioners. There is one small private hospital – Bayview Hospital – which has 30 beds and represents less that 4 per cent of the country's acute bed capacity.

Health Services Delivery

There are six major areas of health service delivery:

1. primary health care
   - maternal and child health
   - family life development
   - care for the disabled, pregnant women and the elderly
   - general medical care with clinics for hypertention, diabetes and STIs
   - nutrition
   - pharmaceutical services
   - community mental health and environmental health care
2. 24-hour acute care
3. secondary, tertiary and emergency care
4. mental health care
5. care for the elderly including rehabilitation services
6. health promotion

The Chief Medical Officer (CMO) is responsible for all public health and medical services in Barbados. The CMO also advises the Minister of Health and Environment on health infrastructure and development.

Health Sector Reform

Barbados has currently embarked on a National Strategic Plan for the years 2002-2012. Ten strategic directions have been identified:

1. health systems development
2. institutional health services
3. family health
4. food, nutrition and physical activity
5. chronic and non-communicable diseases
6. HIV and AIDS
7. communicable diseases
8. mental health and substance abuse
9. health and the environment
10. human resource management

The strategic directions provide the overarching framework for organising health care in the country and for all partners in the health system to link their policy decisions and investments to health outcomes.

The sections of the strategic directions most relevant for an understanding of maternal mortality and abortion are those pertaining to women's sexual and reproductive health, including family health and HIV and AIDS.

Family health

The family health strategy looks at several major components: reproductive health, women's health, men's health, health of adolescents and the elderly, oral health and rehabilitation. The overall goal is the improved health and quality of life of the population.

The National Strategy on HIV/AIDS defines reproductive health as a function of population growth,

total fertility rate and maternal mortality.

Women's health is defined through breast and cervical cancers as well as obesity. Men's health is defined through prostate cancer, percentage of men at the psychiatric hospital, obesity and men's lack-of utilization of services. Adolescent health is defined by cancer and a listing of causes of death among young people.

It is clear from the above definitions that reproductive health and gender and health are not being given adequate attention, nor are the existing definitions of reproductive health (including women's and men's health) adequate. It should also be noted that there is no specific mention of a sexual and reproductive health rights initiative for women, men or adolescents.

Reproductive Health
Priority health issues in this area are inadequate ante/intra/post natal and neo natal services; inadequate breastfeeding programmes; and inadequate family planning services. The strategic goal is improved quality of life for men, women and children.

Key health indicators are:
- Reduce infant mortality rate below 10 per 1,000 live births;
- Maintain present 0 per cent maternal mortality rate;
- Decreased incidence of low birth weight and babies;
- Reduce morbidity and mortality associated with cancers and STIs in men and women by 20 per cent.

Women's Health
Priority issues for women's health are inadequate screening services and violence against women. The strategic goal is improved quality of life for women, and the key health indicator is reducing current mortality and morbidity associated with cancers and STIs in women.

Men's Health
Priority issues in this area are inadequate men's health programmes, limited utilisation of services and inadequate screening programmes for men's health. The strategic goal is improved quality of life for men, and the key health indicator is reducing current mortality and morbidity associated with cancers and STIs in men.

Adolescent Health
The priority issue here is the lack of a comprehensive adolescent health programme. The strategic goal is improved adolescent well being. Key health indicators are:
- Between 2003 and 2012, 80 per cent of adolescents participating in community and school health programmes;
- Between 2003 and 2007 increase health-seeking behaviour among adolescents by 10 per cent;
- By 2012, reduce levels of adolescent obesity by 30 per cent of Adolescent Health and Fitness Study (1999) Survey;
- By 2012, reduce 10 per cent of reported numbers of adolescents expressing feelings of depression and wanting to harm others, as expressed in the 1999 Adolescent Health Survey;
- Reduce injuries due to accidents and violence by 2 per cent per annum;
- By 2012, reduce substance abuse among adolescents by 30 per cent.

Some key indicators designed by the Government to monitor the progress of the strategic plan are:
- 10 per cent coverage in adolescent sexuality programmes established and maintained by 2005 (Indicator 1.5).
- The development of a framework for establishing adolescent health programmes adopted by 2003-2004 (Indicator 3.1).
- Policies for the management of sexual and physical child abuse adopted and implemented between 2003 and 2005 (Indicator 3.2).
- In-service training programme in adolescent health for all adolescent counsellors established and implemented between 2003 and 2005 (Indicator 3.3).
- Programme to sensitise youth leaders on adolescent health issues established and implemented between 2003 and 2012 (Indicator 3.4).

HIV/AIDS
The overall goal is the reduction in the incidence and impact of HIV infection. Priority issues are the inadequate management and care of persons infected and affected with HIV/AIDS; the increasing incidence and prevalence of persons living with HIV/AIDS (PLWHA); and inadequate information, education and communication programmes. The strategic goal is a national multisectoral programme that reduces the incidence and impact of HIV/AIDS. The key health indicator is a 50 per cent reduction in the morbidity and mortality rate and a 50 per cent reduction in the HIV incidence rate between 2002 and 2012.

Notes on and Challenges of the Barbados Strategic Plan for Health

Gender Dimensions
There is recognition of gender as an influential factor in the determinants of health: "Gender norms influence the health system's practices and priorities. Many health issues are a function of gender-based social status or roles."

Women and children are mentioned in Indicator 2.2 under Mental Health-Substance Abuse: "between 2004-2012 treatment and rehabilitation services for women and children established".

Quality Management
In 2000, a Continuous Quality Improvement Programme was started in Barbados with feasibility and sensitisation studies conducted in five Ministry of Health institutions including the Winston Schott Polyclinic, the Mental Hospital, the St. Michael District Hospital and the St. Andrew's Children Centre (Ministry of Health 2002).

Out of this initiative, quality coordinators and quality teams were identified and trained in various features of Continuous Quality Improvement. These individuals were expected to initiate projects to address efficiency, effectiveness and client satisfaction. In addition, policy and procedures manuals were developed to facilitate the sensitisation and continuous training of all staff in these five institutions (ibid.).

Challenges
Although gender is mentioned early on in the Plan, there is very little attention to this throughout the document. While violence against women is raised as a priority issue, no strategic goal has been defined that will assist in lowering rates of such violence.

Within the section on HIV/AIDS, women are not discussed as a priority issue, the disparity in accessing drugs is not addressed, and HIV/AIDS is not placed within a broader sexual and reproductive health and rights framework.

There is no mention of current legislation that restricts adolescent access to family planning due to consent/parent notification laws.

Jamaica

Overview

Over the last three decades Jamaica has implemented a number of far-reaching policies, projects and programmes aimed at reforming its health systems (see Table 20). Although a formally designated Health Sector Reform Programme did not come into being until 1997, there have been other reform initiatives prior to that time. The Ministry of Health has conducted reviews of the policy initiatives over the years, which are outlined in its internal reports. Details of these initiatives follow.

The information on efforts to reform Jamaica's health system shows that family planning and maternal and child health have been central features. However, except for the period 1987-1994, when there was specific reference to achieving the goals of the Population Policy of the time, there has not been another such explicitly stated objective of national health reform programmes/projects.

The 1970s

Faced with widespread health inequalities and an expensive hospital-based health system, the Government, guided by 'democratic socialist'

Table 20: Main Health Reform Projects/Programmes, 1975-2001, Jamaica		
Project/Programme	**External Support**	**Key Objectives**
Second Jamaica Population Project (1970s)	World Bank	• Improve maternal and child health services • Develop primary care infrastructure • Enhance capacity in family planning activities
Health Improvement for Young Children (1977-81)	USAID	• Train and deploy Community Health Aides, especially in Cornwall County • Improve maternal and childcare services
Five-Year Development Plan for Health (1978-82)	PAHO	• Provide primary health care to all • Develop an integrated and comprehensive national health system • Develop human resources • Decentralise management of health services
Health Management Improvement Project (1981-85, ex. 1990)	USAID	• Upgrade management/efficiency of health services • Improve health infrastructure • Develop alternative financing methods • Support decentralisation of services
Jamaica Population and Health Project (1987-94, ex. 1995)	World Bank UNFPA	• Strengthen institutional capacity of MOH and National Family Planning Board • Develop infrastructure • Achieve goals of National Population Policy (1983)
Health Sector Initiatives Project (1989-96, ex. 1998)	USAID	• Enhance cost recovery efforts (Share-care) • Upgrade planning and management capability • Support decentralisation and integration of services • Support private sector role in health
Social Sectors Development Project (1989-94, ex. 1996)	World Bank UNDP	• Improve management and efficiency in health and education • Develop health infrastructure • Develop human resources
Health Services Rationalisation Programme (1990-95, ex. 2002)	IADB	• Strengthen health policy and programme management • Improve quality and availability of secondary care • Develop human resources
Support to Local Health Systems (1991-93, ex. 2001)	Government of Italy	• Promote local health system development • Develop infrastructure • Develop human resources
Health Sector Reform Programme (1997-2001, ex. 2002)	IADB	• Improve ability of the sector to cope with new epidemiological challenges • Enhance financial sustainability, efficiency and quality of health services • Strengthen policy-making role and decentralisation initiatives of Ministry of Health

principles, set about a major restructuring effort in 1974, focusing on the primary health care (PHC) approach. Thus Jamaica had conceived and begun implementation of the PHC approach before its adoption internationally, in 1978, as the preferred strategy to achieve "health for all".

Among the main reform programmes and measures implemented were:

- Expansion of the network of PHC facilities by almost 100 per cent;
- Training and deployment of new categories of health 'auxiliary' workers such as community health aides, pharmacy technicians, dental nurses and nurse practitioners;
- Establishment of PHC regions and districts, with the Ministry of Local Government playing a major role in their management;
- Establishment of community councils with health as one of their main concerns;
- Abolition of user fees for public health services
- Social marketing of "health for all";
- Construction of new regional hospitals.

The 1980s

With a new Government that subscribed to a free market ideological framework and with the imposition of intense structural adjustment measures, this decade saw major shifts in the health sector. In general the reform activities emphasised a more 'managerial' approach, which emphasised 'efficiency' and public-private collaboration. A significant development was the reintroduction of user fees.

Some of the major reform activities included:

- Upgrading management at all levels of the system;
- Implementation of revised user fees in 1984;
- Rationalisation of health facilities with downgrading and restructuring of hospitals;
- Divestment of support services in some hospitals;
- Centralisation of some health functions in the Ministry of Health;
- Proposals for alternative financing mechanisms, such as expanded private health insurance and national health insurance, and for privatisation in the public health sector.

The 1990s (to 2001)

Continuing macroeconomic problems as well as epidemiological, technological and social concerns led to an intensification of health reform and the implementation of a Health Sector Reform Programme beginning in 1997. The reforms have emphasised the 'new public management' approach with a steering and stewardship role for the state while delegating and divesting management and delivery of health services.

The main reform measures and activities in this period have been:

- Decentralisation of the management and delivery of health services with the establishment of four regional health authorities;
- Restructuring of the Ministry of Health Head Office to focus on planning, policy and legal and regulatory functions;
- Implementation of revised user fees (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;[2]
- 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.

In 2000, the World Health Organization rated Jamaica as having the eighth best performing health system out of 191 developed and developing countries.

Suriname

Overview

An estimated 89 per cent of households in Suriname have a polyclinic or health-care centre within a radius of five kilometres (Ministry of

Public Health 1997). The Regional Health Service (RHS), with 50 clinics/stations, is a parastatal foundation responsible for providing primary health care to the poor in the coastal area (peri-urban and rural), and provides services to an estimated 120,000 free medical cardholders and an estimated 25,000 persons covered by the State Health Insurance Fund.

The RHS is supposed to offer free preventive services in cooperation with the national Family Planning Agency[3] and Youth Dental Care (Bakker 1996). Figures for 2003 suggest that it provides primary health care through 62 health posts in eight districts. The largest population served consists of those qualifying for free health care benefits, around 80,000 persons.[4]

Primary health care in the interior is provided by the Medical Mission (MM), an NGO entrusted with this responsibility by the Ministry of Health in 1977. With 45 clinics/stations it is supposed to cover the medical needs of an estimated 48,500 persons (80 per cent Maroons, 20 per cent indigenous peoples).[5] The MM also coordinates secondary and tertiary care for their population through referral and emergency transportation to the capital.

Noting that over the last years the share of total government expenditure going to health care was only 3 per cent (Ministry of Finance 2001), it comes as no surprise that the medical infrastructure has been severely hollowed out. Polyclinics are in a bad state: they are understaffed and continually in need of medicine and equipment. Furthermore, doctors serving in rural areas refer more and more pregnant women to a hospital in the capital, since they are not equipped to deal with possible complications at delivery. They have no anaesthetics and no blood for transfusions.[6] To make things worse, this poor service comes at a high price. Even where services are supposed to be provided for free, in reality patients have to pay.[7] The whole medical infrastructure is suffering greatly from the fact that the Government fails to fulfil its financial obligations. In the capital, out of four hospitals, two are private and church-affiliated, one is a state enterprise and one is a parastatal foundation. In the private hospitals, tariffs for patients are higher and wages for nurses are lower. In recent years, the foundation's Lands Hospital has made headlines due to financial problems and stories of babies being 'kidnapped'. The hospital resorted to keeping babies hostage until the mothers paid their bills as it often experienced problems in collecting payments for deliveries.

Although policy efforts have been made to reorganise the health sector and to expand the system of public health insurance, reality moved the other way. Health institutions and the state's health insurance fund were time and again faced with the Government defaulting in payments. As a consequence, patients are often confronted with the "no pay, no cure" treatment. More and more individuals and companies who could afford it made the shift to private health insurance, thereby further eroding the basis for general health insurance, and widening the gap between those who have access to quality health care and those who do not.[8]

Sex-disaggregated statistics for indigent and insolvent households who are issued a free medical card (from 29,335 in 1990 to 60,200 in 1998) indicate that roughly twice as many female as male heads of household are registered (Ministry of Social Affairs and Housing 1999).[9]

Around 28 per cent of the population, mostly civil servants, receive care through the State Health Insurance Scheme. For 24 per cent the Government provides free medical care through the social services programmes for the poor and near-poor. In addition, private insurance provides care for an estimated 16 per cent of the population, which leaves 32 per cent of the population without health-care arrangements.

Legislation and Norms

Both multi-annual development plans and policy papers from the Ministry of Health underline the ambition to realise good health care and make it accessible to everyone. The Constitution of the Republic declares that everyone has the right to health, and acknowledges the duty of the state to

promote health care in general by improving living and working conditions and by providing health information.[10]

Suriname is also party to the Convention on the Rights of the Child (CRC) and to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), both ratified in 1993. Suriname also ratified the Convention of Belém do Pará in 2002. However, marital rape does not exist in penal law.

In the Multi-annual Development Plan 1999-2003, a structural reform of the health sector was announced with the following priorities:

- Increase of quality and coverage in the health sector;
- Improvement of access to general health care;
- Adjustment of the public health legislation where necessary.

The Ministry of Health, assisted by the Inter-American Development Bank (IADB) initiated a project for Health Sector Reform that consisted of several studies. These studies were debated in seminars to which stakeholders and key institutions and organisations were invited. The first study that laid the groundwork was completed in 1999 by an international consultant (Eichler 1999). Under this project, eight studies ranging from quality of care to payment systems have been completed.

In the meantime, bilateral assistance from the Netherlands underwent a structural change.[11] Instead of broad development cooperation, the Netherlands now opts for a sector approach, under which they support only selected sectors. Since the health sector is selected, they have also invested in several studies called Quick Scans. These formed the basis for the national Health Sector Plan, which was formally introduced in 2004. Since it is not really clear how these two initiatives will be combined by the Ministry of Health, it is hard to guess what implementation will follow when.

Decentralisation Aspects

As stated before, some responsibilities are delegated to NGOs (Stichting Lobi, Medical Mission, Youth Dental Care, the Regional Health Service). Since the Government is highly centralised, there is no decision-making on health matters at district level.

Accountability Mechanisms

The Government should be held accountable by Parliament. Unfortunately, due to a political system that is a combination of a parliamentary and presidential system, Parliament does not have the power it should have. (And, it might be added, parliamentarians in general do not very often question the things they should be questioning.) The last budget account approved by Parliament dates as far back as 1964. Since 1988, budget accounts are not even published any more by the Ministry of Finance, so there is no control on expenditures. Budgets for coming years are submitted without accounting for the expenditure of the previous year (Tjong Ahin 2003).

Over the decade 1990-2000, parastatal utilities did not once submit an annual report. The Central National Accountants Agency (CLAD) is supposed to control these utilities, but it is equipped with only one qualified accountant (National Auditors Office 2000). Women's organisations can only hold the Government accountable through international treaty bodies and through the media, petitions, etc.

Trinidad and Tobago

Overview

After the structural adjustment policies of the 1980s, where 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 experienced four general elections in 10 years. Changes in government administrations prevented the development of and continuity in the public sectors related to health, gender and reproductive rights as well as other sectors.

The sometimes dialectic visions of the administrations have led to the termination or cessation of programmes that fall under umbrella government policies and the loss of momentum for other projects and concepts, depending on the administration's goals for the country. This has affected gender issues more adversely than it has poverty issues where the political approaches of the two major parties have not been radically opposed to each other.

In 1987, the first Women's Bureau in the Ministry of Social Development was created. This was during the National Alliance for Reconstruction (NAR) administration and was devised according to the WID (Women in Development) framework. In the same year, a Policy Statement on the Advancement of Women was crafted, the most nascent form of a gender-related policy for the country.

Under the current People's National Movement (PNM) administration, the Centre for Gender and Development Studies at the University of the West Indies (UWI) St. Augustine was recently commissioned by the Ministry of Community Development, Culture and Gender Affairs to draft a National Gender Policy and Action Plan. The initial draft was submitted to Cabinet in December 2004 for approval.

The Reform Process

The Health Sector Reform Programme (HSRP) was started in Trinidad and Tobago in 1993 as an attempt by the state to resuscitate a failing health-care system. It has been financed primarily by the Inter-American Development Bank (IADB) with the help of several other international funding agencies and organisations that have assisted and continue to assist in the formidable task of re-arranging health-care services. The Pan American Health Organisation (PAHO) and the European Union (EU) have also provided assistance. PAHO has been primarily involved in capacity building, while the EU's involvement has been specifically focused on improving HIV/AIDS-related care and reducing the number of new infections. The World Health Organization (WHO) has also contributed to the health-care reform movement in the country.

In the broadest sense, the HSRP encompasses the rebuilding, upgrading and capacity building of health centres and hospitals, as well as the building of additional facilities and ongoing training for health professionals. Improvements to communication, coordination and collaboration between the various departments within the health sector are also being sought for a more cost-effective and equitable use of resources.

Standardisation in health procedures and a transformation of the techniques employed in the collation of statistics, so that data collection will be qualitative as well as quantative, is also a goal of the HSRP. The 'Accreditation Standard Manual for the Health Sector', for example, is a recently completed document produced by the Ministry of Health. It is a product of a Commission appointed to review and make recommendations for the upgrading of the local health sector. It is the first manual devised according to international standards and is to function as a type of bench-mark, standardising the quality and level of care within the sector, although it is subject to modification according to the needs of the different departments.

All programme activities executed under the HSRP fall under the Project Execution Team (PET), which comprises representatives of the Ministry of Health management executive team, the director of the Project Administration Unit, the chief executive officers of the Regional Health Authorities and the Director of Health Policy and Planning of the Division of Health and Social Services of the Tobago House of Assembly.

Regional Health Authorities Act

According to the Government's website:

> "Under the HSRP, administrative and structural changes are being made to facilitate the shift of responsibility and authority for the management of health-care services from central government control to the region where services

are delivered. In 1994, the *Regional Health Authorities Act (RHAA)* No. 5 was enacted. This legislation aims to (a) improve the efficiency in health-care delivery; (b) educate and train persons in medical research, nursing, dentistry, pharmacy and other health-related fields; (c) collaborate with municipalities on matters related to the construction, operation and maintenance of property; and (d) establish and develop relationships with national, regional and/or international bodies engaged in similar pursuits.

The RHAA establishes Regional Health Authorities in Trinidad and Tobago with the goal of decentralising health services from one Ministry of Health to five Regional Health Authorities (RHAs). The following is a statement by the Government of Trinidad and Tobago on its policy of decentralising health services:

> To ensure coherence and standardisation among the Regional Health Authorities, the Ministry of Health has adopted a series of policy and administrative measures. In the context of decentralisation, the Ministry has assumed the role of "purchaser" of defined services from the RHAs, annually on behalf of the population. These "purchases" relate to service-related needs as identified through analysis of routinely collected health services information and as revealed in the results of a national survey carried out in 1995. In response to the Ministry's Purchasing Intentions, the RHAs develop their service and administrative responses. Documents providing estimated costs form the basis for discussion and negotiation with the Ministry, before submission for government funding.
>
> Once funding has been allocated for the RHAs, annual service agreements (ASAs) are finalised and then signed by the Minister of Health and the chairman of each RHA Board. These documents support monitoring and performance evaluation. Apart from ASAs, the Minister also has authority under the RHA Act to give directions to the boards on matters deemed to be important and necessary."[12]

Division of Labour

When the Government established the five RHAs, it was assumed that all staff that formed part of the Ministry of Health (MOH) would automatically transfer to or join them. Incentives were established – for example, a funded contributory pension plan guarantees that MOH employees transferring to the RHAs would not lose any of their accrued pension benefits. The Plan is a contributory one for RHA employees, with benefits superior to those in the MOH. Despite this effort, however, complications have arisen; as a result, many senior doctors remain in the employ of the MOH while junior doctors are employed by the RHAs. The incongruity of the situation is that the head of every unit in the health service is employed by one authority but works in premises run by another.

The parallel systems have led to the establishment of parallel administrative systems to deal with the two classes of staff. In many cases a duplication 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. The resultant top-heavy RHA administration has resulted in the RHA budget being skewed to the tune of 78 per cent of its annual budget for funding personnel and 10 per cent for goods and services. Thus while the IADB has been pushing for a primary health-care slant to health reform, the RHAs have been left with little to channel to the community. At the same time the per capita expenditure on health has declined annually (from TT$667 in 1982 to TT$279 – approx. US$44 – in 1992).

Concerns over differential rates of pay, working conditions, benefits and pension plans have led to major labour disputes and industrial action by doctors still under the MoH. Doctors and nurses have, however, banded together in spite of the pervasive labour disputes to ensure that health services in the country continue to function.

Coverage

The RHAs have been geographically defined as Central, Eastern, North-Western, South-Western and Tobago (see Table 21).

Table 22: Rural/Urban Distribution of Public Sector Health Facilities, Trinidad and Tobago

Area Type	# of Hospitals	# District Health Facilities	# Health Centres
Urban	5	2	11
Rural	4	3	93
Total	9	5	104

Source: Adapted from CEDAW Report, p. 88

Each authority is expected to function in similar ways, providing the same services to the entire population. The classification according to geographic boundaries ensures that all municipalities are covered and that all persons irrespective of classifications have access to all levels of care. Primary care is provided at the level of district health centres, to which each municipality has access. Secondary and tertiary levels of health care are provided by the general hospitals. There are three specialised hospitals in four districts providing secondary care.

At the level of primary care, four different types of centres operate: District Health Facilities; Enhanced Health Centres offering specialised health services such as radiology, ophthalmology and dentistry; health centres for populations of 24,000 or less; and Outreach Centres for the least populated areas, providing limited services by visiting health professionals

Integration Between Levels of Care

The Ministry of Health is of the view that the establishment of an efficient primary health-care system is the key to real improvement in the nation's health services. Under the NHSP the five general hospitals in Trinidad and Tobago, in addition to the St. Ann's Psychiatric Hospital, are to be supported by a network of some 90 Primary Health Care Facilities, including eight District Health Facilities and four Enhanced Health Centres. The health centres (104) are to be the dispensers of primary care services.

Woodbrook Health Centre in Port of Spain (NWRHA) is being used as a model for the way in which primary care centres are to operate. It offers basic counselling, nursing and medical services. There is a weekly clinic for expecting and new mothers, family planning advice is offered and, at one time, a dentist saw to the dental needs of the local population. At present, however, while there is no real division between the levels of care, measures are being put into place to ensure the smooth facilitation of effective primary, secondary and tertiary levels of services.

Table 21: Distribution of Regional Health Authorities, Trinidad and Tobago

	N.W.	Central	S.W.	Eastern	Tobago
No. of Dependent Municipalities	3	4	5	2	1
No. of Health Centres	18	20	31	16	16
No. of Hospitals	2	1	1	2	1
No. of Extended Care Units	-	-	1	1	-
Other	-	1	-	-	-

Source: Adapted from CEDAW Report, p. 88

Financing

The health sector is financed in part by international sponsors whose funds are matched by those of the Government. This practice of matching funds is one that is done relative to the resources of the country. A budgetary current expenditure vote is also taken by Parliament in which the financing for the health sector is determined. The public health sector has, in the past, been financed from the nation's tax revenues. The current system of financing the health-care sector from

general taxation is neither sustainable nor equitable.

The HSRP looks at alternative models of funding for the sector, prime among which is the introduction of a National Health Insurance Scheme (NHIS). The extent of the HSRP demands a structure of supporting and corollary policies and activities. To this end the NHIS would be funded through contributions from employers and employees, with the Government paying on behalf of the indigent. Local government will develop the NHIS, albeit initially on a pilot basis. Another fundamental supporting/corollary service for the reform programme as part of the NHIS is the articulation of and agreement on a package of basic health-care services in which user fees for some services will be charged. Agreed protocols and standards of care, peer review, systems to capture costs and outcomes in a manner supportive of decision-taking, the provision of a unique identifier to each citizen and user fees for some services are all seen as elements that are germane to the successful implementation of an NHIS.

At present, primary care services at the health centres are free of charge. There is free health care available at hospitals in Port-of-Spain, San Fernando, Mount Hope and Scarborough, at several district hospitals and at the network of community health centres. At the Mount Hope Women's Hospital, there is a TT$25 (US$4) fee for the delivery of babies, which reflects the thrust to improve the services delivered by the RHAs.

In private sector health care, the average cost of a visit to a specialist physician is not less than TT$200 (US$32),[13] but the cost of a visit to a general physician ranges between TT$60 and TT$100.

The Public Debate

The process of health reform has not generated great public debate. The intended changes have been publicised in the media, through public service announcements and with meetings in town/village councils, but most of the changes have taken effect as a result of commission/inquiry recommendations and the obvious shortcomings of the system.

Before the *Regional Health Authorities Act* was passed, the Ministry of Health, on the advice of the Minister, organised a National Consultation to receive comments, suggestions and concerns about the restructuring of the health sector. At this Consultation, to which several interest groups and stakeholders were invited, many suggestions were received. The Trinidad and Tobago Manufacturers Association (T&TMA) advocated the establishment of Hospital Boards to run the institutions, rejecting centralised management, which was felt to be contributing to the inefficiencies of the service. A team of foreign consultants also offered advice.

Although the Government did not implement all of the recommendations made at the Consultation, and the few other meetings that were held in its wake, it represented a level of interest in national opinion by the local administration. However, according to the T&TMA, "...eight years on, while some restructuring has taken place, very little reformation has occurred".[14]

The board that heads the North-West Regional Health Authority (NWRHA) holds a town meeting prior to the end of its term. At these meetings, a report of the previous year is delivered and there is a provision for questions from the public. The audience is usually very diverse, comprising citizens who receive its services and the Authorities' employers and employees. The last town meeting was held in March 2004, and the NWRHA is expecting the installation of a new board. This is perhaps the most official form of public debate that exists within the ambit of the health sector.

Reproductive Health

A large part of the health reform movement in Trinidad and Tobago focuses on the concept of reproductive health introduced at the International Conference on Population and Development (Cairo, 1994). Through the HSRP, the Government has demonstrated a commitment to improving the quality of and access to reproductive health.

As part of the drive to improve sustainability and performance in reproductive health service delivery, the only women's hospital in the country as well as the Caribbean – the Mount Hope Women's Hospital (MHWH) – is being integrated into the Eric Williams Medical Sciences Complex (EWMSC), a vast health services complex that is largely under-occupied and under-utilised. One of the many gains of this integration would be the provision of a greater number of hospital beds for women seeking medical attention.

The Population Programme Unit was established in 1969 to facilitate fertility management. This has been reorganised as a means of improving the health status of the national population by promoting and enhancing access, equity, quality, efficiency and sustainability in the delivery of reproductive health-care services. As its focus has been on maternal services and the provision of contraceptive options, especially for women, the population has reaped commensurate benefits with declining fertility rates. The Unit has also recently completed a nation-wide training programme for nurses to improve the quality of reproductive health care.

In 1989, the Government reconstituted its National Population Council and, after the 1994 ICPD, Trinidad and Tobago adopted a National Population Policy in 1997 as part of the HSRP. Under this 'Policy for the Reorganisation of The Population Programme Unit to Establish Sexual and Reproductive Health Services In Primary Health Care', the Government is mandated to provide gynaecological care, screening for breast and cervical cancers for women and prostate cancer for men, as well as HIV/AIDS-related services (screening, diagnosis, treatment). In addition, with the decentralisation of the national health system, over 100 government health centres now offer family planning as a part of maternal and child 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.

A local group, Advocates for Safe Parenthood Improving Reproductive Equity (ASPIRE), issued a press statement asking the Government to address the issue of maternal morbidity and mortality as it relates to unsafe abortions and in keeping with achieving the Millennium Development Goal (MDG) of improving maternal health.

Legislation and Norms

Trinidad and Tobago has signed the World Health Organization Declaration of Alma-Ata, which committed the country to the goal of health for all by the year 2000 that proceeded from the Beijing Platform for Action. This Declaration recognised women's right to the enjoyment of health as a basic human right, and the right of every human being to complete physical, mental and social well being, and the goal is to be achieved by the adoption of an extensive primary health-care strategy. This may also be taken as a re-affirmation of the country's broader commitment to health-care reform.

Accountability Mechanisms

This drive towards reform is relatively new and still at an inchoate stage. Checks and balances are expected to grow in relation to the developments within the sector, as it struggles to deal with its more immediate challenges of making safe and effective health care available to all.

Maternal Mortality

The challenges in collecting maternal mortality data are demonstrated by the conflicting information available. For example, the data in Table 23 are from UWI statistics and were compiled for a review of the Millennium Development Goals (MDGs). Table 24, on the other hand, uses data recorded by UNFPA to demonstrate the changes in maternal mortality post-ICPD.

Experiences during the research process also illustrated problems associated with obtaining accurate maternal mortality rates. For example, interviewees who were administrators at the Ministry of Health in Barbados stated that in fact the maternal mortality rate in the country had been zero in 2003. Further research is necessary to understand at which point data discrepancies are occurring.

Barbados

Antenatal clinics provide care for pregnant patients, monitor progress and initiate early interventions when the risks of complications are evident. The specific aim of the programme is to promote early registration of antenatal patients by the 12th week of gestation and regularly thereafter for monitoring maternal health and foetal growth as well as to prevent medical complications of the mother and the foetus. Approximately 49.9 per cent of antenatal clients are registered in the first 16 weeks of pregnancy; teenage pregnancies are 24 per cent of total pregnancies (Ministry of Health 2002).

Table 24: Estimated Maternal Mortality (MM) in Barbados, Jamaica, Suriname and Trinidad and Tobago, for ICPD Review (per 100,000 live births)

Country	MM Ca. 1994	MM Ca. 2004
Barbados	70	20
Jamaica	120	106.2
Suriname	88 (1998)	153
Trinidad and Tobago	NA	70.4

All pregnant women seen in polyclinics are referred to Queen Elizabeth Hospital at between 30 and 36 weeks for continued care and delivery (ibid.).

Jamaica

The Ministry of Health has taken several measures to reduce maternal mortality, which has seen a decrease. The ICPD field questionnaire lists the following efforts:

- 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 facility for transportation and referral to higher levels of care;
- High-risk antenatal registers in each parish to identify women for home visiting to ensure

Table 23: Estimated Maternal Mortality (MM) in Barbados, Jamaica, Suriname and Trinidad and Tobago, for MDG Review (per 100,000 live births)

Country	Population	MM 1990	MM 1995	MM 2000	Prevalence of Skilled Birth Attendants 1990-1995	Prevalence of Skilled Birth Attendants 1996-2000
Barbados	275,330	33	81	95	100	91
Jamaica	2,665,636	120	106	87	79	95
Suriname	417,000	230	153	110	98	
Trinidad and Tobago	1,274,799	68	70	160	98	99

Source: UWI data (Keith Hall)

compliance with care;
- In-clinic education for all antenatal clinic attendees regarding the warning signs in pregnancy and the appropriate courses of action.

According to Pate (1997), complications brought on by illegal abortions were among the leading causes of maternal deaths in Jamaica.

Suriname

Between 1986 and 1994, maternal mortality was the fifth leading cause of death in women. However, the Bureau of Public Health, which collects data, expresses difficulties with extrapolating to the per 100,000 ratio. Also, until this year they worked with the census figures from 1980 and tried to correct these with estimated prognoses. It is not yet clear how much information of the census held in 2003 has been saved from a fire. Recently, the General Bureau of Statistics announced that funds were being mobilised to re-collect the most crucial data. There is no policy yet on maternal mortality, although the corrected rates are alarming.

A study conducted in 1991-1992 stated that most incidents of maternal mortality were due to post-delivery haemorrhaging and pregnancy-induced hypertension, accounting for respectively 29 and 19 per cent of these cases. It further stated that these deaths could have been avoided if there had been timely transportation and blood transfusion available (Ketwaru-Nurmohamed 2001).

Health workers in the interior report malnutrition and chronic anaemia suffered by women and children. The anaemia gets worse when the woman gets pregnant. Women themselves do not regard it as a problem, but are in acute danger when the slightest thing goes wrong when they have to deliver. There are also reports that there is pressure in the Maroon community to have children early and to have a lot of them. This causes women in bad economic conditions to exhaust their bodies by having a baby every two or three years. The extra risks of teenage pregnancies have caused some doctors in the interior and rural areas to refer all teenagers to the capital for their first delivery (Guicherit and Pikin 2002).

Trinidad and Tobago

General rates of maternal mortality have declined slightly in the 1990s, falling from 76.2 per cent in 1994 to 70.4 per cent in 2001 (see Table 25).

The 'Policy for the Reorganisation of the Population Programme Unit to Establish Sexual and Reproductive Health Services in Primary Health Care' aims to improve the quality, availability, accessibility and use of sexual and reproductive health services – of which maternal health is a part. As one of its broad objectives, this policy proposes to reduce levels of maternal mortality.

The *Maternity Protection Act* of 1998 and the

Table 25: Maternal Mortality Rates, 1991-2001, Trinidad and Tobago

Year	Maternal Mortality
1991	49.18
1992	60.7
1993	66.4
1994	76.2
1995	67.5
1996	38.9
1997	70.4
1998	44.7
1999	38.2
2001	70.4

Source: Adapted from Republic of Trinidad & Tobago, Central Statistical Office, Population and Vital Statistics Report, 1999 and CEDAW Report, p. 91

Table 26: Maternal Mortality Rates, 1944-1960, Trinidad and Tobago

Year	Maternal deaths, including (septic) abortion
1944	11
1947	14
1951	10
1955	16
1960	7

Occupational Safety & Health (No. 2) Bill of 1999 are legislative initiatives that were enacted to ensure to some extent the protection of the woman and the unborn child.

In respect of pregnancy the *Occupational Safety & Health (No. 2) Bill* proposed to make the following provisions:

> (6) An employer shall, after being notified by a female employee that she is pregnant and upon production of a medical certificate to that effect, adapt the working conditions of the female employee to ensure that she is not (a) Involved in the use of, or exposed to, chemicals, substances or anything dangerous to the health of the unborn child; or (b) Subjected to working conditions dangerous to the health of the unborn child.

Declining maternal mortality rates are evidence of improvements being made to female sexual and reproductive health since the post-1969 independence period, and the efficiency in the delivery of primary health-care services now specifically targeting female reproductive issues.

Unsafe abortion, however, continues to contribute to maternal mortality rates. ASPIRE has publicised the death certificate of at least one woman who died from an unsafe abortion in 2000. There are other anecdoctal stories about women dying from unsafe abortions. Moreover, a glance at the Ministry of Health's Annual Reports shows that, although abortion is illegal, the problem has been documented for more than 50 years (see Table 26).

Outside of research conducted by ASPIRE, there is no investigation into the link between abortion and maternal mortality.

Abortion

Barbados

Available data on abortion comes from the Chief Medical Officer's Report for the years 2000-2001 (see Tables 27 and 28). Legal abortions represented 2.8 per cent of the leading causes for hospitalisation in 1995, compared with 3.9 per cent in 1992 (PAHO 2002).

Abortion Legislation

The *Medical Termination of Pregnancy Act* 1983-1984 provides for the lawful termination of pregnancy. In accordance with this Act:

1. Treatment for the termination of a pregnancy of not more than 12 weeks duration may be administered by a medical practitioner if he is of the opinion, formed in good faith,
   a. that the continuance of pregnancy would involve risk to the life of the pregnant woman

Table 27: Termination of Pregnancies (TOP) at Queen Elizabeth Hospital, Barbados, 1991-2001

Year	Teenage TOP	Total TOP	Teenage TOP as a % of total abortions
1991	163	709	23.0
1992	168	723	23.2
1993	122	593	20.6
1994	118	588	20.1
1995	86	484	17.8
1996	109	533	20.5
1997	105	583	18.0
1998	104	644	16.0
1999	123	526	23.4
2000	89	529	16.9
2001	104	645	16.1

Source: Ministry of Health 2002

Table 28: Termination of Pregnancies by Age of the Mother at the QEH, Barbados, 1997-2001

Age Group in Years	1997	1998	1999	2000	2001
<15	11	7	12	6	8
15-19	94	97	111	84	96
20-24	151	136	112	112	150
25-29	131	173	113	138	128
30-34	81	108	93	86	110
35-39	72	90	64	81	117
40+	42	33	21	22	36
Total	583	644	526	529	645

Source: Ministry of Health 2002

or give injury to her physical or mental health; or

b. that there is substantial risk that if the child were born, it would suffer such physical or mental abnormalities as to be seriously handicapped.

2. 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 subsection 1a.

For pregnancies between 12 and 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 treatment for the termination of pregnancy for a patient under the age of 16 years or of a patient of unsound mind of any age.

Termination is free once it is accessed through the public health system and satisfies the conditions set out in the legislation.

There are currently no statistics available on the number of deaths or illnesses attributable to abortions. Private sector doctors are supposed to report data regarding abortions; however, this is not respected and there is underreporting.[15]

Situation of Abortion

While abortion is legal in Barbados, anecdotal evidence suggests that many women continue to undergo unsafe abortions, evidenced through the admittance of women needing post-abortion care after seeking services in the private sector. Such cases are often recorded under miscarriage or com-

Understanding Abortion Law Reform Case Study Barbados: A 'Quiet' Advocacy Campaign

The liberalisation of abortion laws in Barbados came through the quiet advocacy of Billie Miller, currently acting as the 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 age who sought out abortion services. Miller has also spoken about 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 the Minister of Health and Social Security. During this time she struggled to find the right time to introduce legislation that would change the state of abortion laws. Fearing political backlash, Miller's political party dissuaded her from tabling abortion legislation around times of elections. Miller decided that she would begin a campaign of 'silent' advocacy, canvassing the various stakeholders in abortion laws and policy. She met with members of different churches, community leaders and fellow Ministers in government offices to convince them that liberalising abortion policy was a key element in protecting women's lives and health. Miller admits to feeling that she benefited from the fact that Barbados has a small Catholic community, as the Church has been a strong voice of opposition regionally and internationally to women's repoductive rights.

After spending six years on her campaign, Miller felt that it was time to propose the legislation. In order to introduce this, a bill first had to be drafted. However, the issue was not receiving priority in the Attorney General's Office. In an effort to take matters into her own hands, and through an unprecedented action, Miller raised funds through the International Planned Parenthood Federation (IPPF) to hire a draftsman to draft a bill.

When the bill was drafted, Miller was once again told that it was too close to elections to put forward legislation on abortion. However, in 1981, she was appointed the Minister of Education and Culture. Despite the fact that she no longer held her post in the Ministry of Health, Miller brought the bill to Cabinet and it was passed with no objection. Her quiet campaign of advocacy and activism paid off in the end with legislation that continues to save women's lives today.

plications of pregnancy and are therefore data is not available as to their frequency.[16]

In addition, the use of Misoprostol (Cytotec), a well-known abortifacient, has been documented in Barbados. The specifics of use, including how widespread it is and why women choose to use this drug, are not known (Arilha and Barbosa nd).

Jamaica

Currently, abortion is illegal in Jamaica and falls under the *Offences Against the Persons Act* of 1861. Debates around a woman's right to choose have not gone beyond periodic public discussion.

There is no law or regulation restricting information about abortion. The Medical Council of Jamaica supports the legalisation of abortion and has lobbied for the adoption of an abortion law modelled on the Barbados *Medical Termination of Pregnancy Act*, which allows for abortion before the 20th week of pregnancy and in cases of rape or incest (see above). It is felt that the absence of such legislation further marginalises the promotion, preservation and maintenance of the highest standards of sexual and reproductive health for Jamaican women (Simpson 2005).

A report, *Women of the World: Laws and Policies Affecting Their Reproductive Lives; Latin America and the Caribbean*, notes that "because abortion is illegal in most circumstances in Jamaica, it is difficult to obtain information on its prevalence" (Center for Reproductive Law and Policy 1997) .

A senior representative of the UNFPA in Jamaica indicated to this researcher that preliminary findings of a new Reproductive Health Survey, currently being conducted by the National Family Planning Board, show a 30 per cent drop in the number of women who get pregnant and who actually deliver – adolescents were particularly noted to feature in this finding. One conclusion being drawn from the finding is that abortion may be a significant contributing factor.

Anecdotal accounts indicate that abortions are carried out by doctors in private practice and, while it no longer carries out the procedure, the public Glen Vincent Clinic in Kingston reportedly refers persons for abortions in certain circumstances.

Abortion Legislation

The situation outlined in the report *Women of the World* remains the same today. This indicates that:

> "In Jamaica, abortion is prima facie illegal. It is a felony for anyone to perform an abortion or for a pregnant woman to attempt to abort her foetus by using any instrument, poison or other means…Where the abortion is performed by another person, the woman's consent to the abortion is no defence… Although the penal code provides no exceptions to its proscriptions against abortion, the common law has developed principles permitting specific exceptions." (Center for Reproductive Law and Policy 1997)

Under the law, persons performing or having/attempting abortions are subject to life imprisonment with or without hard labour. The penalty for procuring any poison or instrument for another, knowing she/he intends using it for performing an abortion, is three years with or without hard labour.

Despite the official status under the law, *Women of the World* (ibid.) points out that Jamaican common law follows the precedent set by the ruling in the English case *Rex v. Bourne*, which allowed that an abortion would not be unlawful when the operation was performed in good faith for the purpose of preserving the life of the mother.

In 1975, then Minister of Health and Environmental Control, Dr. Kenneth McNeil, issued a Statement of Policy on abortion. This "called for the amendment of the *Offences Against the Person Act* of 1864…so as to make clear when abortion would be lawful in Jamaica…and to take steps to make rape, carnal abuse and incest a lawful ground for abortion" (ibid.)

The practice in the public health sector was to provide abortion services where:

- two doctors recommend(ed) it on the basis that the pregnant woman is physically or mentally at risk;
- pregnant teenagers under the age of 17 were accompanied by a parent and proof of age was provided;
- a woman had been a victim of rape or incest, provided she was able to show documentary evidence that the pregnancy resulted from the crime committed against her;
- a pregnant woman was referred by the police, the Family Court or a family planning clinic operated by the Ministry of Health, if the referring agency provided proof of need.

The fact that abortions are illegal creates an environment of secrecy. The fact that they are nonetheless available in the public services but limited to certain circumstances means that many women who do not fit the criteria must either pay for the procedure privately, resort to 'back street' arrangements or carry the child to full term.

Management of the complications of 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 Ministry of Health to facilitate the review of the abortion legislation. The impetus for this statement was to better understand the maternal deaths associated with unsafe abortion.

Suriname

Figures on abortion cannot be obtained from the hospitals since abortions are registered under curettage. Findings of the Contraceptive Prevalence Survey conducted in 1992 suggest that 88.7 per cent of all women aged 15-44 never had an abortion (Jagdeo 1993).

Stichting Lobi, however, estimates that between 8,000 and 10,000 abortions take place annually, with a strong representation of women under the age of 24 (Leckie 1997). This implies almost a 1:1 ratio with live births annually. A sample survey of clients of the Lobi clinic revealed that 34 per cent of the women had had at least one abortion.[17] In 1999, a study done in the interior suggested that young girls are very well informed about both modern and traditional methods of abortion (Terborg and en Boven 1999).

Understanding traditional methods of abortion has been difficult due to the diverse practices of different ethnic and cultural groups and the lack of research conducted on the topic. For example, the Javanese use massage techniques for all their reproductive problems, while the Maroons mostly use herbs. Since women in general are reluctant to talk about abortion, there are no scientific data on whether this works and whether it is safe. Anecdotal evidence tells the story of one family (partly Maroon, partly Creole) in which women tell each other to drink the water of a very young coconut. It is said to loosen the foetus and 'rinse' it out of the womb. There has been no scientific effort to determine how effective such methods may be.

Stichting Lobi initiated discussions on abortion several times, through live debates and television talk shows. Though it is silently tolerated, abortion as a right is not advocated. It is interesting to note that attitudes are ambivalent even among women activists and health workers. Recent research in a peri-urban neighbourhood showed that 45 per cent of health workers considered abortion to be murder and thought it should be forbidden (Terborg, Grunberg and Eiloof 2004).

Abortion Legislation

Abortion in Suriname is illegal. According to the law, a woman who intentionally induces abortion is subject to three years imprisonment. The person who conducts the abortion is subject to four years and six months imprisonment and up to 12 years if the woman did not consent. If the woman dies, the penalty is increased to up to six years imprisonment in the former circumstances, and up to 15 years in the latter. If the person performing the abortion is a medical practitioner, midwife or pharmacist, the above-mentioned penalties may be

increased by one-third and the person can be barred from practicing her or his profession.

The code prohibits a person from treating a women or providing treatment to her knowing that thereby her pregnancy may be destroyed. An abortion can, however, be done to save the life of the woman.[18]

Although this law, which was modelled on an old Dutch law, has never been modified, it is not enforced. Moreover, during the research it turned out that most key persons were convinced that abortion was legal in Suriname. The only barrier to having a safe abortion by a real doctor in a real hospital is the money or the distance. Like all prices, the price for abortion has gone up: from SRD 300 in 2002, to SRD 600 in 2004 (about US$222, more than an average monthly salary).

Post-Abortion Care

There is no care after an abortion. The procedure takes place as a polyclinic consultation and the patient is supposed to leave immediately afterwards. Anecdotal evidence suggests that surgeons tend to be more concerned about money than consultation services. When questions were asked, they 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 this from happening in the future. Since abortion that is not on medical indication is illegal, no policy or protocol exists, there is no training and it definitely has no place in the health sector reform debate.

Trinidad and Tobago

In a 1999 PAHO/WHO Report, Trinidad and Tobago was identified as one of the countries in the region where abortion and its complications were the leading causes of maternal morbidity. This has been a huge burden from as early as the 1950s (see Table 29). Table 30 shows that, 40 years later, unsafe abortion remains widespread.

This is clearly a major public health problem. Every year admissions for unsafe abortion were among the top ten leading causes of hospital admissions, competing with intestinal infections, other injuries and skin infections. In at least two years - 1991 and 1992 - complications from abortion were the No. 1 cause of hospital admission. Complications include haemorrhage, fistula, pelvic infection disease, sepsis and incomplete abortion. ASPIRE suggests that these problems would be avoided if the Government would decriminalise abortion so that safe services can be provided to all women.

On average, each of these women will spend approximately four days in the hospital and will require blood tests, blood transfusions, medication and IV treatments. It is estimated that as a result of these needs, the Government spends approximately TT$9 million (approx. US$1.4 million) per year in treating women who are suffering from the complications of unsafe abortion.

Table 29: Hospital Admissions for Complications of Abortion, 1950s, Trinidad and Tobago

Year	Port of Spain Hospital	San Fernando Hospital
1953	954	633
1954	1,090	619
1956	1,379	927

Table 30: Reported Abortions, 1992-1997, Trinidad and Tobago

Hospital	1992	1993	1994	1995	1996	1997
Port of Spain	703	563	1,059	1,179	940	631
Mount Hope Women's	NA	NA	1,238	1,074	1,175	1,304
San Fernando	1,288	1,251	1,452	1,300	1,492	1,329
Sangre Grande	138	133	183	161	218	158
Pt. Fortin	83	72	32	93	28	65
Scarborough	259	196	188	179	182	188
Total	3,465	3,259	4 152	3 986	4,035	3,675

Source: Hospital admission and discharge records

It is estimated that more than a third of gynaecological beds are occupied by women with abortion complications and, according to ASPIRE records, 90 per cent of medical practitioners interviewed believe that a civil law would reduce the number of complications, while 65 per cent agree that a civil law would save the Government money. While they were divided on the extent to which a civil law would improve maternal health, more than half (56 per cent) felt that it would. 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.[19]

Table 31: Types of Abortion as Reported in the Ministry of Health's Annual Report, 1991-1993, Trinidad and Tobago

Types of Abortion	1991		1992		1993	
	Cases	LOS*	Cases	LOS*	Cases	LOS*
Spontaneous	19	59	34	204	22	70
Legally induced	3	25	4	38	2	2
Illegally induced	22	58	29	79	11	29
Other	2,778	8,398	3,465	11,112	3,259	9,025
Total	2,822	8,540	3,532	11,433	3,294	9,126

*Note: *LOS = length of stay (days).*

Table 32: Number of Abortions at Public Health Sector Facilities, 1994, Trinidad and Tobago[a]

Types of Abortion	Number
Spontaneous Abortion	23
Legally Induced Abortion	4
Illegally Induced Abortion	12
Other Abortions[b]	4,226
TOTAL	4,265

Notes:
[a] Data does not reflect abortions in the private sector, statistics on which remain unavailable.
[b] Unspecified incomplete abortions, including induced abortions.

Source: CEDAW Report

Estimate of Numbers of Abortions (illegal or legal)

The incidence of abortions is unknown. Crude estimates exist but they in no way truly reflect the number of operations that are performed every year. According to one hospital, D&C (dilation and curettage) was performed 1,177 times in 1999 and 615 times over the period of June-September 2000.[20]

While data regarding abortions is available for public health institutions, it only represents a small percentage of women – i.e., those who experience related complications. Not every back-street abortion ends up in a hospital. Thus, all of the abortions that do not result in complications remain unrecorded. In addition, those performed at private centres are not accounted for even though it is estimated that 60 per cent of private gynaecological practitioners offer these services.

Based on its research, ASPIRE has estimated that there are as many abortions as births, about 19,000 per year.[21]

Abortion Legislation

Under Trinidad and Tobago's *Offences Against the Person Act*, Sections 56 and 57, Chap. 11:08, of 3 April 1925, abortion is a criminal offence. 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.

The law in its present state is extremely ambiguous because it does not provide guidance to medical practitioners about when an abortion can be *lawfully* performed. As a result, medical practitioners believe that all abortions are illegal. Consequently, when they perform abortions, which many private doctors do, they do so under the cover of secrecy. Research conducted by ASPIRE indicates that over 51 per cent of all women in the country will have

UNDERSTANDING ABORTION LAW REFORM CASE STUDY

Trinidad and Tobago: An Emphasis on Outreach and Alliances

In 2000, Advocates for Safe Parenthood Improving Reproductive Equity (ASPIRE) publicly announced that it was calling on the Government of Trinidad and Tobago to reform the criminal abortion law and enact a civil law that would allow abortion on request in the first trimester.

Until 2004, ASPIRE was the only vocal pro-choice organisation calling for the decriminalisation of abortion. On 28 May 2004, however, in recognition of the International Day of Action for Women's Health, CAFRA Trinidad and Tobago and a newly formed group of lawyers called the Lawyers for Reproductive Rights (LRR) joined ASPIRE in a press conference calling for abortion law reform. The groups received press coverage in two of the three major daily newspapers and on the local cable television news.

ASPIRE's mission is to achieve reproductive equity for all citizens of the country. The campaign for abortion law reform, however, is its major initiative. It has attempted to generate public discussion and dialogue on the issue of abortion. The dialogue involves the Church (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 community persons.

Letter writing is part of ASPIRE's strategy in attempting to change the law, and so the organisation frequently sends letters to the editors of the daily local newspapers. Not all of the letters sent are published, but when they are, this is a catalyst for public debate. ASPIRE has also utilised radio and television programmes and has recently announced that it will be circulating a statement of support that individuals and organisations can sign to express their agreement with ASPIRE's campaign to urge the Government to change the abortion law.

ASPIRE's abortion law reform campaign also includes meetings with interest groups, parliamentary representatives and ministry officials. In addition, ASPIRE has a website, www.ttaspire.org or www.aspire.org.tt, that includes information for the public.

With respect to government and parliamentary agitation for change, the group has completed a draft *Women's Choice on Pregnancy Bill* that was presented to the public on 28 May 2004. It has directed a copy of this draft Bill to the Attorney General and has requested a meeting with him to discuss the status of the current criminal law. The Lawyers for Reproductive Rights group has also requested such a meeting.

According to ASPIRE, the public perception of its work and function as the 'abortion group' that promotes abortions freely precludes widespread open support from many individuals and groups who, although they privately agree with the cause, shy away from being associated with ASPIRE 's work due to fear of being typecast. However, a number of individuals – including prominent Trinidadian businessman Emile Elias – have publicly expressed their concern about the issue and have provided the group with financial assistance. In spite of the obstacles, ASPIRE is in the process of developing a wider base of local support.

Allegiances also currently exist between ASPIRE and other bodies in the Caribbean, Latin America, North America and Europe. Its main partners are the Latin American and Caribbean Women's Health Network, International Projects Assistance Service (Ipas), Catholics for a Free Choice (CFFC) and the Planned Parenthood Federation of America International (PPFA-I).

at least one abortion by age 44.[22] Consequently, the criminalisation of abortion affects most women of reproductive age.

The fact that all abortions are deemed to be criminal, except for abortions performed to preserve the life of the woman, also means that health-care providers generally do not receive official, structured guidance on providing abortion services. In addition, their services are not regulated by the Government in any way, and therefore any abuses or malpractice that occurs may at times not be remedied. Women are sometimes subjected to abuse during termination of pregnancy procedures and are left to suffer in silence.

As a result of the fact that abortion is criminal, public hospitals and clinics by and large only offer post-abortion care services. Consequently, women who cannot afford the fees of private doctors are forced to either seek unsafe abortions from providers who are not trained to deliver health services, self-induce an abortion or carry their pregnancies to term. This situation constitutes a violation of human dignity and results in over 4,000 low income and socially disadvantaged women each year ending up in public hospitals in need of emergency care.

ASPIRE is not aware of any policy initiatives on post-abortion care. It is the group's belief and experience that no significant progress can be made concerning post-abortion care until the law is changed.

Endnotes

[1] Interview with Eleanor Smealy, Barbados Family Planning Association.
[2] The National Health Fund was introduced in 2003.
[3] The Family Planning Agency, Stichting Lobi, is an autonomous NGO, and therefore not dependent on government subsidies.
[4] RGD Management Information System, 2003.
[5] Ibid.
[6] Interview with doctors from the Regional Health Service in the district of Marowijne, 2002.
[7] Seminars on Health Sector Reform, Ministry of Public Health/ PAHO.
[8] Ibid.
[9] The 2001 Situation and Response Analysis (SARA) gives different estimates. Since the number of civil servants has increased over the years, it seems unlikely that family members who are co-insured are counted.
[10] Constitution of the Republic of Suriname, Department 10, Article 36.
[11] Apart from regular bilateral development cooperation with the Netherlands, Suriname is also entitled to an amount of money that was agreed upon when gaining Independence, the so-called Treaty Funds. The Netherlands wanted these funds to be invested in the sectors that they selected, of which health is one.
[12] www.healthsectorreform.gov.tt
[13] CEDAW Report.
[14] www.healthsectorreform.gov.tt
[15] Barbados ICPD review by UNFPA.
[16] Interview with staff member of QEH.
[17] Stichting Lobi, Sample Survey Clients 1988-1989.
[18] UN population information.
[19] Brief Notes of Abortion Research, ASPIRE, 2000.
[20] CEDAW Report.
[21] Brief Notes of Abortion Research, ASPIRE, 2000.
[22] Ibid.

4. Making the Connections between Health Sector Reform, Maternal Mortality and Morbidity, and Abortion

Abortion and Maternal Mortality

Abortion as it relates to maternal mortality is underreported and could account for 30 per cent of maternal deaths, most of which are caused by haemorrhage or sepsis. In some hospitals in the Caribbean, 50 per cent of gynaecology beds are occupied by patients with incomplete abortions – and some patients have been repeatedly admitted for incomplete abortions (Pate 2002).

In some years abortion has been the second leading cause of maternal mortality in Trinidad and Tobago and one of the leading causes of maternal death in Jamaica.

The in-depth health systems overview demonstrated that countries have identified women's health as an issue this tends to fall within two broad categories: basic maternal health or HIV/AIDS/STIs. The latter is normally packaged within the context of PMTCT programmes. Table 33 illustrates the absence of conversation and discussion regarding maternal mortality and morbidity in the health sector reform process that leads to a failure to meet women's health needs.

The lack of prioritisation of abortion-related maternal morbidity and mortality issues has historically occurred in countries regardless of the legal status of abortion. This has only changed in 2005 with the

Table 33: Health Sector Reform, Maternal Mortality and Abortion

Country	Connection between Health Sector Reform and Abortion	Connection between Health Sector Reform and Maternal Mortality	Connection between Health Sector Reform, Maternal Mortality and Abortion
Barbados	Conversations on health sector reform have remained largely silent on the topic of abortion.	The Barbados Strategy for Health contains the maternal mortality policy.	No direct linkages made between maternal mortality and abortion in the context of health sector reform.
Jamaica	Conversations on health sector reform have remained largely silent on the topic of abortion.	Health sector reform in Jamaica has historically been inclusive of maternal and child health.	No direct linkages made between maternal mortality and abortion in the context of health sector reform.
Suriname	Conversations on health sector reform have remained largely silent on the topic of abortion.	No specific mention of maternal mortality; maternal health would fall under improvement of primary health care.	No direct linkages made between maternal mortality and abortion in the context of health sector reform.
Trinidad and Tobago	While conversations on health sector reform have remained largely silent on the topic of abortion, ASPIRE has initiated public dialogue on abortion.	Reproductive health has been a focus of health sector reform.	No direct linkages made between maternal mortality and abortion in the context of health sector reform outside of initiatives taken by ASPIRE to raise awareness around unsafe abortion.

recent interest of the Jamaica Medical Council in making abortion-related maternal mortality a priority policy area. Unfortunately, such a trend has not been noted in other countries in the region where abortion is currently illegal. Most startling and perhaps unique to the Caribbean region, however, is the number of women who do access safe abortions despite the criminalisation of the medical procedure. Research suggests that women who can afford to pay for such services, can access them under appropriate physician care. Women who do not have the means to pay for abortion, however, continue to turn to unsafe methods.

Table 34 presents the legislation, the practice and the reality of women's access to abortions. Reproductive rights activists from within the region have offered perspectives on where, why and how this gap between theory and practice exists. The reliance on activists to fill in the details is symbolic of the lack of qualitative and quantitative data on abortion in the region. The alignment of appropriate legislation, policy and service delivery depends on the prioritisation of abortion-related mortality issues in the context of health sector reform.

Table 34: Abortion Policy v. Practice in Barbados, Jamaica, Suriname and Trinidad and Tobago

Country	Abortion: the Policy/Law	Abortion: the Practice[1]	Reason for the Difference
Barbados	The *Medical Termination of Pregnancy Act* of 1983-4 provides for the lawful termination of pregnancies: The treatment for the termination of a pregnancy of not more than 12 weeks duration may be administered by a medical practitioner if he is of the opinion formed in good faith A) that the continuance of the pregnancy would involve risk to the life of the pregnant woman or grave injury to her physical or mental health; or B) that there is 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 subsection 1a.	Women are able to access abortions free of charge in the public health system. Abortions are also provided under particular conditions (those stipulated by the legislation) at the Barbados Family Planning Association. Abortions are available in the private sector. Despite the existence of free and safe abortions, anecdotal evidence suggests that some women take abortifaciants. In addition, anecdotal evidence also suggests that woman appear in public sector hospitals with incomplete or 'botched' abortions from the private sector.	The continued use of unsafe methods of abortion could be due to fear of stigmatisation by abortion providers. Additionally, given the population size and the presence of only one public hospital, issues of confidentiality may keep women from accessing abortion services in the healthcare system. These challenges could potentially be remedied through sensitisation of providers through training. Further qualitative and quantitative research is needed in order to better understand the nuanced dynamics associated with access to abortion services.

	For pregnancies between 12 and 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 treatment for the termination of pregnancy for a patient under the age of 16 years or for a patient of unsound mind of any age.		
Jamaica	Abortion is illegal and falls under the *Offences Against the Persons Act*. Jamaican common law follows the precedent set by the ruling in the English case *Rex v. Bourne* which allows that an abortion should not be unlawful when the operation is performed in good faith to preserve the life of the mother.	The practice in the public health sector is to provide abortion services when: • Two doctors recommend it on the basis that the pregnant woman is physically or mentally at risk; • Pregnant teenagers under the age of 17 are accompanied by a parent and proof of age was provided; • A woman has been a victim of rape or incest provided she is able to show documentary evidence that the pregnancy resulted from the crime committed against her; • A pregnant woman is referred by the police, the Family Court or a family planning clinic operated by the MOH if the referring agency provides proof of need. If a woman does not fit the criteria and seeks to have an abortion, she must either pay privately for the procedure or seek 'back street' services. According to Pate (1997) complications brought on by illegal abortions were among the leading causes of maternal deaths in Jamaica. Anecdotal accounts indicate that abortions are carried out by doctors in private practice and, while it no longer	There has been little disagreement with abortion to protect the life and/or health of the mother. Indeed the Church in Jamaica has indicated its agreement with this. It is abortion on demand, and set within the framework of reproductive rights, that Church leaders and a significant and vocal sector of the society strongly oppose as a 'sin'. 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 one of the definitions of masculinity, which is male 'headship', i.e., having decision-making power that supersedes that of women. It is also considered to be undermining the aspect of the definition of masculinity that is based on sexual prowess and virility as manifested in having children. The law may not have been formally changed to date due to the expected backlash or outcry by the Church – in particular Roman Catholics and fundamentalists – as well as elements within the dominant male culture in Jamaica. Some entertainers and some religious leaders in particular denounce abortion as criminal. This stig-

		carries out the procedure, the public Glen Vincent Clinic in Kingston reportedly refers persons for abortions in certain circumstances.	matises women, practitioners and potential activists; The lack of a general rights perspective in public policy and programming, in particular where women are concerned, undervalues the importance of this issue as a key policy and programme priority.
Suriname	Abortion in Suriname is illegal. A woman who intentionally induces abortion is subject to three years imprisonment. The person who conducts the abortion is subject to four years and six months imprisonment, and up to twelve years if the woman did not consent. If the woman dies, the penalty in increased to up to six years imprisonment in the first situation and up to 15 years in the second. If the person performing the abortion is a medical practitioner, midwife or pharmacist, the above-mentioned penalties may be increased by one third and the person can be barred from practicing her or his profession. The code prohibits a person from treating a women or providing treatment to her knowing that thereby her pregnancy may be destroyed. An abortion can be done to save the life of the woman.[2]	Safe abortion is accessible to any woman who can afford one. Recent research (2004) shows that 45 per cent of health workers in one peri-urban area considered abortion murder and felt that it should be forbidden. In 1999, a study conducted in the interior of Suriname suggested that young girls are well informed about modern and traditional means of abortion. A sample survey of visitors to the Stiching Lobi clinic revealed that 34 per cent of the women had had at least one abortion. Post-abortion care is not provided. Abortion is done as a polyclinic operation and the patient is supposed to leave as soon as she is physically able to. An abortion can be done to save the life of the woman.[3] The law, which was modelled after an old Dutch law, was never modified. In practice, however, it is not used. The only barrier to having a safe abortion by a real doctor in a real hospital is the money. Like all prices, the price for abortion has gone up: from SRD300 in 2002, to SRD600 in 2004 (equals US$222, more than an average monthly salary). Figures cannot be obtained from the hospitals since abortions are	The difference between law and practice concerning abortion is not exceptional. 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. It is possible that doctors do not want to wake sleeping dogs (religious groups), and the women's movement so far has not been able to come to a collective point of view (support of ICPD notwithstanding). Therefore, there is no group actually lobbying for abortion to be legal. 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, they would in the end choose not to do so because of the public embarrassment.

		registered under curettage. Findings of the 1992 Contraceptive Prevalence Survey suggest that 88.7 per cent of all women aged 15-44 have never had an abortion (Jagdeo 1993). Stichting Lobi, however, estimates that between 8,000 and 10,000 abortions take place annually, with a strong representation of women under the age of 24 (Leckie 1997). This implies almost a 1:1 ratio with live births annually. A sample survey of clients of the Lobi clinic revealed that 34 per cent of the women had had at least one abortion.[4] In 1999, a study done in the interior suggested that young girls are very well informed about both modern and traditional ways of abortion (Terborg and en Boven 1999.	
Trinidad and Tobago	*Offences Against the Person Act* Chap. 11:08: 56. Every woman, being with child, who, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or unlawfully uses any instrument or other means whatsoever with the like intent, and any person who, with intent to procure the miscarriage of any woman, whether she is or is not with child, unlawfully administers to her or causes to be taken by her any poison or other noxious thing, or unlawfully uses any instrument or other means whatsoever with the like intent, is liable to imprisonment for four years. 57. Any person who unlawfully supplies or procures any poison or other noxious	Many private doctors and private facilities provide abortions. This widespread practice of abortion is clearly a major public health problem The practice of admission for unsafe abortion is so routine that in some of the larger hospitals special arrangements have been made to manage these patients. In spite of the law, women with money have easy access to safe abortions from private practitioners. Poor women with similar needs are forced to take risks with unsafe practices. Unsafe abortion has been a leading cause of hospital admission for over 50 years. In some years it is the leading cause of hospital admission.[5] Medical abortions are very	The current law is obsolete. It was established when abortion was a risky procedure and the death rate associated with it was high. Today, abortion is probably the most commonly performed surgical procedure in the country and there are virtually no complications when trained medical practitioners provide treatment. In spite of recording several 'illegal' abortions and thousands of 'other' abortions every year, no legal action is taken against anyone. The truth is that no society has ever effectively enforced this law. Women with unwanted pregnancies will take risks. The law is irrelevant only to those who can afford to pay. This is precisely why it persists. It is not a nuisance to persons of influence and stature.

	thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she is or is not with child, is liable to imprisonment for two years. At common law, under the doctrine of necessity, a medical doctor is empowered to terminate a pregnancy if in his clinical judgement the procedure is necessary to preserve the life of the mother. In the 1938 UK case of *Rex v. Bourne*, Lord McNaughton extended the doctrine of necessity to include danger to the mental health of the pregnant woman. Abortion is therefore legal under restrictive circumstances.	prevalent – the use of drugs (such as Misoprostol or Cytotec) to have an abortion. The criminal law does not lend itself to regulations and so there are no standards of care and protocols. The indiscriminate use of this drug without proper follow-up care etc. often results in grave harm to women.	Persons who possess the political influence to change the law have the economic means to escape its grasp. Those with voice have no need, while those with the need have no voice.

Endnotes

[1] Based on research conducted during the completion of this report.
[2] UN population information.
[3] Ibid.
[4] Stichting Lobi, Sample Survey Clients 1988-1989.
[5] Ministry of Health Annual Reports, 1991-93.

5. Conclusions and Recommendations

The international community has committed itself in a series of political and legal agreements to promote and fulfil sexual and reproductive health and rights. Governments at the International Conference on Population and Development (ICPD) in 1994 agreed to a holistic definition of reproductive health, and at the Fourth World Conference on Women, held in Beijing in 1995, sexual rights were acknowledged as integral to human rights and women's empowerment. These commitments have been renewed in the five- and ten-year reviews of Cairo and Beijing and acknowledged as a key means of implementing agreements such as the Millennium Development Goals (MDGs), which prioritises the reduction of maternal mortality.

In order for Caribbean countries to continue their leadership in the realm of sexual and reproductive rights while fulfilling their obligations both in international forums and to individuals in their countries, there has to be a commitment to reducing maternal mortality and morbidity generally, and particularly in relation to unsafe abortion.

The following are recommendations derived from the above presentation of data and information to move the region closer to the full respect, protection and fulfilment of women's human rights as they pertain to individual and maternal health. In particular, several steps have been identified that would reduce the incidence of incomplete and unsafe abortion.

These recommendations should be examined closely in the context of health sector reform and health systems planning processes. Each recommendation should be understood in the context of a rights-based approach.[1]

Recommendations: Steps to Reduce Maternal Mortality as it Relates to Abortion

Data

The high levels of maternal morbidity and mortality in many Caribbean countries specifically associated with unsafe abortions leads researchers to believe that women's reproductive health needs are not being met. Indeed, this research highlights the fact that the dearth of knowledge and information available about maternal mortality and abortion prevents an accurate assessment of women's health needs. The following recommendations seek to fill this gap in the gathering and management of data:

- In-country and regional standardisation of quantitative data collection in medical institutions, which would include private and public hospitals as well as other settings to standardise data as they pertain to maternal mortality and abortion.
- Collection of qualitative and quantitative data on:
  - women's access to abortion services, experience with abortion providers, and experiences with abortions;
  - the prevalence of self-administered abortion in the region;
  - the impacts of violence against women, particularly as it relates to the ability and desire to access abortion services;
  - the relationship, if any, between violence against women, socio-economic status, rape and incest, contraceptive delivery services, etc.
- All data should be disaggregated by age, sex, gender, socioeconomic status, race, locale (rural/urban) and other criteria.

Focus on Gender

Mainstreaming gender into programmes and policies allows for a more thoughtful programme and policy planning process inclusive of the various dynamics that affect access to health services. The following recommendations suggest the need for a stronger focus on gender mainstreaming:

- Integration of a gender perspective throughout the health reform process and design of health reform strategies. This can be accomplished through a gender assessment of the current health reform strategy. The applied gender perspective would be inclusive of various socio-political and economic factors that impact access to quality services, including but not limited to race, class, sexuality, locale (urban/rural) and age.
- Training of health-care providers to prevent stigmatisation and discrimination of individuals seeking abortion related services.

Appropriate and Integrated Services

Vertical funding structures have worked to limit the integration of health services. This has had a detrimental impact on the delivery of sexual and reproductive health care. Additionally, the focus on maternal health has prevented the development and implementation of appropriate health services for young people, particularly women.

- Integrate HIV/AIDS prevention of mother to child transmission programmes (PMTCT) into maternal and child health programmes, assessing clearly the impact of PMTCT on mothers' as well as children's lives.
- Broaden the scope of reproductive health services to include sexual and reproductive health with a focus on rights.
- Increase the focus on adolescent sexual and reproductive health services, including legislative and policy reform to rectify current laws that act as barriers to accessing services for young people.
- Where abortion is legal, provide training to service providers on abortion counselling and support to better serve the needs of the patient.
- Develop and implement sexual education programmes for young people.

Legislation and Policy

The enabling environment created through policy allows for the most effective implementation of services and programmes. The following recommendations advocate strongly for the legalisation of safe, accessible abortion services and an increased focus on programmes addressing maternal mortality and morbidity:

- Prioritisation of women's health both in general and specifically in regard to maternal mortality and morbidity related to abortion in health sector reform processes.
- Integration of HIV/AIDS programmes into reproductive health services.
- Sensitisation of hospital staff to diversity of clientele, particularly regarding sexual diversity.
- Legislative reform pertaining to abortion in order to create an environment where safe and legal abortions can be obtained.
- Initiatives to educate women about the potential harms of unsafe abortion and about medical abortion to encourage safe and sterile provision.
- Policy research should be conducted to understand the impact of external factors (e.g., religion) on reproductive health decision-making.
- Ensure comprehensive education programmes for school populations including information on abstinence, teen pregnancy, contraceptives, abortion and HIV/AIDS, etc. in an effort to reduce these problems.

Research of external factors that impact reproductive decision-making

This research begins an important discussion around issues that impact reproductive decision-making. Understanding the reproductive choices of individuals translates into appropriate policy responses and service delivery.

The following is an initial list of topics to explore in the context of improving health:

- The impact of religious fundamentalism on

health policy and service delivery.

- The stigma and discrimination faced by members of the lesbian, gay, bisexual and transgender (LGBT) community when attempting to access health services.
- The stigma and discrimination faced by sexually active women.
- The impact of economic vulnerability on sexual decision-making
- The effect of the personal politics of service providers on reproductive decision-making.
- The diversity of factors impacting decision-making regarding health (sexual and reproductive health rights in particular) among the various socio-economic, regional and ethnic groups in the region.
- The impact of violence against women on women's sexual and reproductive health.
- The intersection between HIV/AIDS and other STIs on sexual decision-making.

Endnote

[1] "A rights-based approach to development is a conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights.

"Essentially, a rights-based approach integrates the norms, standards and principles of the international human rights system into the plans, policies and processes of development. The norms and standards are those contained in the wealth of international treaties and declarations. The principles include equality and equity, accountability, empowerment and participation." (UNHCR. http://www.unhchr.ch/development/approaches-04.html. Downloaded 12 October 2004.)

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"There is especially need for discussions on the links between health sector reforms and the outcomes of the International Conference on Population and Development (ICPD); between sexual and reproductive rights, abortion and maternal morbidity and mortality; and between gender equality and women's empowerment and the spread of HIV/AIDS... [T]his study can be used to highlight these linkages and strengthen the work of feminist advocacy in this area."

— From the Introduction by Peggy Antrobus

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